	-	ID HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES					<u>O. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		E SURVEY PLETED
		315386	B. WING				C // 19/2024
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 0-	15/2024
		ALTHCARE AT MAYWOOD		100	WEST MAGNOLIA AVENUE		
				MA	YWOOD, NJ 07607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00			
	conducted by Healtho	Complaint Survey was care Management Solutions, / Jersey Department of					
		06, NJ1153352, NJ1153561, 2, NJ156261, NJ157557, 7, and NJ165747.					
	Survey Dates: 02/15/	24 - 02/18/24					
	Survey Census: 106						
	Sample Size: 29						
F 880 SS=D	42 CFR PART 483, S TERM CARE FACILI RECERTIFICATION A Infection Prevention 8	THE REQUIREMENTS OF UBPART B, FOR LONG TIES BASED ON THIS AND COMPLAINT VISIT. & Control	F 8	80			4/22/24
	infection prevention a designed to provide a comfortable environm	blish and maintain an nd control program a safe, sanitary and nent and to help prevent the nsmission of communicable					
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:					
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE
Electroni	cally Signed						05/08/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 08/05/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315386	B. WING			_		C 19/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ATLAS RE	HABILITATION AND HEA	ALTHCARE AT MAYWOOD			00 WEST MAGNOLIA AVE IAYWOOD, NJ 07607	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	reporting, investigatin and communicable dis staff, volunteers, visite providing services und arrangement based u conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicab- infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the ir involved, and (B) A requirement tha least restrictive possite circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir	m for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other n possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: tion of the isolation, nfectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable in lesions from direct or their food, if direct ne disease; and procedures to be followed	F	880				

If continuation sheet Page 2 of 6

CENTER	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MUU			FORM	D: 08/05/2024 MAPPROVED D: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· /			COMP	C
		315386	B. WING				
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ATI AS RE	HABII ITATION AND HEA	ALTHCARE AT MAYWOOD		10	00 WEST MAGNOLIA AVENUE		
				N	IAYWOOD, NJ 07607		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page identified under the fa corrective actions take §483.80(e) Linens. Personnel must handl transport linens so as infection. §483.80(f) Annual rev The facility will conduct IPCP and update thei This REQUIREMENT by: Based on observation and review of the facil failed to maintain an e program for one of four NJ ex order 26.40 out of 29 samp wear the required per (PPE) while performing enhanced barrier prece Findings include: Review of the facility f Barrier Precautions, " the facility, revealed " facility to implement e for the prevention of the multidrug-resistant or Definitions: "Enhance refer to an infection con	2 cility's IPCP and the en by the facility. e, store, process, and to prevent the spread of iew. ct an annual review of its r program, as necessary. is not met as evidenced n, interview, record review, ity's policies, the facility effective infection control ur residents (Resident (R) 5) 1 led residents. Staff failed to sonal protective equipment g V ex order 26.401 for R5 on cautions.		880	DEFICIENCY) WHAT CORRECTIVE ACTION WILL ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On WOODFFOOD, CNA2NJ ex order 26.4b1 Resident 5 NJ ex order 26.4b1 Resident 5 NJ ex order 26.4b1 Note HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY TO SAME DEFICIENT PRACTICE All residents on enhanced barrier precautions have the potential to be affected by this deficient practice.	BE 01 d.	
	organisms that emplo gloves use during hig activities 4. High-c activities include: a. D	n contact resident care ontact resident care			WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR		

Facility ID: NJ60203

If continuation sheet Page 3 of 6

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		315386	B. WING		C 04/19/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/15/2024
ATLAS RE	EHABILITATION AND HE	ALTHCARE AT MAYWOOD		100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 880	linens f. Changing briefs or a Device care or use: c catheters, feeding tub tubes h. Wound care: a dressing" Observation on 04/16 signage posted on R ⁴ the resident was on Market a state of the resident's name p PPE cart with yellow second drawers locat Continued observation wearing the appropria Nursing Assistant (CN Market appropria Nursing Assistant (CN Mark	assisting with toileting g. entral lines, urinary bes, tracheostomy/ventilator any skin opening requiring 5/24 at 1:25 PM revealed 5's bedroom door indicating J ex order 26:4b1 P" sign was posted below blate, and a three-drawer gowns in the first and ted outside of the room. In revealed, while not ate PPE (gown), Certified NA) 2 Wexoder 20:4b1 der R5 with gloves on while 26:4b1 bservation with CNA2 t wear a gown while tare to R5 because she did wer PPE cart outside of the , or the N Exec Order 26:4b1 he door. ed "Admission Record" nic Medical Record (EMR) o stated R5 was admitted to with diagnoses which	F 880	 On 4/17/24, the facility educator erall facility nursing and therapy stafe enhanced barrier precaution policy including the PPE requirements. Each week x 4 weeks, DON/desig conduct an audit on enhanced barr precautions and PPE requirement compliance. Following the first 4 w the audit will be conducted monthl additional months. HOW WILL THE FACILY MONITO CORRECTIVE ACTIONS TO ENST THAT THE DEFICIENT PRACTICI BEING CORRECTED AND WILL IN RECUR Audit results will be monitored by the Administrator at monthly QAPI me 6 months to ensure compliance. 	f on the / nee will rier veeks, y x 5 R ITS URE E IS NOT he

If continuation sheet Page 4 of 6

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315386	B. WING				C / 19/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
ATLAS RE	EHABILITATION AND HE	ALTHCARE AT MAYWOOD			00 WEST MAGNOLIA AVENUE IAYWOOD, NJ 07607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Interview for Mental S out of 15 indicating he MDS assessment ind Review of R5's comp undated, located in th Plan" tab, revealed N intervention to 'NJ e Review of R5's "Phys Nexorder 26.451 located in th tab, revealed NJ ex Review of the facility's 'NJ ex order 26.451 located in th tab, revealed NJ ex Review of the facility's 'NJ ex order 26.451 provi staff were trained on the the training. During an interview of US FOIA (b)(6) to wear a gown and g NJ ex order 26.451 for it was During an interview of	A staff training titled b1 ded by the facility, revealed the facility's Users order 26.4b1 and staff were required loves while performing as a high contact activity. n 04/17/24 at 12:52 PM, the verified Users order 26.4b1, open and staff order 26.4b1, open and staff ded by the facility.	F	880			

Facility ID: NJ60203

If continuation sheet Page 5 of 6

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					/ APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
			A. BUILDI	ING _			C		
		315386	B. WING				19/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
		ALTHCARE AT MAYWOOD		1	00 WEST MAGNOLIA AVENUE				
ATLAS RE	HABILITATION AND HE	ALTHCARE AT MATWOOD		Ν	IAYWOOD, NJ 07607				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IV	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE		
					DEFICIENCY)				
F 880	Continued From page	5							
1 000	NJExec Order care and NJExec O			880					
	cale and	cale.							
	NJAC 8:39-19.1(a)(b)								
	NJAC 8:39-19.4(a)(b))							

Event ID: HCM111

Facility ID: NJ60203

If continuation sheet Page 6 of 6

Web CP FROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607 100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607 (PA) ID PRETX MA SUMMARY STATEMENT OF DEFICIENCIES (EACH EDRICIENCY MUST BE PRICEEDED BY FULL) (EACH EDRICIENCY MUST BE PRICEEDED BY FULL) MA ID PRETX (EACH COMRECTIVE AT DIV SHOULD BE CROSS-REFFIGURE AT DIV SHOULD BE CROSS-REFFECTED BY THAL DEFICIENCY) ID PRETX (EACH COMRECTIVE ACTION WILL BE ACCOMPLISHED FOR THAL DEFICIENCY) ID PRETX (EACH COMRECTIVE ACTION WILL BE ACCOMPLISHED FOR THAL DEFICIENCY) S 000 Initial Comments S 000 S 000 ID PRETX (EACH COMRECTIVE ACTION WILL BE ACCOMPLISHED FOR THAL DEFICIENT PRACTICE The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. S 560 UHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AND FEFECTED BY THE DEFICIENT PRACTICE The state of New Jersey. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AND THOSE RESIDENTS AND THOSE RESIDENTS AND THOSE The state of New Jersey Department of Health (NLDOH) memor, dated 01/28/2021, "Compliance with N, J, S.A. (New Jersey Department of Health (NLDOH) memor, dated 01/28/2021, "Compliance with N, J, S.A. (New Jersey Department of Health (NLDOH) memor, dated 01/28/2021, "Compliance with N, J, S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nurusing homes	ND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Instruction Instruction Instruction Instruction (M) ISURATION AND HEALTHCARE AT MAY STREET ADDRESS, CITY, STATE, JP CODE 100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607 (M) ISURATION AND HEALTHCARE AT MAY 100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607 PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST THE PRECEDED BY FULL (EACH DEPICIENCY OR LSCIENTER/ING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE CORRECTIVE ACTION SHOULD BE (EACH DEPICIENCY OR LSCIENTER/ING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPICIENCY) OD PREFIX TAG S 000 Initial Comments S 000 ID PREFIX TAG S 000 ID PREFIX TAG OP PREFIX TAG OP PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPICENCY) OD PREFIX TAG S 000 Initial Comments S 000 ID PREFIX TAG S 000 ID PREFIX TAG			A. BOILDING.		С
Start Retribution And Healthcare at M2 100 WEST MAGNOLIA AVENUE marking of the start memory of DEFICIENCY (PAU) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY IP OPERATION STATEMENT OF DEFICIENCY <		60203	B. WING		04/19/2024
STLAS REHABILITATION AND HEALTHCARE AT MAY MAYWOOD, NJ 97607 (20) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) 000 S 000 Initial Comments S 000 S 000 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) 000 S 000 Initial Comments S 000 S 000 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) 000 S 000 Initial Comments S 000 S 000 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) 000 S 000 Initial Comments S 000 S 000 S 000 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BE TACK CORRECTIVE ACTION SHOLD BE ACCOMPTICE THAT PLAN OF CORRECTIVE ACTION WILL BE ACCOMPTICE THAT PLAN OF CORRECTIVE ACTION WILL BE ACCOMPTICE THAT ALL TO BE ACTION SHOLD BE PROVIDER'S PLAN OF CORRECTIVE ACTION WILL BE ACCOMPTICE THAT ALL TO BE AFFECTED BY THE DEFICIENT PRACTICE The staff-to-resident ratios as mandated by the state of New Jersey. WHAT CORRECTIVE ACTION WILL BE ACCOMPTICE THAT ALL TO BE AFFECTED BY THE DEFICIENT PRACTICE The staffing coordinator was immediately re-aducated by the Administrator on the State of New Jersey. WHAT CORRECTIVE ACTION WILL BE ACCOMPTICE TRACTICE The staffing coordinator was immediately re-aducated by the Administrator on the	AME OF PROVIDER OR SUP	PLIER STRE	ET ADDRESS, CITY, ST	ATE, ZIP CODE	
Image: Construct of the constraint the regulations. S 560 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PAACTICE This REQUIREMENT is not met as evidenced by: S 560 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PAACTICE The state of New Jersey Department of Health (NIDOP) memor, added 01/28/2021, "Compliance with N.J.S.A. (New Jersey Department of runsing homes," indicated the New Jersey Constraints for nursing homes," indicated the New Jersey Constraint of the collicity constraint on the ACCOMPLISHED FOR THOSE AVENUES AND AVENUES THE CONSTRAINT AND THE POTENTIAL TO BE AFFECTED BY THI	TLAS REHABILITATION	AND HEALTHCARE AT MAY		VENUE	
Internet (EACH DEPICIENCY WUST BE PRECEDED BY PULL REGULATORY OR LS. IDENTIFYING INFORMATION) PAERX TAS CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE PREOPERATE CONTINUE					
The facility was not in compliance with the standards in the New Jersey Administrative code, 8:33, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations. \$ 560 \$ 39-5.1(a) Mandatory Access to Care \$ 560 \$ 4/22/2 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. \$ 560 \$ 560 \$ 4/22/2 This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility failed to maintain the required minimum direct care staft-to-resident ratios as mandated by the state of New Jersey. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law PL. 2020 c 112, conflience at N.J.S.A. (New Jersey Statutes Annotated) account of a th.J.S.A. (New Jersey Statutes Annotated) account of the N.J.S.A. (New Jersey Statutes Annotated) account on the N.J.S.A. (New Jersey Statutes Annotated) account on the N.J.S.A. (New Jersey Statutes Annotated) account on the state of New	PREFIX (EACH I	DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE COMPLE
standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations. \$ 560 4/22/2 \$ 560 8:39-5.1(a) Mandatory Access to Care \$ 560 4/22/2 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. \$ 560 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE Residuent the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The staffing coordinator was immediately re-educated by the doministrator on the State of New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING THE DEFICIENT PRACTICE The staffing coordinator was immediately re-educated by the Administrator on the State of New Jersey required minimum direct care staff-to-resident ratios.	S 000 Initial Comm	ents	S 000		
 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE ACCOMPLISHED FOR THOSE ACCOM	standards in 8:39, standa Facilities. Th Correction, in deficieny and implemented result in enfo the provision Code, Title 8	the New Jersey Administrative code, ds for licensure of Long Term Care e facility must submit a Plan of acluding a completion date for each l ensure that the plan is . Failure to correct deficiencies may recement action in accordance with s of the New Jersey Administrative , chapter 43E, enforcement of			
by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey.WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The staffing coordinator was immediately re-educated by the Administrator on the State of New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), whichWHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICEby: Codified at N.J.S.A. 30:13-18 (the Act), whichWHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THIS SAME DEFICIENT PRACTICE All Residents have the potential to be affected by this deficient practice.	(a) The facili Federal, Sta	y shall comply with applicable	S 560		4/22/24
nursing homes. The following ratio(s) were WHAT MEASURES WILL BE PUT IN	by: Based on rev documentation failed to main care staff-to- state of New Findings incl Reference: N (NJDOH) me with N.J.S.A. 30:13-18, ne nursing hom- Governor sig codified at N	view of pertinent facility on, it was determined the facility itain the required minimum direct resident ratios as mandated by the Jersey. ude: lew Jersey Department of Health mo, dated 01/28/2021, "Compliance (New Jersey Statutes Annotated) w minimum staffing requirements for es," indicated the New Jersey ned into law P.L. 2020 c 112,		ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The staffing coordinator was immediat re-educated by the Administrator on th State of New Jersey required minimum direct care staff-to-resident ratios. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY TH SAME DEFICIENT PRACTICE All Residents have the potential to be affected by this deficient practice.	ely e n

Electronically Signed

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If continuation sheet 1 of 3

05/08/24

PRINTED: 08/05/2024 FORM APPROVED

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 60203 B. WING NAME OF PROVIDER OR SUPPLIER ATLAS REHABILITATION AND HEALTHCARE AT MAY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	C 04/19/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ATLAS REHABILITATION AND HEALTHCARE AT MAY 100 WEST MAGNOLIA AVEN MAYWOOD, NJ 07607 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	E, ZIP CODE	
ATLAS REHABILITATION AND HEALTHCARE AT MAY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	,	
ATLAS REHABILITATION AND HEALTHCARE AT MAY MAYWOOD, NJ 07607 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	:NUE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)	LETE
S 560 Continued From page 1 S 560		
One Certified Nurse Aide (CNA) to every eight	PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR	
residents for the day shift.COne direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be Signed in to work as a CNA and shall perform nurse aide duties: andMOne direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.M1. For the 9 weeks of Complaint staffing from 10/03/2021 to 12/04/2021, the facility was deficient in CNA staffing for residents on 14 of 45 day shifts as follows:M-10/24/21 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -10/28/21 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs.T-10/29/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-10/29/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-10/29/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-10/30/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-10/30/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-10/30/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-10/30/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-10/30/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.T-11/14/21 had 14 CNAs for 118 residents on the 	Online recruitment ads to be monitored for FT, PT, and PD shifts Referral bonus to be offered to existing staff. Marketing in Local colleges and CNA programs to increase local community recruitment Use of Agency staff to meet staffing requirements. Nursing leadership utilized in CNA capacity as needed to offset needs. Sign on bonuses to be offered. Bonuses to be offered to staff for extra shifts worked. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON/Designee will meet with the staffing needs and call outs x 30 days. The DON/Designee will audit staffing ratios compliance weekly x 3 months and the results of the audits will be monitored by the administrator at monthly QAPI committee x3 months to ensure compliance.	

New Jersey Department of Health

HCM111

PRINTED: 08/05/2024 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY	
		60203	B. WING		04	C 04/19/2024	
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, 2				
TLAS RI	EHABILITATION AND HE	AI THCARF AT MAY	ST MAGNOLIA AVEN OD, NJ 07607	UE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
S 560	day shift, required at -11/22/21 had 13 CN day shift, required at -11/24/21 had 13 CN day shift, required at -11/27/21 had 13 CN day shift, required at -11/28/21 had 13 CN day shift, required at -11/28/21 had 13 CN day shift, required at -10/09/2022 to 10/22/ deficient in CNA staff day shifts as follows: -10/09/22 had 13 CN day shift, required at -10/18/22 had 13 CN day shift, required at -10/18/2023 to 01/14/ deficient in CNA staff day shifts as follows: -01/14/23 had 13 CN day shift, required at 4. For the 7 weeks of 02/12/2023 to 04/01// deficient in CNA staff day shifts as follows:	As for 118 residents on the least 15 CNAs. As for 116 residents on the least 14 CNAs. As for 115 residents on the least 14 CNAs. As for 113 residents on the least 14 CNAs. As for 113 residents on the least 14 CNAs. f Complaint staffing from 2022, the facility was ing for residents on 2 of 14 As for 113 residents on the least 14 CNAs. As for 113 residents on the least 14 CNAs. As for 111 residents on the least 14 CNAs. omplaint staffing from 2023, the facility was ing for residents on 1 of 7 As for 116 residents on the least 14 CNAs. f Complaint staffing from 2023, the facility was ing for residents on 1 of 35 as for 109 residents on the	S 560				

STATE FORM

HCM111

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
315386 _{Y1}	B. Wing	Y2	6/12/2024	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD		100 WEST MAGNOLIA AVENUE				
		MAYWOOD. NJ 07607				

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	м	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix	F0880	Correction	ID Prefix	Correction	ID Prefix	C	Correction
Reg. #	483.80(a)(1)(2)(4))(e)(f) Completed	Reg. #	Completed	Reg. #	C	Completed
LSC		04/22/2024			LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	C	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	C	Completed
LSC							
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	C	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	C	Completed
LSC							
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	C	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	C	Completed
LSC							
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	C	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	C	Completed
LSC			LSC		LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	1	DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOW 4/19/2024	JP TO SURVEY CO 4	DMPLETED ON		ANY UNCORRECTED DEFICIENCIE TED DEFICIENCIES (CMS-2567) SEM			D NO

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT			
	B. Wing	Y2	6/12/2024	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD		100 WEST MAGNOLIA AVENUE				
		MAYWOOD, NJ 07607				

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix S0560		Correction	ID Prefix		Correction	ID Prefix		Correction
8:39-5.1(a))	O a mars la ta d						O a man la ta d
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		04/22/2024	LSC		_			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		·
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEWED BY STATE AGENCY		VIEWED BY ITIALS)	DATE	SIGNATURE OF	SURVEYOR		DATE	
REVIEWED BY CMS RO		VIEWED BY ITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURV 4/19/2024	VEY COMPI	LETED ON		DR ANY UNCORREC		5. WAS A SUMMARY OF T TO THE FACILITY?		6 🗌 NO
				Page 1 of 1		EVENT I	D: HCM112	

ND PLAN OF CORRECTION		(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION 2		E SURVEY PLETED	
		B. WING	04	/19/2024		
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
ATLAS RE	HABILITATION AND HE	ALTHCARE AT MAYWOOD		00 WEST MAGNOLIA AVENUE IAYWOOD, NJ 07607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
K 000	LLC on behalf of the I	care Management Solutions, New Jersey Department of The facility was found to 42 CFR 483.73	K 000			
	Healthcare Managem behalf of the New Jer Health Facility Survey 04/19/24 was found to the requirements for p Medicare/Medicaid at Safety from Fire, and National Fire Protection	42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING				
K 271 SS=F	is a three-story buildin composed of Type II p facility is divided into generator does appro	nd Healthcare at Maywood ng built in 2008 and is protected construction. The nine - smoke zones. The eximately 100 % of the aintenance Director. The s are 109 of 118.	K 271			5/14/24
	provides a level walki provisions of 7.1.7 with elevation and shall be obstructions. Addition	nged in accordance with 7.7, ng surface meeting the th respect to changes in maintained free of ally, the exit discharge shall weather travel surface.				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM A OMB NO. 0	PPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 02	(X3) DATE SU COMPLET	RVEY
	315386		B. WING		04/19/	/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
ATLAS RE	HABILITATION AND HE	ALTHCARE AT MAYWOOD		100 WEST MAGNOLIA AVENUE		
				MAYWOOD, NJ 07607		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
K 271	by: Based on observation failed to ensure the o with handrails on both accordance with NFP (2012 Edition) Section practice had the pote residents who resided Findings include: An observation on 04 the exterior stair outs only had one handrai handrails, one on eaco	is not met as evidenced n and interview, the facility utside stair was equipped h sides of the stair in A 101 Life Safety Code n 7.2.2.4.1.2. This deficient ntial to affect all 109 d at the facility. /19/24 at 12:15 PM revealed ide the south exit stairway I and not the required two ch side of the stair. t the time of observation, the confirmed the exterior	К 27		ION WILL BE DSE Y THE andrail on the buth exit IDENTIFY NG THE TED BY THIS ICE tial to be actice. E PUT IN ANGES THE LL NOT vill conduct a ior and hand rail the stairwell. ate the e Discharge vill conduct a ensure	
				stairwells. HOW WILL THE FACILY MO CORRECTIVE ACTIONS TO THAT THE DEFICIENT PR/	ONITOR ITS O ENSURE	

Event ID: HCM121

Facility ID: NJ60203

If continuation sheet Page 2 of 7

	S FOR MEDICARE &				OMB NO. 0938 (X3) DATE SURVE	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING (COMPLETED		
		315386	B. WING		04/19/202	24
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ATLAS RE	EHABILITATION AND HE	ALTHCARE AT MAYWOOD		00 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMP	X5) PLETIC ATE	
K 271	Continued From page	2	K 271	BEING CORRECTED AND WILL NO RECUR	т	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101		K 291	Audit results will be reviewed by the Administrator at monthly QAPI meetir 3 months to ensure compliance.	ngs x 5/17/2	24
	is provided automatic 18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on observatio failed to ensure emer at the emergency ger the generator walk-in with NFPA 110, Stand Standby Power Syste 7.3.1. This deficient p affect all 109 resident Findings include: An observation on 04 emergency lighting w emergency generator the electrical room.	19/24 at 1:34 PM revealed as not present at the		WHAT CORRECTIVE ACTION WILL ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Emergency lighting was installed at th emergency generator transfer switch at the generator walk in enclosure. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY T SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE	ne and / ſHIS	
	During an interview a observations, the US	t the time of the		DEFICIENT PRACTICE WILL NOT OCCUR The Administrator will educate the US FOIA (b)(6) on the emerger	псу	

Event ID: HCM121

Facility ID: NJ60203

If continuation sheet Page 3 of 7

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	A. BUILDING 02		
		315386	B. WING	04/19/2024		
JAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ATLAS RE	EHABILITATION AND HE	ALTHCARE AT MAYWOOD				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC	
K 291	Continued From pag	e 3	К 29	1		
		nerator transfer switch or at		lighting requirements.		
	the emergency gene	rator walk-in enclosure.		A facility wide audit was conducted to		
	NJAC 8:39-31.2(e)			ensure emergency lighting is present required areas.		
	NFPA 99, 110			The Maintenance Director will condu-	ct	
				weekly audits x 4 weeks, then month		
				months, to ensure lighting functionali	ty.	
				HOW WILL THE FACILY MONITOR	ITS	
				CORRECTIVE ACTIONS TO ENSUR		
				THAT THE DEFICIENT PRACTICE I		
				BEING CORRECTED AND WILL NO RECUR	T	
				Audit results will be reviewed by the Administrator at monthly QAPI meeti 3 months to ensure compliance.	ngs x	
K 311 SS=F	Vertical Openings - E CFR(s): NFPA 101	Enclosure	K 31	1	6/10/24	
	Vertical Openings - E 2012 EXISTING	Enclosure				
		hafts, light and ventilation				
		ther vertical openings				
		nclosed with construction ice rating of at least 1 hour.				
		ed in accordance with 8.6.				
	19.3.1.1 through 19.3					
		s are properly enclosed with				
	resistance rating, als	g at least a 2-hour fire				
	box.					
	This REQUIREMEN	T is not met as evidenced				
	by:					
		on and interview, the facility out of nine fire rated door		WHAT CORRECTIVE ACTION WILL	BE	
		ay exit doors were one-hour		RESIDENTS AFFECTED BY THE		
		in accordance with NFPA		DEFICIENT PRACTICE		

Event ID: HCM121

Facility ID: NJ60203

If continuation sheet Page 4 of 7

ENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED
	315386		B. WING		04/19/2024
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•
		ALTHCARE AT MAYWOOD		100 WEST MAGNOLIA AVENUE	
		ALTICARE AT MATWOOD		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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC
K 311	Continued From page	e 4	K 31	1	
	101 Life Safety Code 19.3.1.1. This deficie	e (2012 Edition) Section nt practice had the potential ents who resided at the		Nine stairway exit doors with appropria fire resistance ratings are installed.	ate
	facility. Findings include:			HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY T	
	-			SAME DEFICIENT PRACTICE	
	2:30 PM revealed the	I/19/24 from 12:00 PM to e stairway exit doors were doors and not the required		All residents have the potential to be affected by this deficient practice.	
	one-hour fire rated do	•		WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES	
	US FOIA (b)(6)	It the time of observation, the confirmed the stairway ninute fire rated doors.		MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR	
	NJAC 8:39-31.2(e)			A facility wide audit was conducted to ensure that all fire rated doors at vertic	cal
	()			openings are one hour fire rated. The Administrator will educate the	
				US FOIA (b)(6) on the requirem for vertical opening enclosures.	
				The Maintenance Director will conduct monthly audit x 3 months to ensure fire door integrity and placement.	
				HOW WILL THE FACILY MONITOR IT CORRECTIVE ACTIONS TO ENSUR THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT	E
				RECUR	
				Audit results will be reviewed by the Administrator at monthly QAPI meetin 3 months to ensure compliance.	gs x
K 919 SS=F	Electrical Equipment CFR(s): NFPA 101	- Other	K 91		5/17/24
	Electrical Equipment	- Other			

Facility ID: NJ60203

If continuation sheet Page 5 of 7

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
315386		315386	B. WING			04	/19/2024
NAME OF PROVIDER OR SUPPLIER		1		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ATLAS RE	HABILITATION AND HE	ALTHCARE AT MAYWOOD			0 WEST MAGNOLIA AVENUE		
				M	AYWOOD, NJ 07607		
(X4) ID PREFIX TAG			ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
PREFIX (EACH DEFICIENCY MUST BE PRECEDE		 section any NFPA 99 I Equipment, requirements of by the provided K-Tags, information, along with the code or NFPA standard cluded on Form CMS-2567. is not met as evidenced n and interview, the facility mergency generator was one manual stop station in PA 110 Standard for dby Power Systems (2010) 5.6. This deficient practice ffect all 109 residents who 	KS	919	WHAT CORRECTIVE ACTION WILL E ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE A remote manual stop station was installed outside the external emergence generator. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY TH SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice.	су	
	US FOIA (B) (6)	t the time of observation, the confirmed the generator h a remote manual stop			WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Administrator will educate the US FOIA (b)(6) on the requirement for manual stop stations. The Maintenance Director will conduct monthly audit x 3 months for placement and functionality of the remote manual stop station.	a t	

Event ID: HCM121

Facility ID: NJ60203

If continuation sheet Page 6 of 7

						0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 02	(X3) DATE S COMPLE	
		315386	B. WING		04/1	9/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD				100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
K 919	Continued From pag	je 6	K 91	19 CORRECTIVE ACTION THAT THE DEFICIENT BEING CORRECTED A RECUR	PRACTICE IS	
				Audit results will be rev Administrator at monthl 3 months to ensure con	y QAPI meetings x	

Event ID: HCM121

Facility ID: NJ60203

If continuation sheet Page 7 of 7

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 02 - NEW BUILDING		DATE OF REVISIT	
	B. Wing		6/12/2024	Y3
10000 H	3	Y2		13
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ATLAS REHABILITATION AND HE	ALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE		
		MAYWOOD. NJ 07607		

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ITE	м	DATE	ITEM	ITEM DATE		ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	NFPA 101 K0271	Correction Completed 05/14/2024	Reg. #	NFPA 101 K0291	Correction Completed 05/17/2024	ID Prefix Reg. # LSC	NFPA 101 K0311		Correction Completed 06/10/2024
ID Prefix Reg. # LSC	NFPA 101	Correction Completed 05/17/2024	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIGNATURE	E OF SURVEYOR			DATE	
REVIEWED BY CMS RO REVIEWED BY (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON 4/19/2024 Form CMS - 2567B (09/92) EF (11/06)			СНЕС	K FOR ANY UNCOR	RECTED DEFICIENCIES NCIES (CMS-2567) SEN				