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 06/16/2025

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 #: NJ186633 Census: 150 Sample Size: 3 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.	F 000		
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		7/7/25

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

Electronically Signed | 06/27/2025

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
	315246	A. BUILDING _____ B. WING _____	C 06/16/2025

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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 585	Continued From page 1 of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately	F 585		

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	315246	A. BUILDING _____ B. WING _____	C 06/16/2025

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

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F 585	Continued From page 2 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Complaint #: NJ186633 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 5/28/25 and 5/30/25, it was determined that the facility failed to provide a resident (Resident #2), who voiced a grievance, a written summary of the investigation in accordance with the facility's Grievance Policy.	F 585	1. Resident #2s grievance dated [redacted] was re-reviewed. A written summary of the investigation, including the outcome and actions taken, was immediately completed and hand-delivered to Resident #2. The resident was provided with an opportunity to review and discuss the findings. Documentation of this delivery was	

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	315246	A. BUILDING _____ B. WING _____	C 06/16/2025

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

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F 585	Continued From page 3 The deficient practice was identified for 1 of 3 residents, Resident #2, and evidenced by the following: According to the "Admitting Face Sheet," Resident #2 had NJ Ex Order 26. 4B1 [redacted]. According to the resident's Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2[redacted], Resident #2 had a Brief Interview Mental Status score of [redacted]/15, which indicated that Resident # was NJ Ex Order 26. 4B1. The MDS also indicated that the Resident required NJ Exec Order 26.4b1 with activities of daily living (ADLs). A review of a facility document titled "Grievance/Concern Form" dated NJ Exec Order 26.4b[redacted], with date of occurrence on NJ Ex Order 26. 4B1, revealed that Resident #2 reported to the facility that he/she 'NJ Ex Order 26. 4B1 [redacted]". During interview with surveyor on 5/30/25 at 1:55 p.m., Resident #2 stated, NJ Ex Order 26. 4B1 [redacted]." During interview with surveyor on 5/30/25 at 2:58 p.m., the U.S. FOIA (B) (6) stated, 'NJ Ex Order 26. 4B1 [redacted]."	F 585	maintained in accordance with the facility grievance policy. 2. An audit of all grievance logs from the past six months (12/16/2024- 06/16/2025) was conducted to identify any residents who filed a grievance but may not have received a written resolution. Any gaps identified were immediately addressed by completing the appropriate documentation and providing written summaries to the residents or their representatives involved. No additional residents were identified as affected. 3. The facilitys grievance policy was reviewed, revised, and implemented effective 06/04/2025. The revised policy now explicitly states: A written summary will be provided to the resident/residents representative upon request. Staff responsible for addressing grievances were in-serviced on 06/04/2025 regarding their responsibility to resolve all resident grievances in accordance with facility policy and federal regulations. The in-service emphasized that grievance resolutions must be communicated to residents both verbally and in writing (if requested), and that documentation of delivery must be retained. 4. The Administrator or designee will conduct monthly audits of grievance records for three months to verify that written notifications were issued when requested by the resident or their representative and that all required elements of the grievance process were	

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	315246	A. BUILDING _____ B. WING _____	C 06/16/2025

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

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F 585	Continued From page 4 During Exit Conference on 5/30/25 at 3:44 p.m., the U.S. FOIA (B) (6) stated, "There was nothing that showed that a copy of the resolution was given to the resident (Resident #2) in writing. Yes, according to the policy, there should have been something in writing what the resolution was." Review of facility's policy titled, "Grievances/Complaints, Filing" with a "Revision Date" of 4/2024, "Policy Interpretation and Implementation," included but were not limited to the following: 12. "The resident, ... will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems." b. "A written summary of the investigation will be provided to the resident ...." NJAC 8:39-13.2(c)	F 585	completed in accordance with policy. Any identified deficiencies during audit review will result in immediate follow-up, including re-education of the staff responsible and documentation of corrective actions taken. Audit findings will be submitted quarterly to the QAPI Committee for ongoing review, discussion of trends, and implementation of corrective actions as needed.	

New Jersey Department of Health

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 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT V	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

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S 000	Initial Comments Complaint #: NJ186633 Census: 150 Sample Size: 3 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 #: NJ186633 Based on interviews and review of facility documents on 05/28/2025 and 5/30/25, 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.	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	7/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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 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 complaint survey from 05/11/2025 to 05/24/2024, the facility was deficient in CNA staffing for residents on 3 of 14-day shifts as follows: On 05/11/25 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. On 05/22/25 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. On 05/24/25 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs.	S 560	deficient practice. C. Facility to implement weekly recruitment meetings to discuss hirings, wages, incentive, and job ads. 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 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.	

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
315246 Y1	A. Building B. Wing Y2	7/9/2025 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 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 F0585	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.10(j)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/07/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/16/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060807 Y1	A. Building B. Wing Y2	7/9/2025 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	07/07/2025	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	
6/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO