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 07/09/2024

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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS C/O # NJ 167426, 168185, 169372, 170022, 170808, 172515, 172554, 172574, 172819, 173688, 173801 Standard Survey Census: 125 Sample Size: 35+ 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. In addition, a complaint investigation was completed.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		8/13/24

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

Electronically Signed | 07/25/2024

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.

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F 690	Continued From page 1 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to ensure that there was a physician order for the use of a [NJ Ex Order 26.4(b)(1)] for 1 of 2 residents reviewed for [NJ Ex Order 26.4(] use (Resident #115). This deficient practice was evidenced by the following: On 06/26/2024 at 09:49 AM the [U.S. FOIA (b) (6)] told the surveyor that we tried a [NJ Ex Order 26.4(b)(1)] and the resident [NJ Ex Order] and then the [NJ Ex Order 26.4(b)(1)] was [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b) (6)] then told the surveyor Resident #115 was scheduled for a surgical procedure in [NJ Ex Ord]	F 690	" The attending physician was immediately notified on [NJ Ex Order 26.4(b)(1)], and a verbal order for the use of the [NJ Ex Order] was obtained and documented in Resident #115's medical record. A written order was subsequently obtained and filed. Resident #115's [NJ Ex Order 26.4(b)(1)] was reassessed to ensure proper placement and function. [redacted] effects were noted. " All residents with foley catheters are at risk with this deficient practice. A comprehensive audit of all residents with Foley catheters was conducted on 06/26/2024 to ensure there are physician	

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F 690	Continued From page 2 On 06/26/2024 at 12:15 PM, Resident # 115 was observed self-propelling in their wheelchair in the hallway. The [NJ Ex Order 26.4(b)(1)] was noted inside a [NJ Ex Order 26.4(b)(1)] A review of the Admission Record revealed Resident #115 was admitted to the facility with diagnoses including but not limited to: [NJ Ex Order 26] with [NJ Ex Order 26.4(b)(1)] A review of the most recent Minimum Data Set (MDS), an assessment tool, dated [NJ Ex Order 26.4(b)(1)], revealed Resident #115 had a Brief Interview for Mental Status (BIMS) score [NJ Ex]/15 indicating the resident had [NJ Ex Order 26.4(b)(1)]. The MDS further indicated the resident used an [NJ Ex Order 26.4(b)(1)] A review of the Physician Order sheet revealed the following orders: AHC: NJ Ex Order 26.4(b)(1) in place at all times every shift for Care with a start date of [NJ Ex Order 26.4(b)(1)] and discontinued (d/c) date of [NJ Ex Order 26.4(b)(1)]. AHC: NJ Ex Order 26.4(b)(1) every shift for care with a start date of [NJ Ex Order 26.4(b)(1)]4 and d/c date of [NJ Ex Order 26.4(b)(1)]. AHC: NJ Ex Order 26.4(b)(1) monitoring: Monitor [NJ Ex Order 26.4(b)(1)] every shift. Every shift for monitoring with a start date of [NJ Ex Order 26.4(b)(1)] and d/c date of [NJ Ex Order 26.4(b)(1)]. AHC: NJ Ex Order 26.4(b)(1) PRN (as needed) change [NJ Ex Order 26.4(b)(1)] (NJ Ex Order 26.4(b)(1)) change prn based on clinical indications such as [NJ Ex Order 26.4(b)] [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)] [NJ Ex Order 26.4(b)(1)] or when the [NJ Ex Order 26.4(b)(1)] is	F 690	orders for each catheter. This audit included review of current physician orders, progress notes, and treatment administration records. No other residents were found to have a Foley catheter without a proper physician order. " The facility policy on Catheter Care was reviewed. Staff Education: All licensed nursing staff have received training on the Catheter Care policy and the importance of obtaining and documenting physician orders for Foley catheters. This training was completed on 06/26/2024 and will be ongoing for all new hires and as needed. The Director of Nursing (DON) or designee will conduct weekly audits of residents with Foley catheters to ensure compliance with the revised policy. These audits will continue for three months and then monthly for an additional three months. " The findings from the audits will be reported to the QAPI committee monthly 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 these corrective actions quarterly and make adjustments as needed to ensure sustained compliance.	

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F 690	Continued From page 3	F 690		

compromised with a start date of NJ Ex Order 26.4(b)(1) and d/c date of NJ Ex Order 26.4(b)(1).

There were no further orders regarding the use and care of Resident #115's NJ Ex Order 26.4(b)(1) after having been discontinued on NJ Ex Order 26.4(b)(1).

A review of the Treatment Administration Record (TAR) dated NJ Ex Order 26.4(b) - NJ Ex Order 26.4(b)(1) revealed the following physician orders:

AHC: NJ Ex Order 26.4(b)(1) in place at all times every shift for Care with a start date of NJ Ex Order 26.4(b)(1) and discontinued (d/c) date of NJ Ex Order 26.4(b)(1).

AHC: NJ Ex Order 26.4(b)(1) every shift for care with a start date of NJ Ex Order 26.4(b)(1) and d/c date of NJ Ex Order 26.4(b)(1).

AHC: NJ Ex Order 26.4(b)(1) monitoring: Monitor NJ Ex Order 26.4(b)(1) every shift. Every shift for monitoring with a start date of NJ Ex Order 26.4(b)(1) and d/c date of NJ Ex Order 26.4(b)(1)
AHC: NJ Ex Order 26.4(b)(1) PRN (as needed) change NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) change prn based on clinical indications such as NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) or when the NJ Ex Order 26.4(b)(1) is compromised with a start date of NJ Ex Order 26.4(b)(1) and d/c date of NJ Ex Order 26.4(b)(1).

A review of the TAR for NJ Ex Order 26.4(b - NJ Ex Order 26.4(b)(1 did not include the above orders.

A review of a Progress Note (PN) dated NJ Ex Order 26.4(b)(1 at 10:20 AM revealed the NJ Ex Order was NJ Ex Order 26.4(b without difficulty.

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F 690	Continued From page 4 A PN dated [NJ Ex Order 26.4(b)(1)] at 12:07, revealed "pt (patient) [NJ Ex Order] was [NJ Ex Order 26.4(b)(1)]. pt was [NJ Ex Order 26.4] today by this nurse. pt is [NJ Ex Order 26.4(b)] at NJ Ex Order 26.4(b)(1)). this nurse was instructed by MD (physician) to place [NJ Ex Order] pt was able to tolerate [NJ Ex Order] [NJ Ex Order] is [NJ Ex Order 26.4(b)(1)] During an interview with the surveyor on 07/01/2024 at 01:02 PM, Licensed Practical Nurse (LPN #1) was asked what physician orders are required for the care of residents. LPN #1 responded, "In general we need physician orders for medications, if [NJ Ex Order] placed or taken out, and if [NJ Ex Order] remains in place, diet order, oxygen, BP, vital signs, wound treatments. When asked who is responsible for getting the orders LPN #1 said the nurses are responsible to obtain physician orders. During an interview with the surveyor on 07/01/2024 at 02:13 PM, the U.S. FOIA (b) (6)) was asked what physician orders are required for the care of residents. The [U.S. FOIA] replied, "Orders to provide care, medications, treatment orders, [NJ Ex Order 26.4] and [NJ Ex Order 26] The surveyor asked if the [U.S. FOIA] saw a physician order for the use and care of the [NJ Ex Order] for Resident #115 and the [U.S. FOIA] responded I did not see a physician order for the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] confirmed, "There should have been a physician order for the [NJ Ex Order 26.4(b)(1)]." A review of a facility policy titled Catheter Care, Urinary with a revised date of August 2022, did not include that a resident requires a physician order for use of a Foley. NJAC 8:39 27.1(a)	F 690		

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents, it was determined that the facility failed to maintain a detailed record of receipts and accurate reconciliation of [NJ Ex Order 26.4(b)(1)]	F 755	" The Director of Nursing (DON) immediately completed the missing information on the seven DEA 222 forms, including the delivery amount and date	8/13/24

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F 755	Continued From page 6 NJ Ex Order 26.4(b)(1) This deficient practice was evidenced by the following: On 06/27/2024 at 01:38 PM, the surveyor requested and reviewed all the Drug Enforcement Administration (DEA) 222 forms (a form used for ordering controlled substances) for the last 6 months from the U.S. FOIA (b) (6)) for the past 6 months. At that time the surveyor also requested copies of those seven forms. The U.S. FOIA (provided the surveyor with seven (7) DEA 222 forms. A review of the DEA 222 forms showed there was no entered delivery amount and date for 7 of 7 DEA 222 forms and 2 of 7 NO. (number) of packages were not completed and accurately documented as follows: 1. DEA 222 Order form #230109741 dated 1/22/2024 contained an order for package size 6 Hydrocodone-Acetaminophen 5-325, package size 25 Oxycodone HCL 5 mg (milligrams), package size 6 oxycodone HCL 10 mg, package size 25 Oxycodone HCL 15 mg, package size oxycodone-Acetaminophen 7.5-325, package size 17 Oxycodone-acetaminophen 5-325, and package size 2 Oxycontin ER (extended release) 10 mg. 2. DEA 222 Order Form 230109749 dated 2/12/2024 contained an order for 1 package of 50 Oxycodone HCL 5mg, 1 package of 21 Oxycodone HCL 10 mg, 1 package of 9 Oxycodone HCL 15 mg, 1 package of 10 Oxycodone-Acetaminophen 7.5-325, 1 package of 14 Oxycontin 10mg and 1 package of oxycontin 20mg. A review of the DEA 222 form did not include the number of packages received and the date received.	F 755	received, upon identification of the deficiency on 06/27/2024. All current and pending DEA 222 forms were reviewed for completeness, and any missing information was promptly filled in. " All residents are at risk with this deficient practice. On 6/27/2024 an audit of all controlled substance order records for the past six months was conducted to identify any additional instances of incomplete DEA 222 forms. Any deficiencies found during the audit were corrected immediately, and the audit results were documented and reviewed with the administrative team. " The policy and procedure for the proper completion of DEA 222 forms was reviewed, to ensure it included the requirement to document the number of packages received and the date received was in place. This policy includes detailed steps for both the ordering and receiving processes. The U.S. FOIA (b) and all staff involved in the ordering and receiving of controlled substances will be trained on the proper policy and the proper completion of DEA 222 forms by the Regional Director of Nursing. This was completed on 6/27/2024. The DON or designee will conduct weekly audits of all DEA 222 forms to ensure compliance with the procedure. These audits will continue for three months and then transition to monthly audits for an additional three months.	

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F 755	Continued From page 7 3.DEA 222 Order Form #230109748 dated 3/18/2024 contained an order for 1 package of 30 Morphine Sulfate ER 15mg, 1 package 24 Morphine Sulfate 30mg, 1 package Oxycodone HCL 5mg, 1 package of 14 Oxycodone HCL 10mg, 1 package of 21 Oxycodone HCL 15 mg, 1 package 34 Oxycontin 10 mg, and 1 package of 30 Oxycontin 20 mg. A review of the DEA 222 form did not include the number of packages received and the date received. 4. DEA 222 Order form 230109747 dated 4/22/2024, contained an order for 1 package 16 Hydrocodone-Acetaminophen 5-325, 1 package 24 Morphine Sulfate 15 mg, 1 package 26 Morphine Sulfate 30 mg, 1 package 36 Oxycodone HCL 5 mg and 1 package Oxycodone HCL 10 mg. A review of the DEA 222 form did not include the number of packages received and the date received. 5. DEA 222 Order Form # 240397650 dated 5/1/2024, contained an order for an order for package size 3 Morphine Sulfate liquid 20mg/ml (milliliter). The DEA 222 dorm did not include the number of packages ordered. A further review of the DEA 222 form did not 5/24 contained an order for 1 package of 50 Oxycodone HCL 5 mg, and 1 package of 32 Oxycodone HCL 10 mg. A review of the DEA 222 form did not include the number of packages received and the date received. 6. DEA 222 Order Form 240397649 dated 5/15/2024 contained and order for 1 package of 50 Oxycodone HCL 5 mg and 1 package of 32 Oxycodone HCL 10 mg. A review of the DEA 222 form did not include the number of packages received or the date received.	F 755	" The findings from the audits will be reported to the QAPI committee monthly 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 these corrective actions quarterly and make adjustments as needed to ensure sustained compliance.	

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F 755	Continued From page 8 7. DEA 222 Order Form # 03202024 dated 6/10/2024 contained an order for 1 package of 50 Oxycodone HCL 5 mg and 1 package of 40 Oxycodone 10mg. A review of the DEA 222 form did not include the number of packages received and the date received. During an interview with the surveyor on 07/01/2024 at 02:15 PM, the [redacted] was asked who is responsible for completing the DEA 222 forms when the medications are ordered. The [redacted] replied that she was, and she kept a copy of the form, and the original was sent to the pharmacy. The [redacted] said she kept the delivery slips when the medications came and attached them to the copy. The surveyor asked why Part 5 was not completed on the forms and the [redacted] responded, "I didn't know I had to fill that in as I kept copies of delivery slips." On 07/02/2024 at 10:44 AM, the surveyor requested a copy of facility policy for DEA 222 form from the [redacted] On 07/02/2024 at 11:07 AM, the [redacted] said the facility does not have a policy for DEA 222 forms. A review of the printed instructions on the front of the DEA 222 form indicated: Part 1: to be filled in by the Purchaser. A further review of the instructions revealed Part 5: "To BE FILLED IN BY PURCHASER, number of packages received, and date received."	F 755		
F 812 SS=F	NJAC 8:39-27.9(c) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/13/24

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F 812	Continued From page 9 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 6/26/2024 from 9:17 to 9:56 AM, the surveyor, accompanied by the U.S. FOIA (b) (6), observed the following in the kitchen: 1. Upon entry to the kitchen a U.S. FOIA (b) (6) was observed to have lengthy braids extending to the shoulder area. The braids on either side of the head were not contained in the hair net and were exposed.	F 812	On 06/26/2024 The U.S. FOIA (b) (6) with exposed hair was immediately instructed to properly contain hair within a hair net. The employee was educated on proper policy, the whole dietary department was inserviced on the proper policy. The dented can of "Pear Diced" was removed and placed in the designated damaged can area. All wet nested pans were rewashed, sanitized, and air-dried before storage. The high temperature dishwasher was shut down, and all dishware washed during the malfunction was rewashed once the dishwasher was repaired. Spoiled parsley and lettuce were	

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F 812	Continued From page 10 2. In the dry storage room on an upper shelf a can of "Pear Diced" had a significant dent on the upper seam of the can. The U.S. FOIA removed the dented can to the designated dented/damaged can area on a lower shelf of the room. 3. A stack of 5 half pans on the middle rack of the pot/pan storage rack were in the inverted position. The surveyor lifted the top pan on the stack and felt the bottom of the pan below. The pan was wet to the touch and there was a watery substance on the bottom edge of the pan a condition known as wet nesting (occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow). The U.S. FOIA agreed that the pans were wet and proceeded to remove the half pans from the rack. When interviewed the U.S. FOIA agreed that all dishware should be air dried prior to storage. The U.S. FOIA removed the effected half pans from the storage rack to be rewashed and sanitized and air dried before storage. 4. At 9:34 AM the surveyor and U.S. FOIA went to observe the high temperature dish machine which was actively in use at the time washing dishware used for resident meals. The surveyor upon arrival to the dishwasher area reviewed the June 2024 [facility name] DISHWASHER TEMPERATURE LOG. Observation of the log reveled the following: Minimum temperature for wash cycle: 160 F (Fahrenheit) rinse cycle: 180 F. The log further revealed that "If temperatures were below standard, the person in charge was notified and dish machine was stopped."	F 812	discarded. All undocumented refrigerator and freezer temperatures were immediately recorded, and the staff responsible were reminded of the documentation requirements. Unlabeled and expired food items were discarded. " All residents are at risk from this deficient practice. On 06/26/2024 an audit of all kitchen areas and equipment was conducted to identify any additional instances of non-compliance with kitchen sanitation policies. Any deficiencies found during the audit were corrected immediately, and the audit results were documented and reviewed with the administrative team. " On 06/26/2024, the kitchen sanitation policies, including hair containment, dented can management, wet nesting prevention, dishwasher temperature monitoring, and food storage, were reviewed and updated where necessary. On 06/26/2024 all dietary staff received training on the kitchen sanitation policies and procedures. This training included proper hair containment, handling of dented cans, preventing wet nesting, monitoring dishwasher temperatures, and ensuring proper food storage and labeling. Staff were trained on the importance of maintaining correct temperatures and the procedure for shutting down the dishwasher if temperatures are not met. On 06/26/2024 regular inspections of food storage areas were implemented to	

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F 812	Continued From page 11 A review of the log for breakfast on 6/26/2024 revealed the following temperatures: Wash: 160 and Rinse: 180. At 9:34 AM, the surveyor observed the high temperature dishwasher wash and rinse temperatures while staff were actively washing dishware and the U.S. FOIA was present. The surveyor observed a wash temperature of 140 F and a rinse temperature of 140 F. The surveyor immediately conducted an interview with the U.S. FO responsible for loading dirty dishware into the dishwasher and monitoring machine temperatures. The U.S. FO stated that she had observed and recorded the wash and rinse temperature of the high temperature dishwasher at approximately 9:15 AM and recorded a wash temperature of around 150 F and a rinse temperature of around 140 F. The surveyor then asked the U.S. FO what the minimum temperature requirements were for the high temperature dishwasher to effectively clean and sanitize dishware. The U.S. FO responded, "The rinse should be around 180 F and the wash around 160 F." The surveyor asked the U.S. FO what should happen if the dishwasher is not meeting minimum temperatures for the wash and rinse. The U.S. FO stated, "I should've shut it down and notified the U.S. FOIA (D At that time the U.S. FOIA agreed that the machine was not meeting minimum temps for wash and rinse. " On 06/26/2024 at 09:43 AM, the surveyor accompanied by the U.S. FOIA and U.S. FO observed the high temperature dishwasher again for the wash and rinse temperatures. The following temperatures were observed: Wash = 142 F rinse = 140 F. The U.S. FOIA agreed that the high temperature dishwasher was not meeting minimum wash and rinse temperatures and the dishwasher was shut down at 9:45 AM. The U.S. FOIA stated that the facility had a sufficient supply of paper products to serve the lunch meal. The U.S. FOIA	F 812	ensure all food items are properly labeled, dated, and stored. Spoiled or expired items are to be discarded immediately. " Weekly audits of the kitchen, food storage areas, and temperature logs will be conducted by the FSD or designee. Daily rounds by the Food Service Director will be done to ensure policy compliance. 4. The Findings of the weekly audits will be presented to the QAPI committee MOnthly for a period of three months.The QAPI committee will review the effectiveness of the corrective actions quarterly and make necessary adjustments to ensure ongoing compliance.	

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also told the surveyor that all dishes that had been washed up to shutting down the dishwasher would be rewashed and that he would call the facility contracted service company immediately to service and fix the high temperature dishwasher. On 06/27/2024 at 9:16 AM, the facility U.S. FOIA (b) (6) provided the surveyor with a copy of the "Extra Service Request" for the dishwasher that was dated 6/26/2024 at 1:53 PM. The request sheet revealed the following under the Service Comments: "Arrived and tested rinse. Did not register on gauge. Replaced rinse gauge. Tested. Did reach sanitation temp (error, should read did not). Tested booster power. There was no power. Found circuit breaker in off position. Turned on and tested. Reached 180. Reviewed with staff."

5. In the walk-in refrigerator on an upper shelf a clear plastic bag contained whole parsley. The parsley was darker green and slimy on the bottom of the clear plastic bag. On the same shelf a cardboard box was opened and contained heads of lettuce. A clear plastic bag in the box contained 2 separate romaine lettuces. The bag was opened, and the lettuce was exposed. The lettuce was noted to be brown and slimy. The U.S. FOIA removed the parsley and lettuce to the trash.

On 06/27/2024 from 08:32 to 8:38 AM, the surveyor, accompanied by the Registered Nurse/Unit Manager (UM/RN#1) observed the following on the 1st floor/East Wing pantry:

1. Observation of the Non Dietary Dept. Refrigerator/Freezer/Cold Pack Machine Temperature Log, dated 6/24 revealed that no temperatures were documented on 6/26/2024 for the refrigerator and freezer and no temperatures

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were recorded for 6/27/2024 for the refrigerator and freezer. According to UM/RN#1, temperatures are to be recorded for the refrigerator and freezer daily by the 11-7 nursing staff.

2. Inside the refrigerator four (4) what appeared to be salami sandwiches on white bread were stored on the refrigerator door shelf. The sandwiches were in wax paper bags. The bags had no dates. A resident designated, zippered, food storage/carry bag contained a clear plastic container with what appeared to be cucumber/tomato/onion salad. The container was labeled "eat by 6/18." In addition, an unidentified food item wrapped in tin foil had no date. RN/UM #1 removed all unlabeled, undated, and expired food to the trash. In addition, RN/UM #1 stated to the surveyor, "The temperatures should be done daily for the freezer and refrigerator by the 11-7 nursing staff. I checked it yesterday, but I must have forgotten to write it down."

The surveyor reviewed the facility policy titled Dishwasher Temperature, Date Reviewed/Revised: 4/9/24. The following was revealed under the heading Policy: "It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures." The policy further revealed under Policy Explanation and Compliance Guidelines:

1. All items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items.

2. Manufacturer's instructions shall be followed for machine washing and sanitizing.

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3. For high temperature dishwashers (heat sanitization):
a. The wash temperature shall be 150-165 degrees F:
b. The final rinse temperature shall be 180 degrees F or above but not to exceed 194 degrees F (165 degrees F for stationary rack, single temperature machine). Corrective actions shall be taken for final temperatures below the required final rinse temperatures.

6. Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes.

The surveyor reviewed the facility policy titled Food Safety Requirements, Date Reviewed/Revised: 4/9/24. The following was revealed under Policy: "It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. The following was revealed under Policy Explanation and Compliance Guidelines:

1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the foods to the resident. Elements of the process include the following:

b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms.

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e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food.

3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage.
c. Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safe refrigerated storage include:
iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded and
v. Keeping foods covered or in tight containers.

6. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination.
a. Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment.

7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects.
d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.
e. Hairnets should be worn during cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad. However, staff do not need to wear hairnets when distributing foods to residents at the dining table(s) or when assisting residents to dine.

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F 812	Continued From page 16 The surveyor reviewed the facility policy titled Use and Storage of Food Brought in by Family or Visitors, Date Reviewed/Revised: 4/2/24. The following was revealed under the heading Policy Explanation and Compliance Guidelines: 2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. b. The prepared food must be consumed by the resident within 3 days. c. If not consumed within 3 days, food will be thrown away by facility staff. NJAC 18:39-17.2(g)	F 812		

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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: S560 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 1.) 5 of 7 day shifts for the week of complaint staffing from 9/10/2023 to 09/16/2023, 2.) 7 of 7 day shifts for the week of complaint staffing from 10/01/2023 to 10/07/2023, 3.) 7 of 7 day shifts for the week of complaint staffing from 11/12/2023 to 11/18/2023, 4.) 7 of 7 day shifts for the week of complaint staffing from 12/10/2023 to 12/16/2023, 5.) 7 of 7 day shifts for the week of complaint staffing from 12/24/2023 to 12/30/2023, 6.) 7 of 7 day shifts for the complaint staffing from	S 560	" Facility immediate efforts include ongoing hiring nursing staff, increasing employee incentives, and increasing agency use to fill any open shifts. " All residents have the potential to be affected by this practice. " Facility to implement weekly recruitment meetings to discuss hiring, wages, incentive, and job ads. The Administrator and Staffing Coordination will review staffing schedules daily to ensure adequate staffing for the facility. If insufficient staffing is identified and can not be filled with staff or agency, licensed department heads will be mandated to fill	8/13/24

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

Electronically Signed | 07/25/24

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S 560	Continued From page 1 01/21/2024 to 01/27/2024, 7.) 6 of 7 day shifts for the complaint staffing from 02/02/2024 to 02/10/2024, 8.) 7 of 7 day shifts for the week of complaint staffing from 03/31/2024 to 04/06/2024, and 9.) 14 of 14 day shifts for the 2 weeks of staffing prior to the recertification survey from 06/09/2024 to 06/22/2024. 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 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 week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -09/10/23 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs.	S 560	in. " 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 the effectiveness of these corrective actions quarterly and make adjustments as needed to ensure sustained compliance.	

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S 560	Continued From page 2 -09/11/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -09/12/23 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -09/15/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -09/16/23 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. 2. For the week of Complaint staffing from 10/01/2023 to 10/07/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/01/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/02/23 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/03/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/04/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/05/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -10/06/23 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. -10/07/23 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. 3. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -11/12/23 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -11/13/23 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. -11/14/23 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs.	S 560		

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S 560	Continued From page 3 -11/15/23 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -11/16/23 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -11/17/23 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -11/18/23 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. 4. For the week of Complaint staffing from 12/10/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/10/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/11/23 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/12/23 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/13/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/14/23 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/15/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/16/23 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs. 5. For the week of Complaint staffing from 12/24/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/24/23 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/25/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/26/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs.	S 560		

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ATLAS REHABILITATION & HEALTHCARE AT WEST D	550 JESSUP ROAD WEST DEPTFORD, NJ 08066

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S 560	Continued From page 4 -12/27/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/28/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -12/29/24 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. -12/30/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. 6. For the week of Complaint staffing from 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/21/24 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -01/22/24 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs. -01/23/24 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -01/24/24 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs. -01/25/24 had 14 CNAs for 129 residents on the day shift, required at least 16 CNAs. -01/26/24 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -01/27/24 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. 7. For the week of Complaint staffing from 02/04/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -02/04/24 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/06/24 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/07/24 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs.	S 560		

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 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT WEST D	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 5 -02/08/24 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -02/09/24 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -02/10/24 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs. 8. For the week of Complaint staffing from 03/31/2024 to 04/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/31/24 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -04/01/24 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs. -04/02/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -04/03/24 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -04/04/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -04/05/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -04/06/24 had 14 CNAs for 134 residents on the day shift, required at least 17 CNAs. 9. For the 2 weeks of staffing prior to survey from 06/09/2024 to 06/22/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -06/09/24 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/10/24 had 11 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/11/24 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/12/24 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs.	S 560		

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 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT WEST D	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 6 -06/13/24 had 11 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/14/24 had 11 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/15/24 had 8 CNAs for 133 residents on the day shift, required at least 17 CNAs. -06/16/24 had 8 CNAs for 133 residents on the day shift, required at least 17 CNAs. -06/17/24 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -06/18/24 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/19/24 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/20/24 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/21/24 had 9 CNAs for 130 residents on the day shift, required at least 16 CNAs. -06/22/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs On 07/01/2024 at 02:20 PM, the surveyor conducted an interview with the facility Licensed Nursing Home Administrator (LNHA), Director of Nursing and Regional Director of Operations. The surveyor asked the LNHA if he was familiar with the minimum staffing requirements for nursing homes. The LNHA stated that he was aware of the staffing mandates and told the surveyor the following: "7-3 requires 1 certified nursing assistant (CNA) to 8 residents, 1 to 10 CNAs for the 3-11 shift, and 1 to 14 CNAs for the 11-7 shift. The surveyor then asked the LNHA if the facility was consistently meeting the minimum staffing requirements and the LNHA replied, "Consistently, we try to meet them." The facility did not provide a policy or procedure for facility staffing.	S 560		

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 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT WEST D	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
S2120	8:39-31.1(c) Mandatory Physical Environment (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 7/8/24 in the presence of the Maintenance Director (MD) it was determined the facility failed to ensure the quarterly local fire inspections were performed in accordance with the New Jersey Uniform Fire Safety Code, N.J.A.C. 5:70. This deficient practice had the potential to affect 125 residents and was evidenced by: Record review at 12:25 PM revealed there were no records of the quarterly local fire inspections required by the New Jersey Uniform Fire Safety	S2120	A. The Local Fire Department was contacted and conducted Quarterly Fire Inspections. B. All residents have the potential of being affected by this deficient practice. C. The RDPO In-serviced the MD on policy and procedure on scheduling and conducting Quarterly Fire Safety and Inspections in accordance to New Jersey Uniform Fire Safety Code. Fire Inspection was completed, please attached documentation 07/08/24.	8/13/24

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 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION & HEALTHCARE AT WEST D	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
S2120	Continued From page 8 Code. In an interview at the same time the MD stated the local fire department only came out once for the liquid oxygen permit, and that they never came to the facility since he has been here for the local fire inspection. Then MD stated he has been employed at the facility 5 months. The Administrator, Regional Director of Operations, RDPO and MD were informed of the findings at 3:15 PM during the Life Safety Code exit conference.	S2120	D. The Maintenance Director will conduct weekly audits of all Quarterly, Semi Annual and Annual inspections to obtain compliance. E. The findings from the weekly audits will be reported to the QAPI committee monthly for a period of three months to determine that audits are sustained and if corrective actions are necessary.	

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	9/3/2024 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 F0690	Correction	ID Prefix F0755	Correction	ID Prefix F0812	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	08/13/2024	LSC	08/13/2024	LSC	08/13/2024
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?
7/9/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060807 Y1	A. Building B. Wing Y2	9/3/2024 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 S2120	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.1(c)	Completed	Reg. #	Completed
LSC	08/13/2024	LSC	08/13/2024	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/9/2024	☐ 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
	315246	A. BUILDING **01** B. WING _____	**07/09/2024**

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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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 7/8/2024 and 7/9/2024 and Promedica Skilled Nursing at West Deptford 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 Occupancies. Promedica Skilled Nursing at West Deptford is a two-story, Type II Protected building that was built in June 1987. The facility is divided into 9 smoke zones. There are 2 elevators. There are 156 beds. The facility has a 175 KW diesel fueled emergency power generator located outside. The generator anunciator panel is located at the 1st Floor East nurses station and the transfer switch is located in the main electrical closet off the maintenance shop. The facility is fully sprinklered. There are 3 dry sprinkler systems and 1 wet system, a Fire Department Connection (FDC) and 2 fire hydrants maintained by the facility. The rooms and common areas are smoke detector protected.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the	K 222		8/13/24

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

Electronically Signed | 07/25/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted] it was determined the facility failed to ensure in an exit path of egress, locks if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side in accordance with NFPA 101:2012 Edition, Section 19.2.2.2.1, 7.2.1.5.1 and 7.2.1.5.3. These deficient practices had the potential to affect 125 residents and were evidenced by: An observation at 12:16 PM revealed the front main entrance and exit sliding double doors were equipped with a manually operated turning latch that could physically lock the doors together preventing them from opening without operating the lock when engaged. In an interview at the time, the U.S. FOIA (b) [redacted] and U.S. FO	K 222	Egress Doors A. Upon notification of the deficient practice, Director of Maintenance Immediately removed the latch from the front double doors. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit was conducted on all egress doors to ensure there is no latch and key and was found to be in compliance. D. The RDPO In serviced the U.S. FOIA (b) (6) [redacted] on the proper policy and procedure on maintaining an exit path of egress, free from locks or use of key in accordance with the NFPA. E. The Maintenance Director will conduct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 3 confirmed the observation. The U.S. FOIA (b) (6) U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FO were informed of the findings at 3:15 PM during the Life Safety Code exit conference. N.J.A.C. 8:39-31.2 (e)	K 222	random weekly audits x 4 weeks to ensure compliance. F. The Maintenance Director will bring his findings to the QAPI committee monthly for a period of three months. The QAPI committee will review the effectiveness of these audits make adjustments as needed to ensure sustained compliance.	
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6), the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) it was determined the facility failed to ensure 2 of 8 stairwell exit doors closed into their door frames when opened to 90 degrees and released in accordance with NFPA 101:2012 Edition, Section 19.2.2.7, 19.3.1.7 and	K 223	Doors with Self Closing Devices: A. The Maintenance Director immediately repaired stairwell number 4 and stairwell number 1 exit door to ensure proper closure of doors within its door frame. See Attached work order and supporting videos.	8/13/24

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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
K 223	Continued From page 4 7.1.3.2. These deficient practices had the potential to affect all 125 residents and were evidenced by: An observation at 11:21 AM revealed the second floor stairwell number 4 exit door self closing device hit the door frame, preventing it from closing into the frame when opened to 90 degrees and released. The test was repeated two times with the same results. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observation. An observation at 11:37 AM revealed the second floor stairwell number 1 exit door self closing device hit the door frame, preventing it from closing into the frame when opened to 90 degrees and released. The test was repeated by the U.S. FO with the same results. In an interview at the time the U.S. FOIA (b) and U.S. FO confirmed the observation. The U.S. FOIA (b) (6) U.S. FOIA (b) (6), U.S. FOIA (b) and U.S. FO were informed of the findings at 3:15 PM during the Life Safety Code exit conference. N.J.A.C. 8:39-31.2 (e)	K 223	B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit on all stairwells exit doors was conducted by MD to ensure proper closure of doors within its door frame when opened to 90 degrees and released in accordance with NFPA and found to be in compliance. D. The RDPO In-serviced the U.S. FO on the proper policy and procedure on maintaining standard on self-closing doors to ensure closure within its door frame when opened to 90 degrees and released in accordance with NFPA. E. The MD will conduct random weekly audits x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	
K 291 SS=E	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	K 291		8/13/24

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	315246	A. BUILDING **01** B. WING _____	**07/09/2024**

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K 291	Continued From page 5 by: Based on observation and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6) [redacted] U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to ensure battery powered emergency lighting was provided at the emergency power generator transfer switch in accordance with NFPA 101:2012 Edition, Section 7.9, 19.2.9.1 and NFPA 110:2010 Edition, Section 7.3. This deficient practice had the potential to affect 125 residents and was evidenced by: An observation at 11:59 AM revealed a battery powered emergency light was not present at the emergency power generator transfer switch located in the main electrical closet. In an interview at the time, the NJ Ex Order 2 [redacted] and NJ Ex O [redacted] confirmed the observation. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) [redacted] and U.S. FO [redacted] were informed of the findings at 3:15 PM during the Life Safety Code exit conference. This deficient practice was cited at the previous Life Safety Code survey dated 11/1/22. N.J.A.C. 8:39-31.2 (e)	K 291	Emergency Lighting A. The Maintenance Director installed a battery powered emergency light at the emergency power generator transfer switch located in the main electrical closet. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit on all emergency lighting devices was conducted to ensure battery backup lighting in all areas including emergency power generator switch location are functional in accordance with NFPA and found to be in compliance. D. The RDPO In serviced the U.S. FO [redacted] on policy and procedure of ensuring presence of battery power emergency lighting in generator transfer switch location in accordance with NFPA. E. The MD will conduct a random weekly audit x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	
K 300 SS=F	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the	K 300		8/13/24

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K 300	Continued From page 6 applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure every opening in a fire barrier was protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other in accordance with NFPA 101 2012 Edition, Section 8.3.4, 8.3.5, 8.3.5.1, 8.3.5.6 and 19.3. These deficient practices had the potential to affect 125 residents and were evidenced by: An observation at 10:56 AM revealed a 23 inch by 38 inch opening in the firewall between the second floor and the attic space in the 2nd Floor West storage closet by room 214. There was a fixed ladder going through a 24 inch by 48 inch opening in the drop ceiling below the firewall opening. There were multiple wire penetrations going through the fire wall to the attic and wire penetrations going through the vertical drywall smoke barrier wall in the location. In an interview at the time the U.S. FOIA (b) and U.S. FO confirmed the observations. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) , U.S. FOIA (b) and U.S. FO were informed of the findings at 3:15 PM during the Life Safety Code exit conference.	K 300	Protection A. By west storage closet by room 214, The Maintenance Director installed a Fire-rated door hatch to cover the opening in the firewall between the second floor and the attic space on the second-floor storage room. Moreover, the MD sealed the multiple wire penetrations going through the fire wall to the attic with fire-rated foam retardant caulking. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit on all areas that require fire barriers and found to be in compliance. D. The RDPO In-serviced the U.S. FO on proper policy and procedure on protection barriers to limit the spread of fire and restrict the movement of smoke in accordance with NFPA. E. The MD will conduct a random weekly audits x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	

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K 300	Continued From page 7 N.J.A.C. 8:39-31.2(e)	K 300		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6)), U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) , it was determined the facility failed to	K 324	Cooking Facilities A. The Semiannual hood and suppression system inspection was performed on the kitchen hood and	8/30/24

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K 324	Continued From page 8 ensure the semiannual kitchen hood and cooking line fire suppression system inspection was performed in accordance with NFPA 101:2012 Edition, Section 19.3.2.5, 9.2.3 and NFPA 96:2011 Edition. This deficient practice had the potential to affect 125 residents and was evidenced by: An observation and record review at 11:41 AM revealed 2 of 2 kitchen suppression system inspection tags marked the last semiannual inspection performed was dated July 2023, 12 months since the previous inspection. There were no other inspection documents provided for the fixed kitchen suppression system. In an interview at the time the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FO confirmed the observation and record review. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) , U.S. FOIA (b) and U.S. FO were informed of the findings at 3:15 PM during the Life Safety Code exit conference. N.J.A.C. 8:39-31.2 (c), 31.2(e) NFPA 96	K 324	cooking line fire suppression system. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit on all quarterly, semi- annual and annual inspections was conducted and found to be in compliance. D. The RDPO in-serviced U.S. FO on ensuring that the fire suppression system inspection is completed as necessary in accordance with the NFPA and all necessary scheduled inspections are done. Kitchen system inspection completed and scheduled semi annually going forward, see attached invoice. E. The MD will conduct random weekly audits x 4 weeks to ensure compliance to inspections and proper documentations are in place. F. The MD will bring results of the audit findings to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		8/13/24

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K 353	Continued From page 9 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 7/8/24 and 7/9/24 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) it was determined the facility failed to ensure the automatic fire sprinkler system was inspected, tested and maintained in accordance with NFPA 101:2012 Edition, Section 19.3.5.1, 19.3.5.4, 9.7, NFPA 13:2010 Edition and NFPA 25:2011 Edition. These deficient practices had the potential to affect 125 residents and were evidenced by: Record review on 7/8/24 at 11:05 AM of the fire sprinkler system inspection reports revealed the following: 1. The last 5 year internal inspection on 7/9/21 identified 3 of 3 dry sprinkler systems failed for heavy residue in pipe and excessive corrosion /scale build up in system. Only 1 of the 3 systems, the West Wing system has documentation of repairs on 6/26/24. The Main dry and East Wing dry systems have no documentation of corrosion repairs or a passing inspection. After being identified as noncompliant on 7/9/21, the deficiencies are stated as	K 353	Sprinkler System Maintenance and Testing A. 1.1 Corrosion repairs for the Main and East dry system wings have been completed a passing inspection have been obtained. 1.2 The repair of the piping from Fire Department Connection to the check valve was completed and passing inspection was obtained. 1.2 a. The repair quote was approved, and the repairs were conducted and completed, and the passing results were obtained. 1.2 b. The repair on piping of the 2 of 3 dry systems were done and a full trip test on the Main and East dry systems were completed. Passing inspections obtained. 1.2 c. The Maintenance Director contacted the fire alarm company and wiring the valve tamper and waterflow switch for the elevator shaft devices to the Fire Alarm Control Panel was done. B. All residents have the potential of	

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K 353	Continued From page 10 noncompliant in the following subsequent inspections: 4/22/24 quarterly, 12/14/23 quarterly, 7/7/23 annual and 7/18/22- 3 year inspection. The reports state the customer is aware in the comments. 2. On 7/9/21 during the 5 year inspection a hydrostatic test of the piping from the Fire Department Connection (FDC) to the check valve failed and no documentation of repair or passing inspection were provided by the facility. 3. The last 3 year fire sprinkler system inspection report conducted on 7/18/22 identified: a.) Two of the 3 dry fire sprinkler systems, the Main and East Wing dry systems failed the 3 year air leakage tests by loosing 3 pounds per square inch of pressure in 1 hour during the 2 hour duration test. The noncompliance for failing the air leak test for the 2 systems are stated and noted as not being conducted on the following subsequent inspection reports: 4/22/24 quarterly, 12/14/23 quarterly, 7/7/23 annual and 7/18/22- 3 year inspection. The reports state customer is aware in the comments. Facility was quoted on 9/21/23 to repair the leaks. No documentation of repairs or passing test results for either system were provided. b.) A full trip test has not been performed on 2 of the 3 dry sprinkler systems. The Main dry and East dry sprinkler systems were due for a full trip test during the 3 year inspection conducted on 7/18/22. The test could not be conducted because of the poor condition of the pipes discovered on and not corrected since 7/9/21. The noncompliance for no full trip test for the 2 systems are stated and noted as not being	K 353	being affected by this deficient practice. C. A facility- wide audit of Sprinkler system and Maintenance and testing of the 3 systems was done to ensure that the automatic fire sprinkler system and the standpipe system were inspected, tested and maintained and found to be in compliance. See attached invoice of inspection. D. The RDPO In serviced the [redacted] on policy and procedure of maintenance and testing of the automatic sprinkler system and the standpipe system in accordance with the NFPA. E. The MD will conduct a random weekly audit x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	

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K 353	Continued From page 11 conducted due to the poor condition of the piping and failing the air leak test on the following subsequent inspection reports: 4/22/24 quarterly, 12/14/23 quarterly, 7/7/23 annual and 7/18/22- 3 year inspection. The reports state customer is aware in the comments. There was no document provided for the repairs being done or the trip tests completed. c.) There is a comment that first appears on the 7/18/22 -3 year inspection for the facility to contact the fire alarm company to wire the valve tamper and waterflow switch for the elevator shaft devices to the Fire Alarm Control Panel (FACP). The comment is repeated in the following inspections: 7/7/23 annual sprinkler inspection, 12/14/23 quarterly sprinkler inspection, and quarterly sprinkler inspection 4/22/24. There was no evidence of the work being done. In an interview on 7/9/24 at 3:10 PM the NJ Ex Order 2 and NJ Ex O stated they were not aware of the elevator shaft devices having to be wired to the FACP. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) , U.S. FOIA (b) and U.S. FO were informed of the findings at 3:15 PM during the Life Safety Code exit conference. N.J.A.C. 8:39-31.2 (c), 31.2(e) NFPA 13, 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		8/13/24

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K 363	Continued From page 12 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6)	K 363	Corridor Doors A. The Maintenance Director	

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K 363	Continued From page 13 U.S. FOIA) it was determined the facility failed to ensure corridor doors closed and latched into their frame without impediment and resisted the passage of smoke in accordance with NFPA 101 2012 Edition, Section 19.3.6.3. This deficient practice had the potential to effect all residents residing in the location and was evidenced by: An observation at 11:12 AM revealed the corridor door to room 227 was equipped with a automatic door closer and held open by a magnetic device at 90 degrees to the opening. When released, the door hit the door frame and prevented it from closing into the frame. In an interview at the same time, the U.S. FOIA (b) and U.S. FO confirmed the observation. An observation at 1:40 PM revealed the corridor door to room 104 was equipped with a automatic door closer and held open by a magnetic device at 90 degrees to the opening. When released, the door hit the door frame and prevented it from closing into the frame. In an interview at the same time, the U.S. FOIA (b) and U.S. FO confirmed the observation. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were informed of the findings at the Life Safety Code exit conference on 7/9/24 at 3:15 PM. N.J.A.C. 8:39-31.2 (e)	K 363	immediately repaired corridor door to room 227 and to door to room 104 to ensure that the door closes into the door frame. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit on all corridor doors equipped with automatic door closers held by magnetic device at 90 degrees to the opening was conducted to ensure that corridor doors closed and latched into the frames without impediment and resisted the passage of smoke in accordance with NFPA and found to be in compliance. D. The RDPO In serviced the U.S. FO on ensuring that policy and procedures on maintaining proper corridor closing and latching into the frames without impediment and resisted the passage of smoke in accordance with NFPA. E. The MD will conduct random weekly audits x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 374		8/13/24

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K 374	Continued From page 14 Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined the facility failed to ensure 2 of 6 smoke barrier doors resist the transfer of smoke when released from their hold open devices in accordance with NFPA 101:2012 Edition, Section 19.3.7, 19.3.6.3 and 8.5. These deficient practices had the potential to affect 125 residents and were evidenced by: An observation at 11:16 AM revealed one of the doors for the double smoke doors by room 211 failed to close into its door frame when released from the hold open device. One door hit the other door, blocking it from closing and resisting the transfer of smoke and/or fire. The test was repeated with the same results. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observation.	K 374	Smoke Barrier Doors A. The Maintenance Director installed a door sweep at the bottom of the smoke barrier doors next to the Human Resources office which reduced the vertical space to 3/4 inch. Furthermore, immediate repair was done on the smoke door by room 211 to ensure closure of the door to its frame. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit was done on all Smoke Barrier doors to ensure that the doors resist the transfer of smoke when released from their hold open devices in accordance with NFPA and found to be in compliance. D. The RDPO In serviced the U.S. FO on policy and procedure on ensuring that smoke barrier doors resist the transfer of smoke when released from their hold open devices and that vertical clearance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315246	A. BUILDING **01** B. WING _____	**07/09/2024**

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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K 374	Continued From page 15 An observation at 12:20 revealed the smoke barrier doors by the Human Resources office had a 1-1/16 inch space between the floor and the bottom of the door when closed on 1 of the 2 doors which exceeded the maximum of 3/4 inch. In an interview at the time, the [NJ Ex Order 2] and [NJ Ex O] confirmed the observation and the measurement. The [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] were informed of the finding at the Life Safety Code exit conference at 3:15 PM. N.J.A.C. 8:39-31.2 (e)	K 374	does not exceed a maximum of 3/4 inch in accordance with NFPA. See attached work order. E. The MD will conduct random weekly audits x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/9/24 in the presence of the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)], it was determined the facility failed to ensure 6 of 13 bathroom exhaust fans observed were operational in accordance with NFPA 101:2012 Edition, Section 19.5.2.1, 9.2. These deficient practices had the potential to affect 16 of 125 residents and were evidenced by:	K 521	HVAC A. The Maintenance Director repaired exhaust fans in resident bathrooms: 224, 136, 128, 104, 130 and 119. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit was done on all bathroom exhaust fans and found to be in	8/13/24

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	315246	A. BUILDING **01** B. WING _____	**07/09/2024**

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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K 521	Continued From page 16 Observations during a facility tour between 10:35 AM and 2:05 PM revealed the exhaust fans in resident rooms: 224, 136, 130, 128, 104 and 119 bathrooms did not operate when tested by the DM in the presence of the surveyor. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observations. The U.S. FOIA (b) (6) U.S. FOIA (b) (6) , U.S. FOIA (b) and U.S. FO were informed of the findings at 3:15 PM during the Life Safety Code exit conference. N.J.A.C. 8:39-31.2 (e)	K 521	compliance. D. The RDPO In serviced the U.S. FO on policy and procedures of maintaining proper heating, ventilation, and air conditioning. E. The MD will conduct random weekly audits of resident bathrooms to ensure that exhausts are functional x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		8/13/24

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K 918	Continued From page 17 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 7/8/24 in the presence of the U.S. FOIA (b) (6) it was determined the facility failed to ensure the emergency power generator was inspected weekly for 30 of 44 weeks prior and exercised monthly under load for 6 of the last 13 months reviewed in accordance with NFPA 101:2012 Edition, Section 19.2.9.1, 7.8, 7.9, NFPA 110:2010 Edition, Sections 8.3 and 8.4 and NFPA 99:2012 Edition, Sections 6.4.4, 6.5.4, 6.6.4. These deficient practices had the potential to affect 125 residents and were evidenced by: Record review of the emergency power generator reports from 9:35 AM to 10:17 AM revealed the following: 1. There was no record of emergency generator weekly inspections for the months of June 2024, May 2024, and August to December 2023 and there were 3 missing in April 2024.	K 918	Electric Systems A. The Maintenance Director contacted the Electrical Generator company and completed a generator inspection and testing. B. All residents have the potential of being affected by this deficient practice. C. The RDPO in serviced the U.S. FOIA (b) (6) on the policy and procedures of essential electrical system maintenance and testing in accordance with NFPA. D. The Maintenance Director will conduct a weekly audit of generator inspections and logs x 4 weeks to ensure compliance. See attached logs. E. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	

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	315246	A. BUILDING **01** B. WING _____	**07/09/2024**

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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K 918	Continued From page 18 2. There was no record of emergency generator monthly load tests for the months of April 2024, March 2024 and June to November 2023. In an interview at the time, the [U.S. FO] confirmed the record review and stated he will see if he can find the missing reports. In an interview at 10:14 AM, the [U.S. FO] provided 1 monthly load test report for June 2024 and stated that was all he could find. No further inspection reports were provided. The [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)], [U.S. FOIA (b)] and [U.S. FO] were informed of the findings at 3:15 PM during the Life Safety Code exit conference on 7/9/24. N.J.A.C. 8:39-31.2 (e), 31.2(g) NFPA 99, 110	K 918		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K 923		8/13/24

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	315246	A. BUILDING **01** B. WING _____	**07/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 19 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 7/9/24 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined that the facility failed to store cylinders of compressed Oxygen in a manner that would protect the cylinders against tipping and rupture and failed to provide mechanical ventilation to rooms containing bulk liquid oxygen tanks in accordance with NFPA 99. These deficient practices had the potential to affect all residents and were evidenced by the following: 1. At 2:05 PM, the surveyor along with the U.S. FO and U.S. FOIA (b) (6) observed there were 4 H-tanks of compressed Oxygen stored in the main Oxygen storage room that were free-standing and	K 923	A. The Maintenance Director immediately secured 4H tanks of compressed oxygen in the main storage room with the appropriate support chains. Furthermore, repair of the exhaust fan in the main storage was completed and an annual inspection was performed. B. All residents have the potential of being affected by this deficient practice. C. A facility-wide audit of all oxygen tank storage rooms was done to ensure that compressed oxygen tanks are secured and found to be in compliance. D. The RDPO In serviced the U.S. FO on the policy and procedure on safety, mechanical ventilation and proper storage	

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K 923	Continued From page 20 not secured from tipping and rupture. 2. The surveyor, U.S. FC and U.S. FOIA (b) (6) also observed that the room contained 2 large liquid Oxygen tanks serving the piped-in Oxygen system. The tanks were not provided with a vent to the outside and the exhaust fan in the room was not operational leaving no way for venting Oxygen from the tanks to exhaust from the room. 3. There was no annual inspection report provided as required by NFPA 99. In an interview at the time, the facility's U.S. FC stated the tanks should be secured and confirmed the ventilation fan was not operable. The U.S. FC stated he was not aware of an annual piped oxygen system inspection report and did not know if there was one. The U.S. FOIA (b) (6) U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FC were informed of the findings at 3:15 PM during the Life Safety Code exit conference. N.J.A.C. 8:39-31.2 (e) NFPA 99	K 923	of compressed oxygen in a manner that prevents it from tipping and rupture in accordance to NFPA. E. The MD will conduct random weekly audits x 4 weeks to ensure compliance. F. The findings from the audits will be reported to the QAPI committee monthly for a period of three months to determine if further corrective actions are necessary.	

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 01 - MAIN BUILDING 01 B. Wing Y2	9/3/2024 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	08/13/2024	LSC K0223	08/13/2024	LSC K0291	08/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0300	08/13/2024	LSC K0324	08/30/2024	LSC K0353	08/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	08/13/2024	LSC K0374	08/13/2024	LSC K0521	08/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	08/13/2024	LSC K0923	08/13/2024	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	
7/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO