

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER ATLAS REHABILITATION AND HEALTHCARE A		STREET ADDRESS, CITY, STATE, ZIP CODE 100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Survey: 11/25/2024</p> <p>Census: 117</p> <p>A project survey was conducted on 11/25/2024 at Atlas Rehabilitation and Healthcare at Maywood regarding renovation to expand the Physical Therapy Gym and Occupational Therapy Suite, new salon, common bathrooms, lobby, laundry and office areas was found to be in compliance with N.J.A.C 8:39-31.1 and NFPA 101:2012.</p> <p>The identified areas may not be occupied until the New Jersey Certificate of Need and Licensing notifies the facility of approval.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/29/24