STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315246	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT WEST DEPTFOR	**550 JESSUP ROAD , WEST DEPTFORD, New Jersey, 08066**

(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
F0000	INITIAL COMMENTS Complaint #: 402411, 2583964 Survey Dates: 8/26/25 Census: 154 Sample Size: 4 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 COMPLAINT VISIT.	F0000		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F0842	A. Corrective actions accomplished for residents affected: For Resident #2, the missing documentation on the Treatment Administration Record (TAR) for [NJ Exec Order 26 redacted], was addressed. The Director of Nursing (DON) met with the nurse involved, and the treatment was verified as completed but not documented. The resident's medical record has been updated to reflect the care that was provided, and the grievance has been resolved. Resident #2 remain without [NJ Exec Order 26.4b1 redacted] related to this documentation deficiency. B. How other residents with the potential to be affected were identified and corrective actions taken: All residents' TARS and treatment records for the past 30 days were audited by the DON and or designee to ensure that all treatments ordered were documented accurately and timely. Any missing documentations was immediately corrected with late entries and follow-up verification by supervisory staff. C. Measures/ Systemic changes put into place to	09/16/2025

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 reverse for further 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.

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

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F0842 SS = D	Continued from page 1 (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations	F0842	Continued from page 1 ensure the deficient practice will not recur: Re-education was provided by the DON and/ or designee to all licensed nurses on the facility's Charting and Documentation Policy, with emphasis on the requirement that all treatments, including "as needed" wound care, be documented at the time they are performed. All new hires will receive orientation by the DON and / or designee on proper documentation standards as part of the onboarding process. D. Monitoring to ensure the deficient practice will not recur (Quality Assurance): The DON/designee will audit five random residents' for four weeks to ensure that treatments are being accurately documented. Audit results will be reported to the QA Committee monthly for review, trend analysis and follow-up. The QA Committee will determine if additional staff education or corrective actions are required. The monitoring will continue until the facility can demonstrate sustained compliance.	09/16/2025

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F0842 SS = D	Continued from page 2 conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT#: NJ00187516 / 402411 Based on interview and review of medical records and other pertinent facility documents it was determined that the facility failed to maintain an accurately documented and complete medical records in accordance with acceptable standards and practice. This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed and was evidenced by the following: A review of Resident #2's Admission Record revealed that that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4 indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, indicating that the resident's NJ Exec Order 26. was NJ Ex Order A further review of Resident #2's medical record revealed that the resident filed a grievance on NJ Ex Order 26, which indicated that a nurse had changed their NJ Ex Order 26.4(b)(1). A review of Resident #2's Treatment Administration Record (TAR) for NJ Ex Order 26.4(b)(revealed an order dated NJ Ex Order, that the NJ Ex Order 26.4(b)(1) was to be changed, along with an order for the application of NJ Ex O prep dated NJ Ex Order. Both indicated that they were to be completed "as needed for NJ Ex Order 26.4 A further review of the TAR revealed no documentation that the NJ Ex Order 26.4 was changed nor the that the NJ Ex O prep was applied on NJ Ex Order 26.4(	F0842		09/16/2025

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F0842 SS = D	Continued from page 3 A review of Resident #2's Progress Notes did not reveal any documentation that the resident's treatments were completed or not completed on [redacted]. During an interview with Resident #2 on 8/26/25 at 2:35 P.M., the resident recalled filing the grievance because the primary nurse did not change the [redacted] after a [redacted], but that the next shift had taken care of it. The resident stated that they could not recall the exact date of the grievance at the time of the interview. During an interview with the [redacted]) Shift Supervisor on 8/26/25 at 3:55 P.M., in the presence of the surveyor, she reviewed the grievance for Resident #2 dated [redacted]. The [redacted] stated that she recalled the incident and that while completing her rounds, she was approached by a Certified Nursing Assistant (CNA) who stated that there was a concern with Resident #2. The [redacted] stated that she immediately went to the resident's room, where the resident told her that [redacted] care needed to be provided due to a [redacted] The [redacted] stated that she immediately gathered the necessary supplies and went in with another nurse to provide the treatment. The [redacted] also stated that it was important to document all care provided to a resident, "because others may think it wasn't done if it wasn't documented." In the presence of the surveyor, she also reviewed the Resident's TAR for [redacted] and stated, "I made sure it got done and with it being change of shift, I forgot to document it." She further stated that she should have signed the TAR. During an interview on 8/26/25 at 4:16 P.M., the [redacted]) stated that she expected that all care provided to a resident to be documented as done, "So that everyone knows it was done." In the presence of the surveyor, the [redacted] reviewed Resident #2's TAR for [redacted], and stated that the nurse should have signed a treatment if it was done. A review of the facility's "Charting and Documentation" policy, revised July 2023, revealed that all services provided to the resident would be documented in a resident's medical record, including, "… Treatment or services performed…"	F0842		09/16/2025

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F0842 SS = D	Continued from page 4 N.J.A.C. 8:39-27.1(a)	F0842		09/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060807	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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S0000	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 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.	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 2 day shifts. The deficient practice was evidenced by the following: 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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were 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 of all staff members shall be CNAs and each direct staff member shall be signed	S0560	A. Facility made immediate efforts to include ongoing hiring of nursing staff, increasing employee incentives, and increasing agency use and utilization of Instant Messaging Applications (OnShift) to fill open positions. B. All residents have the potential to be affected by this practice, No negative outcome to the residents because of this deficient practice C. Facility to implement weekly recruitment meetings to discuss hirings, wages, incentive and job advertisements. The Administrator and Staffing Coordinator will review staffing schedules daily to ensure adequate staffing for the facility. If insufficient staffing is identified and cannot be filled by staff or agency, licensed department heads will be mandated to fill in. D. Recruitment numbers and results will be submitted to the Quality Assurance Committee for a period of three months. Any patterns of non-compliance will be addressed with additional staff education and process improvements as necessary. The QAPI committee will review the effectiveness of the corrective actions quarterly and make adjustments as needed to ensure sustained compliance.	09/16/2025

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S0560	Continued from page 1 into work as a certified nurse aide 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. For the weeks of Complaint staffing from 08/10/2025 to 08/23/2025, the facility was deficient in CNA staffing on 2 of 14 day shifts as follows: -08/10/25 had 16 CNAs for 137 residents on the day shift, required at least 17 CNAs. -08/16/25 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs.	S0560		09/16/2025

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 9/29/25 in relation to the 8/26/25 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		10/03/2025

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 reverse for further 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.

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New Jersey Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 9/29/25 in relation to the 8/26/25 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		10/03/2025

Office of Primary Care and Health Systems Management

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