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	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Rehabilitation & Healthcare at West Deptfor	550 Jessup Road West Deptford, NJ 08066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	COMPLAINT#: NJ00187516 / 402411Based on interview and review of medical records and other pertinent facility documents it was determined that the facility failed to maintain an accurately documented and complete medical records in accordance with acceptable standards and practice.This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed and was evidenced by the following: A review of Resident #2's admission Record revealed that that the resident was admitted to the facility with diagnoses that included but were not limited to: quadriplegia, neurogenic bowel (a condition where the nerves that control bowel function are impaired, leading to abnormal bowel movements), and neuromuscular dysfunction of bladder. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 6/30/25, indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the resident's cognition was intact. A further review of Resident #2's medical record revealed that the resident filed a grievance on 4/30/25, which indicated that a nurse had changed their wound dressing. A review of Resident #2's Treatment Administration Record (TAR) for April 2025 revealed an order dated 4/4/25, that the wound vacuum dressing was to be changed, along with an order for the application of skin prep dated 3/8/25. Both indicated that they were to be completed as needed for soilage. A further review of the TAR revealed no documentation that the dressing was changed nor the that the skin prep was applied on 4/30/25. A review of Resident #2's Progress Notes did not reveal any documentation that the resident's treatments were completed or not completed on 4/30/25. During an interview with Resident #2 on 8/26/25 at 2:35 P.M., the resident recalled filing the grievance because the primary nurse did not change the wound vacuum after a bowel movement, but that the next shift had taken care of it. The resident stated that they could not recall the exact date of the grievance at the time of the interview. During an interview with the Licensed Practical Nurse (LPN) Shift Supervisor on 8/26/25 at 3:55 P.M., in the presence of the surveyor, she reviewed the grievance for Resident #2 dated 4/30/25. The LPN stated that she recalled the incident and that while completing her rounds, she was approached by a Certified Nursing Assistant (CNA) who stated that there was a concern with Resident #2. The LPN stated that she immediately went to the resident's room, where the resident told her that wound care needed to be provided due to a bowel movement. The LPN stated that she immediately gathered the necessary supplies and went in with another nurse to provide the treatment. The LPN also stated that it was important to document all care provided to a resident, because others may think it wasn't done if it wasn't documented. In the presence of the surveyor, she also reviewed the Resident's TAR for April 2025 and stated, I made sure it got done and with it being change of shift, I forgot to document it. She further stated that she should have signed the TAR. During an interview on 8/26/25 at 4:16 P.M., the Director of Nursing (DON) stated that she expected that all care provided to a resident to be documented as done, So that everyone knows it was done. In the presence of the surveyor, the DON reviewed Resident #2's TAR for April 2025, and stated that the nurse should have signed a treatment if it was done. A review of the facility's Charting and Documentation policy, revised July 2023, revealed that all services provided to the resident would be documented in a resident's medical record, including, . Treatment or services performed. N.J.A.C. 8:39-27.1(a)