STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	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) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint #: NJ151106, NJ1153352, NJ1153561, NJ153951, NJ160672, NJ156261, NJ157557, NJ159569, NJ162397, and NJ165747. Survey Dates: 02/15/24 - 02/18/24 Survey Census: 106 Sample Size: 29 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607

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F 880	Continued From page 1 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	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) COMPLETION DATE
F 880	Continued From page 2 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, the facility failed to maintain an effective infection control program for one of four residents (Resident (R) 5) NJ ex order 26.4b1 out of 29 sampled residents. Staff failed to wear the required personal protective equipment (PPE) while performing NJ ex order 26.4b1 for R5 on enhanced barrier precautions. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions," dated 03/20/24, provided by the facility, revealed "Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: "Enhanced barrier precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities ... 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing	F 880	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On NJ ex order 26.4b, CNA2 NJ ex order 26.4b1 Resident 5 NJ ex order 26.4b1 noted. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents on enhanced barrier precautions 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 DEFICIENT PRACTICE WILL NOT OCCUR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607

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F 880	Continued From page 3 linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing ...." Observation on 04/16/24 at 1:25 PM revealed signage posted on R5's bedroom door indicating the resident was on NJ ex order 26.4b1 [redacted], a "STOP" sign was posted below the resident's name plate, and a three-drawer PPE cart with yellow gowns in the first and second drawers located outside of the room. Continued observation revealed, while not wearing the appropriate PPE (gown), Certified Nursing Assistant (CNA) 2 NJ ex order 26.4b1 [redacted] under R5 with gloves on while R5's NJ ex order 26.4b1 [redacted]. Interview at time of observation with CNA2 confirmed she did not wear a gown while performing NJ Exec Order 26. [redacted] care to R5 because she did not see the three-drawer PPE cart outside of the room, the STOP sign, or the NJ Exec Order 26.4b1 [redacted] sign on the door. Review of R5's undated "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab stated R5 was admitted to the facility on NJ ex order 26.4b1 [redacted] with diagnoses which included NJ ex order 26.4b1 [redacted] Review of R5's quarterly "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of NJ ex order 26.4b1 [redacted], located in the EMR under the "MDS" tab, revealed the resident had a "Brief	F 880	On 4/17/24, the facility educator educated all facility nursing and therapy staff on the enhanced barrier precaution policy including the PPE requirements. Each week x 4 weeks, DON/designee will conduct an audit on enhanced barrier precautions and PPE requirement compliance. Following the first 4 weeks, the audit will be conducted monthly x 5 additional months. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR Audit results will be monitored by the Administrator at monthly QAPI meetings x 6 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607

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F 880	Continued From page 4	F 880		

Interview for Mental Status (BIMS)" score of [NJ ex] out of 15 indicating he [NJ ex order 26.4b1]. The MDS assessment indicated he [NJ ex order 26.4b1] .

Review of R5's comprehensive "Care Plan" undated, located in the EMR under the "Care Plan" tab, revealed [NJ ex order 26.4b1] " with an intervention to "[NJ ex order 26.4b1] .

Review of R5's "Physician's Order" dated [NJ ex order 26.4b1] located in the EMR under the "Orders" tab, revealed [NJ ex order 26.4b1] .

Review of the facility's staff training titled "[NJ ex order 26.4b1] provided by the facility, revealed staff were trained on the facility's [NJ Exec Order 26.4b1] Policy and CNA2 attended the training.

During an interview on 04/17/24 at 11:53 AM, the [US FOIA (b)(6)]) confirmed R5 [NJ ex order 26.4] and staff were required to wear a gown and gloves while performing [NJ ex order 26.4b1] for it was a high contact activity.

During an interview on 04/17/24 at 12:52 PM, the [US FOIA (B) (6)] verified [NJ Exec Order 26.4b1] were required for residents that had an [NJ Exec Order 26.4b1], open [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1] and staff must wear a gown and gloves during [NJ Exec Order 26.4b1] activities such as [NJ Exec Order 26.4b1], and during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	**100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607**

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F 880	Continued From page 5 [redacted] care and [redacted] care. NJAC 8:39-19.1(a)(b) NJAC 8:39-19.4(a)(b)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60203	A. BUILDING: _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAY	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	Initial Comments The facility was not in compliance with the 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (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 established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	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 required minimum direct care staff-to-resident ratios. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All Residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN	4/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/08/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60203	A. BUILDING: _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAY	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 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One 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. 1. 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: -10/24/21 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -10/26/21 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. -10/29/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/30/21 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -11/14/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -11/15/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -11/16/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -11/17/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs.	S 560	PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR 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 coordinator daily to review census vs. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60203	A. BUILDING: _____ B. WING _____	C 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAY	100 WEST MAGNOLIA AVENUE MAYWOOD, NJ 07607

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S 560	Continued From page 2 -11/18/21 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -11/22/21 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -11/24/21 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/27/21 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs. -11/28/21 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of Complaint staffing from 10/09/2022 to 10/22/2022, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -10/09/22 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/18/22 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. 3. For the week of Complaint staffing from 01/08/2023 to 01/14/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -01/14/23 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. 4. For the 7 weeks of Complaint staffing from 02/12/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 1 of 35 day shifts as follows: -03/20/23 had 7 CNAs for 109 residents on the day shift, required at least 14 CNAs.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315386	A. Building B. Wing	6/12/2024

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/22/2024	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
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/19/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
60203		6/12/2024

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 (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/22/2024	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING **02** B. WING _____	**04/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	**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) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 04/19/2024. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/19/24 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Atlas Rehabilitation and Healthcare at Maywood is a three-story building built in 2008 and is composed of Type II protected construction. The facility is divided into nine - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 109 of 118.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	K 271		5/14/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING **02** B. WING _____	**04/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	**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) COMPLETION DATE
K 271	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the outside stair was equipped with handrails on both sides of the stair in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.2.4.1.2. This deficient practice had the potential to affect all 109 residents who resided at the facility. Findings include: An observation on 04/19/24 at 12:15 PM revealed the exterior stair outside the south exit stairway only had one handrail and not the required two handrails, one on each side of the stair. During an interview at the time of observation, the US FOIA (B) (6) confirmed the exterior stairs only had one handrail. NJAC 8:39-31.2(e)	K 271	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Facility installed a second handrail on the exterior stairs outside the south exit stairway. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS 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 DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director will conduct a facility wide audit of all interior and exterior stairwells to ensure hand rail placement on both sides of the stairwell. The Administrator will educate the Maintenance Director on the Discharge from Exits requirements. The Maintenance Director will conduct a monthly audit x 3 months to ensure handrail placement is secure in all facility stairwells. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING **02** B. WING _____	**04/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	**100 WEST MAGNOLIA AVENUE** **MAYWOOD, NJ 07607**

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K 271	Continued From page 2	K 271	BEING CORRECTED AND WILL NOT RECUR Audit results will be reviewed by the Administrator at monthly QAPI meetings x 3 months to ensure compliance.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch and at the generator walk-in enclosure in accordance with NFPA 110, Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3.1. This deficient practice had the potential to affect all 109 residents who resided at the facility. Findings include: An observation on 04/19/24 at 1:05 PM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical room. An observation on 04/19/24 at 1:34 PM revealed emergency lighting was not present at the emergency generator walk-in enclosure. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the emergency lighting was not present	K 291	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Emergency lighting was installed at the emergency generator transfer switch and at the generator walk in enclosure. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS 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 DEFICIENT PRACTICE WILL NOT OCCUR The Administrator will educate the US FOIA (b)(6) on the emergency	5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING **02** B. WING _____	**04/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	**100 WEST MAGNOLIA AVENUE** **MAYWOOD, NJ 07607**

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K 291	Continued From page 3 at the emergency generator transfer switch or at the emergency generator walk-in enclosure. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	lighting requirements. A facility wide audit was conducted to ensure emergency lighting is present in all required areas. The Maintenance Director will conduct weekly audits x 4 weeks, then monthly x 2 months, to ensure lighting functionality. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR Audit results will be reviewed by the Administrator at monthly QAPI meetings x 3 months to ensure compliance.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure nine out of nine fire rated door assemblies of stairway exit doors were one-hour fire rated assemblies in accordance with NFPA	K 311	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE	6/10/24

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	315386	A. BUILDING **02** B. WING _____	**04/19/2024**

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K 311	Continued From page 4 101 Life Safety Code (2012 Edition) Section 19.3.1.1. This deficient practice had the potential to affect all 109 residents who resided at the facility. Findings include: An observation on 04/19/24 from 12:00 PM to 2:30 PM revealed the stairway exit doors were 45-minute fire rated doors and not the required one-hour fire rated doors. During an interview at the time of observation, the US FOIA (b)(6) confirmed the stairway doors were only 45-minute fire rated doors. NJAC 8:39-31.2(e)	K 311	Nine stairway exit doors with appropriate fire resistance ratings are installed. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS 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 DEFICIENT PRACTICE WILL NOT OCCUR A facility wide audit was conducted to ensure that all fire rated doors at vertical openings are one hour fire rated. The Administrator will educate the US FOIA (b)(6) on the requirements for vertical opening enclosures. The Maintenance Director will conduct a monthly audit x 3 months to ensure fire door integrity and placement. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR Audit results will be reviewed by the Administrator at monthly QAPI meetings x 3 months to ensure compliance.	
K 919 SS=F	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other	K 919		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING **02** B. WING _____	**04/19/2024**

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	**100 WEST MAGNOLIA AVENUE** **MAYWOOD, NJ 07607**

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K 919	Continued From page 5 List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency generator was equipped with a remote manual stop station in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 5.6.5.6. This deficient practice had the potential to affect all 109 residents who resided at the facility. Findings include: An observation on 04/19/24 at 1:35 PM revealed that the external emergency generator was not equipped with a remote manual stop station (Emergency Stop Switch) anywhere on the premises. During an interview at the time of observation, the US FOIA (B) (6) confirmed the generator was not equipped with a remote manual stop station. NJAC 8:39-31.2(e) NFPA 99, 110	K 919	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE A remote manual stop station was installed outside the external emergency generator. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS 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 DEFICIENT PRACTICE WILL NOT OCCUR The Administrator will educate the US FOIA (b)(6) on the requirements for manual stop stations. The Maintenance Director will conduct a monthly audit x 3 months for placement and functionality of the remote manual stop station. HOW WILL THE FACILY MONITOR ITS	

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K 919	Continued From page 6	K 919	CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR Audit results will be reviewed by the Administrator at monthly QAPI meetings x 3 months to ensure compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315386 Y1	A. Building 02 - NEW BUILDING 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0271	05/14/2024	LSC K0291	05/17/2024	LSC K0311	06/10/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0919	05/17/2024	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO