STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT WEST DEPTFOR	**550 JESSUP ROAD WEST DEPTFORD, NJ 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
F 000	INITIAL COMMENTS Complaint #: NJ183158, NJ183469, NJ183516 Census: 149 Sample: 4 THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG-TERM CARE FACILITIES.	F 000		

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

Electronically Signed | 03/07/2025

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060807	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT V	550 JESSUP ROAD WEST DEPTFORD, NJ 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) 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 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ183158, NJ183469, NJ183516 Based on interviews and review of facility documents on 02/20/2025 and 02/221/2025, it was determined that the facility failed to ensure staffing ratios were met for 3 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. 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	S 560	A. Facility made immediate efforts to include ongoing hiring of nursing staff, increasing employee incentives, and increasing agency use to fill any open shifts. 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 ads. The Administrator and Staffing Coordinator will	3/28/25

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

Electronically Signed | 03/07/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060807	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT V	550 JESSUP ROAD WEST DEPTFORD, NJ 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) COMPLETE DATE
S 560	Continued From page 1 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 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 2 weeks of staffing prior to survey from 02/02/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: On 02/02/25 had 16 CNAs for 148 residents on the day shift, required at least 18 CNAs. On 02/07/25 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. On 02/15/25 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs.	S 560	review staffing schedules daily to ensure adequate staffing for the facility. If insufficient staffing is identified and cannot be filled with 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 monthly for a period of three (3) months. Any patterns of non-compliance will be addressed with additional staff education and process improvements as necessary. The QAPI committee will review effectiveness of the corrective actions quarterly and make adjustments as needed to ensure sustained compliance.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060807 Y1	A. Building B. Wing Y2	3/25/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT WEST DEPTFOR	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/28/2025	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	
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	
2/21/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO