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	12/10/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete reference checks and background checks on employees before their start date. The deficient practice was identified for 1 of 151 employees reviewed for background checks (Employee #30) and 57 of 151 employees reviewed for reference checks (Employee #1, Employee #2, Employee#3, Employee #4, Employee #5, Employee #6, Employee #7, Employee #8, Employee #9, Employee #10, Employee #11, Employee #12, Employee #13, Employee #14, Employee #15, Employee #16, Employee #17, Employee #18, Employee #19, Employee #20, Employee #21, Employee #22, Employee #23, Employee #24, Employee #25, Employee #26, Employee #27, Employee #28, Employee #29, Employee #30, Employee #31, Employee #32, Employee #33, Employee #34, Employee #35, Employee #36, Employee #37, Employee #38, Employee #39, Employee #40, Employee #41, Employee #42, Employee #43, Employee #44, Employee #45, Employee #46, Employee #47, Employee #48, Employee #49, Employee #50, Employee #51, Employee #52, Employee #53, Employee #54, Employee #55, Employee #56, and Employee #57) and was evidenced by the following:On 12/4/25 at 10:03 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) the personnel files of all the new employees who were hired since the last standard survey (7/9/2024), whether currently employed or terminated, for review by the survey team. 1.) A review of the employee personnel files revealed the following:For Employee #30, the admission Coordinator with a start date of 2/10/25, there was no evidence of a background check prior to the start of employment. 2.) A review of the employee personnel files revealed the following:For Employee #1, a Certified Nursing Assistant (CNA) with a start date of 10/23/24, there was no evidence of a reference check prior to the start of employment.For Employee #2, a CNA with a start date of 9/25/24, there was no evidence of a reference check prior to the start of employment.For Employee #3, a Nursing Assistant (NA) with a start date of 10/9/24, there was no evidence of a reference check prior to the start of employment.For Employee #4, a CNA with a start date of 11/14/24, there was no evidence of a reference check prior to the start of employment.For Employee #5, a Housekeeper with a start date of 1/29/25, there was no evidence of a reference check prior to the start of employment.For Employee #6, a CNA with a start date of10/9/24, there was no evidence of a reference check prior to the start of employment.For Employee #7, a Dietary Aide with a start date of 9/25/24, there was no evidence of a reference check prior to the start of employment.For Employee #8, Dietary with a start date of 11/20/24, there was no evidence of a reference check prior to the start of employment.For Employee #9, a Dietary [NAME] with a start date of 1/29/25, there was no evidence of a reference check prior to the start of employment.For Employee #10, a Dietary Aide with a start date of 8/28/24, there was no evidence of a reference check prior to the start of employment.For Employee #11, an Activities staff with a start date of 10/9/24, there was no evidence of a reference check prior to the start of employment.For Employee #12, an Activities Aide with a start date of 3/12/25, there was no evidence of a reference check prior to the start of employment.For Employee #13, a NA with a start date of 3/26/25, there was no evidence of a reference check prior to the start of employment.For Employee #14, a CNA with a start date of 2/18/25, there was no evidence of a reference check prior to the start (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of employment.For Employee #15, an Activities Aide with a start date of 7/31/24, there was no evidence of a reference check prior to the start of employment.For Employee #16, a CNA with a start date of 6/25/24, there was no evidence of a reference check prior to the start of employment.For Employee #17, a Licensed Practical Nurse (LPN) with a start date of 11/19/25, there was no evidence of a reference check prior to the start of employment.For Employee #18, a NA with a start date of 10/7/25, there was no evidence of a reference check prior to the start of employment.For Employee #19, a LPN with a start date of 12/18/24, there was no evidence of a reference check prior to the start of employment.For Employee #20, a LPN with a start date of 11/20/24, there was no evidence of a reference check prior to the start of employment.For Employee #21, a CNA with a start date of 10/9/24, there was no evidence of a reference check prior to the start of employment.For Employee #22, a NA with a start date of 9/11/24, there was no evidence of a reference check prior to the start of employment.For Employee #23, a NA with a start date of 2/18/25, there was no evidence of a reference check prior to the start of employment.For Employee #24, a LPN with a start date of 7/17/24, there was no evidence of a reference check prior to the start of employment.For Employee #25, a LPN with a start date of 11/21/24, there was no evidence of a reference check prior to the start of employment.For Employee #26, a LPN with a start date of 10/9/24, there was no evidence of a reference check prior to the start of employment.For Employee #27, a NA with a start date of 2/18/25, there was no evidence of a reference check prior to the start of employment.For Employee #28, a NA with a start date of 12/4/24, there was no evidence of a reference check prior to the start of employment.For Employee #29, a LPN with a start date of 9/11/24, there was no evidence of a reference check prior to the start of employment.For Employee #30, an admission Coordinator with a start date of 2/10/25, there was no evidence of a reference check prior to the start of employment.For Employee #31, a CNA with a start date of 7/2/24, there was no evidence of a reference check prior to the start of employment.For Employee #32, a Receptionist with a start date of 1/13/25, there was no evidence of a reference check prior to the start of employment.For Employee #33, an Activities staff with a start date of 2/12/25, there was no evidence of a reference check prior to the start of employment.For Employee #34, a LPN with a start date of 11/20/24, there was no evidence of a reference check prior to the start of employment.For Employee #35, a NA with a start date of 7/2/24, there was no evidence of a reference check prior to the start of employment.For Employee #36, a Housekeeper with a start date of 3/12/25, there was no evidence of a reference check prior to the start of employment.For Employee #37, a CNA with a start date of 10/23/24, there was no evidence of a reference check prior to the start of employment.For Employee #38, a LPN with a start date of 3/7/25, there was no evidence of a reference check prior to the start of employment.For Employee #39, a CNA with a start date of 12/4/24, there was no evidence of a reference check prior to the start of employment.For Employee #40, a CNA with a start date of 9/1/24, there was no evidence of a reference check prior to the start of employment.For Employee #41, a CNA with a start date of 2/18/25, there was no evidence of a reference check prior to the start of employment.For Employee #42, a Dietary Aide with a start date of 8/28/25, there was no evidence of a reference check prior to the start of employment.For Employee #43, a CNA with a start date of 1/29/25, there was no evidence of a reference check prior to the start of employment.For Employee #44, a CNA with a start date of 12/21/24, there was no evidence of a reference check prior to the start of employment.For Employee #45, a Registered Nursing (RN) with a start date of 12/18/24, there was no evidence of a reference check prior to the start of employment.For Employee #46, a LPN with a start date of 1/15/25, there was no evidence of a reference check prior to the start of employment.For Employee #47, a Dietary [NAME] with a start date of 2/12/25, there was no evidence of a reference check prior to the start of employment.For Employee #48, a Housekeeper with a start date of 11/25/24, there was no evidence of a reference check prior to the start of employment.For Employee #49, a Housekeeping Aide with a start date of 2/12/25, there was no evidence of a reference check prior to the start of employment.For Employee #50, a Dietary Aide with (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a start date of 9/25/24, there was no evidence of a reference check prior to the start of employment.For Employee #51, a CNA with a start date of 1/29/25, there was no evidence of a reference check prior to the start of employment.For Employee #52, a Nursing Supervisor with a start date of 1/15/25, there was no evidence of a reference check prior to the start of employment.For Employee #53, a Housekeeper with a start date of 1/29/25, there was no evidence of a reference check prior to the start of employment.For Employee #54, a CNA with a start date of 7/2/24, there was no evidence of a reference check prior to the start of employment.For Employee #55, a Housekeeper with a start date of 3/12/25, there was no evidence of a reference check prior to the start of employment.For Employee #56, a Dietary Aide with a start date of 8/15/24, there was no evidence of a reference check prior to the start of employment.For Employee #57, Dietary with a start date of 7/10/24, there was no evidence of a reference check prior to the start of employment.On 12/9/25 at 10:33 AM, the surveyor interviewed the Human Resource Director (HRD) who stated that a background check would be obtained on every new hired employee. The HRD further stated that that a minimum of two reference checks would be obtained on every new hired employee. The HRD stated that it was important to obtain a background and reference check on every new hired employee to confirm the employee was a good worker, had good attendance, and did not have any abnormalities such as drug issues.On 12/9/25 at 12:45 PM, in the presence of the survey team and the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) acknowledged that background checks should be done prior to hire, and two reference checks should be documented in the employee file. On 12/10/25 at 10:16 AM, in the presence of the survey team, the LNHA, and the DON, the HRD acknowledged that all pre-employment documents, including the background and reference checks, should be kept in the employee personnel files. A review of the facility's Abuse, Neglect and Exploitation policy, revised 7/2024, included: The components of the facility abuse prohibition plan are discussed herein: I. Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Screenings may be conducted by the facility itself, third party agency or academic institution. The facility will maintain documentation of proof that the screening occurred . NJAC 8:39-4.1(a)(5); 9.3(b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to maintain the training room toilets in the resident shower rooms in a clean and homelike environment. This deficient practice was identified for 2 of 3 shower rooms inspected on 2 of 3 nursing units (East and West) and was evidenced by the following:On 12/5/25 at 10:57 AM, the surveyor observed the East Wing Shower Room in the presence of Licensed Practical Nurse/Unit Manager (LPN/UM) #2. When the surveyor entered the training toilet bathroom, there was a strong odor noted around the toilet. When the surveyor asked LPN/UM #2 if the area smelled of urine, the LPN/UM stated, a little bit. LPN/UM #2 then stated it should have been cleaned that morning. The surveyor observed yellow staining with dirt and debris at the rear and on the sides of the base of the toilet. LPN/UM #2 stated that it appeared as if the yellow staining had not just happened. LPN/UM #2 added that the residents utilized the shower room twice a week.At 11:02 AM, LPN/UM #2 confirmed and informed the surveyor that no residents were showered yet that day.At 11:08 AM, the surveyor interviewed Housekeeping Associate (HA) #1 who stated she was not assigned to clean East Wing the day prior, and that she had cleaned it on Tuesday, 12/2/25. At that time, the HA #1 stated the yellow staining around the base of the toilet was probably urine and it did not look like it had just happened. HA #1 stated she normally cleaned both sides of the toilet. The surveyor observed brown matter below the handle on the front of the toilet. HA #1 stated it looked and smelled like someone just had a bowel movement. HA #1 further stated it looked like there was also feces above the handle on the front of the toilet. HA #1 added that if there was feces on the toilet and the toilet was not cleaned, it was an infection control problem, and a resident could catch something. At 11:19 AM, the surveyor interviewed the Environmental Services Director (ESD) in the presence of HA #1. The ESD stated that the training toilet in the East Wing bathroom was cleaned early that morning, but HA #1 then stated, no, not yet.At that time, the ESD stated the yellow staining on the base of the toilet looked dirty, like urine, and that it needed to be cleaned. The ESD stated it did not look like it had just happened to be honest. The ESD further stated the brown matter above toilet handle was dirty and may have been touched by a dirty hand with feces on it. The ESD added that the toilet was very dirty and it was an infection control concern. At 11:34 AM, the surveyor inspected the [NAME] Unit Shower Room training toilet in the presence of Concierge #1. There were dark colored matter and debris on both sides of the base of the toilet. The concierge stated the toilet needed to be cleaned because it looked like there was a combination of dirt and staining on the base of the toilet.At 1:35 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that it was an infection control issue if the toilets were not cleaned prior to resident usage. The IP further stated that hand hygiene would be required after usage to prevent the spread of infection. On 12/9/2025 at 12:49 PM, the Licensed Nursing Home Administrator (LNHA) was made aware of the concerns that were identified with the training room toilets. A review of the facility's Housekeeping-General policy, revised 8/1/2017, included:All rooms of the Facility are kept clean and as free as possible of germs and other contaminating agents at all times, while maintaining a pleasant and homelike atmosphere for our residents.NJAC 8:39-31.4 (a) (f)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that the Minimum Data Set (MDS), an assessment tool, accurately reflected the resident's smoking status.This deficient practice was identified for 1 of 30 sampled residents (Resident #141), and was evidenced by the following: On 12/8/25 at 1:03 PM, the surveyor, accompanied by the Certified Nursing Assistant (CNA) #1, observed Resident #141 go outside in the smoking area and smoke two cigarettes. On 12/8/25 at 1:30 PM, the surveyor reviewed the medical record for Resident #141. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: chronic obstructive disease (a progressive lung disease making breathing difficult), and solitary pulmonary nodule (a single, small spot in the lung). A review of the resident's comprehensive MDS, dated [DATE], included that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. Further review of the MDS, section J1300, revealed that the resident was not a smoker. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 7/18/24, that the resident liked to smoke and had a history of smoking. Interventions included: Ascertain the resident's wishes about smoking and respect the resident's decision. A review of the Smoking/Nicotine Devices assessment, an assessment to determine the level of supervision needed for the resident who smokes, dated 6/17/25 and 9/15/25, revealed that Resident #141 used smoking/tobacco/nicotine products and did not require supervision while smoking. A review of the Progress Notes (PN) included a social services note, dated 11/4/25 at 10:31 AM, which revealed, resident was a smoker. On 12/9/25 at 10:13 AM, the surveyor interviewed CNA#1, who stated that the resident had been a known smoker to her since she had been employed at the facility since February 2025. On 12/9/25 at 10:16 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #2, who stated that the resident goes out to smoke three times a day. On 12/9/25 at 10:22 AM, the surveyor interviewed the MDS Coordinator (MDSC), who also confirmed that Resident #141 was a smoker and that he/she was the facility's only smoker. The MDSC pulled up the electronic medical record (EMR) of the resident and confirmed that the comprehensive MDS, dated [DATE], was coded incorrectly and that it should reflect that Resident #141 was a smoker. She further stated that the MDS should be an accurate picture of the resident, because it drives the care plan. On 12/9/25 at 10:32 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the MDS should be accurate. The DON further stated that when completing the MDS, the MDSC should review the hospital records, if applicable, review the progress notes, and see the residents to ensure that the MDS was completed accurately. A review of the facility's Resident Assessments policy, revised October 2023, included, Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. NJAC 8.39-11.1

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that an air mattress was accurately set according to the resident's weight. This deficient practice was identified for 1 of 1 resident, (Resident #13) reviewed for pressure ulcers and was evidenced by the following:On 12/5/25 at 10:43 AM, the surveyor observed Resident #13 lying in bed awake with the head of the bed elevated. At that time, the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 presented to the room and attempted to offer the resident a drink of water. The resident did not respond verbally when they were spoken to. The resident was on an air mattress that was set at 160 pounds (lbs). On 12/5/25, the surveyor reviewed the medical record of Resident #13.A review of the admission Record, an admission summary, revealed that the resident was admitted to the facility with diagnoses which included but were not limited to: Stage four sacral pressure ulcer (full-thickness skin loss that extends into underlying muscle, tendon, cartilage, and bone), pressure ulcer of left hip unstageable, pressure ulcer of right buttock unspecified stage, chronic osteomyelitis (inflammation of bone or bone marrow, usually due to an infection), aphasia (loss of ability to understand or express speech) following cerebral infarct (stroke), and protein-calorie malnutrition.A review of the quarterly Minimum Data Set (MDS), an assessment, dated 11/26/25, revealed that the resident weighed 141 pounds. A further review of the MDS revealed that the resident had two stage three pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible), and one stage four pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) that was present upon admission to the facility. A review of the resident's Care Plan Report revealed that the resident had a focus area dated 8/19/25, which indicated that the resident had a draining wound to the sacrum (a small triangular bone at the base of the spine), and interventions included: low air loss mattress. A review of the resident's Order Summary Report (OSR) dated as of 12/5/25, included the following Physician's Order (PO):-A PO dated 12/5/25, for a Low Air Loss Mattress: Check placement and function every shift.A review of the resident's most recent weight in the electronic medical record (EMR) revealed that on 11/12/25, the resident weighed 140.8 pounds. On 12/8/25 at 10:51 AM, the surveyor observed the resident lying in bed asleep with the head of the bed slightly elevated on an air mattress. The air mattress pump was set at 200 pounds. On 12/8/25 at 10:55 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #2 who stated that she was working as an aide today. LPN #2 stated the resident had three wounds which included wounds on the left and right ischium, and a sacral wound. LPN #2 stated that the resident had an air mattress that was set according to the resident's weight. LPN #2 stated they did monthly weights, and the nurses were supposed to check to ensure that the air mattress pumps were set to the correct weight setting. LPN #2 then accompanied the surveyor into the resident's room and stated the air mattress pump was set at 200 pounds. LPN #2 then looked up resident weight in the computer and stated that resident weighed 140.8 lbs. as of 11/12/25, and the pump should have been set at 140 lbs. On 12/8/25 at 11:00 AM, LPN #2 returned to resident's room and adjusted the weight on the pump between 120 lbs. and 140 lbs. to achieve the closest weight to the resident's actual weight of 140.8 lbs. LPN #2 stated if the weight was set too high, it would be too firm and could apply too much pressure to the wounds and placed the resident at an increased risk of the wound worsening. On 12/8/25 at 11:08 AM, the surveyor interviewed LPN #1, the resident's assigned nurse, who stated that she had not checked the air mattress pump yet, as the resident was scheduled to be weighed today (12/8/25). On 12/9/25 at 8:53 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the nurses were responsible to check the low air loss mattress pump settings as it was used for wound prevention and active wounds. LPN/UM #1 further stated that the importance of setting the low air mattress pump at the resident's current weight was to prevent any further damage to the skin.On 12/9/25 at 11:42 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the low air mattress pump was set to the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's body weight to off load the pressure and the nurse was responsible to check the setting on the pump for accuracy each shift. The DON stated that if it were set too high, it could affect the pressure under the patient. On 12/9/25 at 12:49 PM, in the presence of the survey team, the surveyor informed the Licensed Nursing Home Administrator (LNHA) of the concerns that the resident's low air mattress pump settings were not accurately set according to the resident's body weight.A review of the facility's Use of Support Surfaces policy, dated 10/3/24, included:The goal and preferences of the resident and/or authorized representative will be included in the plan of care and support surface selection.Support surfaces will be utilized in accordance with manufacturer recommendations (including considerations for contraindications)A review of the Owner's Manual revealed, When the resident is placed on the mattress surface, the mattress firmness is adjusted automatically after the resident's height and weight are entered on the display panel. This distributes the body weight uniformly across the mattress surface. NJAC 8:39 27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure respiratory equipment was stored in an appropriate way to prevent the spread of infection, for 1 of 4 residents (Resident #162) reviewed for respiratory care.This deficient practice was evidenced by the following:On 12/4/25 at 10:01 AM, the surveyor observed Resident #162 in their room sitting on the bed with oxygen infusing at three liters via a nasal canula (tubing used to deliver oxygen). The surveyor also observed a Bilevel Positive Airway Pressure (BiPAP) machine (a non-invasive breathing device used to treat sleep apnea by delivering pressurized air through a mask) on the resident's nightstand. The mask was uncovered on the nightstand. On 12/4/25 at 1:33 PM, the surveyor reviewed the resident's medical record. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: sleep apnea (a serious sleep disorder where breathing repeatedly stops and starts, most commonly due to airway blockage), chronic respiratory failure with hypoxia (a long term condition where the lungs does not get enough oxygen into the blood), and chronic obstructive pulmonary disease (a progressive lung disease making breathing difficult, characterized by airflow obstruction). A review of the resident's Social Services Assessment and Documentation (a comprehensive assessment), dated 12/1/25, revealed that Resident #162 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated that the resident's cognition was moderately impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 12/2/25, that the resident had sleep apnea. The interventions included: observe respiratory status, reposition the resident every two to four hours as tolerated, and monitor to for any changes in the mental status. A review of the physician's order, dated 12/3/25 at 3:13 PM, included, place BIPAP at 17/13 with three liters per minute of oxygen at bedtime and to remove in the morning.A review of the December 2025 Treatment Administration Record (TAR) revealed that the resident had used the BiPAP in the night of 12/3/25 and 12/7/25. On 12/8/25 at 11:34 AM, the surveyor conducted a follow-up visit to the resident's room. Resident #162 was lying in bed with oxygen infusing via nasal canula at three liters. The resident's BiPAP mask was uncovered and touching the surface of the nightstand. At that time, the Licensed Practical Nurse/Unit Manager (LPN/UM) #3 walked up to the resident's room in the surveyor's presence and observed the BiPap mask uncovered and touching the surface of the nightstand. LPN/UM #3 stated the mask should be in a bag to prevent infection and cross contamination.On 12/8/25 at 11:37 AM, the surveyor interviewed LPN/UM #3 who stated that the resident used his/her BiPAP at night. She further stated, that the BiPAP mask should be stored in a bag to prevent bacteria from building up when it was not in use. On 12/8/25 at 1:23 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that BiPAP mask should be in a bag when it was not being used. She further stated that storing it in a bag would reduce the risk of an infection. On 12/8/25 at 1:53 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the BiPAP mask should be kept in a bag when it was not being used for infection control purposes. A review of the facility's BiPAP and CPAP (continuous positive airway pressure) Policy and Procedure policy, undated, included, Store mask in an open bag or container. N.J.A.C. 8:39- 19.4(a)

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	12/10/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, it was determined that the facility failed to a.) maintain kitchen equipment in a clean, safe, and sanitary manner and b.) maintain nutrition room equipment in 2 of 3 units (East and 2nd) in a clean, safe and sanitary manner as evidenced by the following:On 12/4/25 at 11:02 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following in the kitchen:1. Two (2) of two (2) convention ovens (1-upper and 1-lower unit), had baked on food debris on the two glass doors and on the inside surfaces. The FSD acknowledged that it was not cleaned according to facility policy. 2. One (6 burner) stove top, had all 6 burners with debris on the grates and around the cooker hats. The FSD acknowledged that it was not cleaned according to facility policy. 3. The oven (attached to the 6-burner unit) interior was dirty with a brown, sticky thick substance dripping down from the cooktop area into the interior oven doorframe. The FSD acknowledged that it was not cleaned according to facility policy. On 12/9/25 at 10:48 AM, in the presence of the east wing Licensed Practical Nurse Unit Manager (LPN/UM#2), the surveyor observed the following in the East Nutrition room: 1. 2 of 2 cabinet drawers had multicolored crumb debris loosely among resident snacks (i.e. cookies, crackers). The LPN/UM #2 acknowledged that it was not cleaned according to facility policy and could attract unwanted pest and rodents.2. The refrigerator on the East unit had a cracked and ripped refrigerator door seal with black debris in the track of the seal. The interior of the frost-free freezer had sheets of ice present. The LPN/UM #2 acknowledged that it was not cleaned according to facility policy.3. The microwave had multicolored splatters, and debris were present on the interior ceiling surface. The LPN/UM #2 acknowledged that it was not clean according to facility policy. On 12/9/25 at 11:00 AM, in the presence of the 2nd floor Licensed Practical Nurse Unit Manager (LPN/UM#1) the surveyor observed the following in the 2nd floor Nutrition room:1. The 2 of 2 cabinet drawers had multicolored crumb debris loosely among resident snacks (i.e.cookies, crackers). The LPN/UM #1 acknowledged that it was not cleaned according to facility policy and could attract unwanted pests and rodents.2. The refrigerator on the East unit had a cracked and ripped refrigerator door seal with black debris in the track of the seal. The interior of the frost-free freezer had ice present on the back panel. The LPN/UM #1 acknowledged that it was not cleaned according to facility policy. On 12/9/25 at 11:25 AM, the surveyor interviewed the Environmental Services Director (ESD) who stated the housekeepers process was to surface clean the nutrition rooms daily and deep clean the nutrition room on Wednesdays every week. The surveyor revealed the pictures that were taken in the nutrition rooms. The ESD stated that if there were visible debris, the housekeeping staff was required to wipe and clean the questionable areas daily. The ESD acknowledged the surveyor concerns and agreed it was not clean according to the facility policy. A review of policy, Sanitation, revised in November 2022, revealed, All kitchen areas are kept clean.free of debris and protected from rodents and insects.all kitchen equipment is kept clean, maintained in good repair. NJAC 8:39-17.2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to adhere to infection control standards and procedures during the provision of wound treatments. This deficient practice was identified for 1 of 1 resident (Resident #13) reviewed for pressure ulcers and was evidenced by the following:On 12/5/25 at 10:43 AM, the surveyor observed Resident #13 lying in bed awake with the head of the bed elevated. The resident did not respond verbally when they were spoken to and was lying on an air mattress. On 12/5/25, the surveyor reviewed the medical record of Resident #13.A review of the admission Record, an admission summary, revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: Stage four sacral (a small triangular bone at the base of the spine) pressure ulcer (full-thickness skin loss that extends into underlying muscle, tendon, cartilage, and bone), pressure ulcer of left hip unstageable, pressure ulcer of right buttock unspecified stage, chronic osteomyelitis (inflammation of bone or bone marrow, usually due to an infection), aphasia (loss of ability to understand or express speech) following cerebral infarct (stroke), and protein-calorie malnutrition.A review of the quarterly Minimum Data Set (MDS), an assessment, dated 11/26/25, revealed that the resident had two stage three pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible), and one stage four pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) that was present upon admission to the facility. A review of the resident's Care Plan Report revealed that the resident had a focus area dated 11/12/25, with a focus of on enhanced barrier precautions due to indwelling urinary catheter and wounds. Interventions included: Wash hands appropriately before/after caring for a resident, donning (putting on)/removing personal protective equipment (PPE) to prevent the spread of infection. On 12/9/25 at 9:01 AM, the surveyor met with Licensed Practical Nurse (LPN) #3 to observe the provision of a wound treatment for Resident #13. LPN #4 was also present and stated that he planned to assist with the wound treatment.At 9:04 AM, both LPN #3 and LPN #4 cleaned their hands with alcohol-based hand rub (ABHR) before they both donned a gown and gloves outside of the resident's room prior to entry. At 9:06 AM, LPN #3 then used a sanitizing wipe to clean the table before she immediately placed the wound treatment supplies directly on the over bed table. At 9:07 AM, LPN #4 picked up the trash can with his gloved hands and passed the trash can to LPN #3, who then placed the trash can on the floor with her gloved hands and then used it to discard the soiled dressings. At 9:09 AM, LPN #3 failed to doff (remove) her gloves and perform hand hygiene before she proceeded to open the packaging of the foam dressing and dated it with a permanent marker. LPN #3 then immediately proceeded to remove the resident's soiled sacral dressing. At 9:10 AM, LPN #3 doffed her gloves and used ABHR to sanitize her hands and then donned gloves. A malodorous (foul odor) was noted after the dressing was removed from the sacral wound.At 9:11 AM, LPN #3 proceeded to cleanse the sacral wound with gauze soaked in Vashe (wound cleansing solution) that was placed in a clear, plastic cup by LPN #3. At 9:13 AM, LPN #3 failed to doff her gloves and perform hand hygiene before she proceeded to pour Dakin's solution (diluted bleach solution) into a clear plastic cup and soaked gauze pads in the solution before she packed it into the sacral wound.At 9:14 AM, LPN #3 then proceeded to apply skin prep (a protective barrier) around the outside of the wound edges.At 9:15 AM, the outer packing fell out of the sacral wound onto the resident's incontinence brief. LPN #4 then proceeded to pick up the gauze pad with his gloved hands from the incontinence brief and placed it back into the sacral wound. At 9:16 AM, LPN #3 doffed her gloves and cleaned her hands with ABHR.At 9:17 AM, LPN #3 donned gloves before she proceeded to open the outer foam dressing and dated it in preparation for the wound treatment to be applied to the resident's right ischial (the large bone in the lower part of the hip) wound. At 9:18 AM, LPN #3 cleansed the right ischial wound with three separate gauze pads soaked in Vashe. At 9:20 AM, LPN #3 failed to doff her gloves and perform hand hygiene before she proceeded to soak gauze pads in Dakin's solution and packed it into the resident's right ischial wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:21 AM, LPN #3 applied skin prep to the outer edges of the wound and covered the wound with a foam dressing. At 9:22 AM, LPN #3 doffed her gloves and performed hand hygiene with ABHR. She then moved the table to the left side of the bed and doffed her gloves and washed her hands for 20 seconds. At 9:27 AM, LPN #3 removed the soiled dressing from the left ischial wound and failed to doff her gloves and perform hand hygiene after. At 9:28 AM, LPN #3 soaked a gauze pad in Vashe and cleansed the left ischial wound. LPN #3 then patted the wound dry with a gauze pad. At 9:29 AM, LPN #3 doffed her gloves and failed to immediately perform hand hygiene after and stated that she needed to get a cotton tipped swab from the wound treatment cart that was in the doorway of the room. LPN #3 then stated that the other resident whose bed was positioned next to the doorway needed to be repositioned as they were too close to the edge of the bed. LPN #3 then placed her bare hands on either side of the resident's shoulders to assist them to sit up straight in their bed without first performing hand hygiene. At 9:30 AM, LPN #3 picked up the cotton tipped swab and placed it on top of the over bed table before she washed her hands for 20 seconds and donned gloves. At 9:32 AM, LPN #3 then opened the cotton tipped applicator and applied Triad (a sterile coating) to the tip of the applicator that was then applied in the resident's left ischial wound. At 9:33 AM, LPN #3 then applied skin prep to the outer perimeter of the wound bed and then placed a foam dressing over the left ischial wound. At 9:34 AM, LPN #3 and LPN #4 repositioned the resident for comfort and LPN #3 doffed her gloves after. LPN #3 failed to perform hand hygiene before she proceeded to pick up a package of gauze pads and secured the package closed with her bare hands. At 9:36 AM, LPN #3 washed her hands for 20 seconds. At 9:37 AM, LPN #3 returned the wound treatment supplies to the wound treatment cart without first cleaning the outside of the bottles of Vashe, Triad, and Dakin's solution. LPN #3 then proceeded to pick up the bag of gauze pads and placed them in the bottom drawer of the treatment cart inside of a box bedside sealed package of 4 x 4 gauze pads. At 9:34 AM, LPN #3 cleaned the over bed table with a sanitizing wipe. When interviewed at that time, LPN #3 was unable to tell the surveyor what the kill time (time needed for the product to contact a surface to kill germs) was for the disinfectant wipes that she used to clean the over bed table both before and after use. At 9:39 AM, when interviewed, LPN #3 stated that there was a potential for the spread of infection if gloves were not doffed and hands sanitized after handling the trash can and prior to handling a wound dressing and removal of the outer dressing. LPN #3 stated she could spread germs if she doffed her gloves without performing hand hygiene and then accessed the treatment cart and assisted another resident to reposition in bed. LPN #3 stated she should have wiped down the resident's supplies before she returned them to the cart. LPN #3 also acknowledged that cross-contamination was a concern when she used the same gloves to clean the wound as she used to pack it.On 12/9/2025 at 9:56 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated there was a risk of contamination if supplies were placed on table before the table dried. The LPN/UM #1 stated that there was also a concern for cross-contamination if gloves were not doffed and hand hygiene were not performed after the trash can was passed between the nurses, the outer treatment was dated, and the soiled sacral dressing was removed.LPN/UM #1 stated that both the field and the wound were contaminated if the nurse did not doff their gloves and perform hand hygiene after the wound was cleansed, and then immediately placed Dakin's-soaked gauze into the wound bed. She stated there was a risk a risk of cross-contamination to both the resident and the treatment cart. At that time, the LPN/UM #1 stated that if LPN #4 placed the Dakin's-soaked gauze that fell on the brief back into the wound bed, he contaminated the wound bed and he should have gotten a new one. On 12/9/25 at 10:08 AM, the surveyor interviewed LPN #4 who stated the whole packing did not fall out, and if the whole packing fell out you could not use it, and that it was an infection control concern. On 12/9/25 at 10:20 AM, the surveyor interviewed the Infection Preventionist (IP) who stated it was an infection control issue if the gloves were not doffed, and the hands were not washed, and clean gloves were put on after the wounds were cleansed and before the wound treatment was administered. The IP further stated, the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whole thing is cross-contamination.On 12/9/25 at 10:42 AM, the surveyor interviewed the Director of Nursing (DON) who stated her concern was for cross-contamination if hand hygiene was not performed after the trash can was touched prior to handling dressing packaging and removal of outer sacral dressing. The DON stated it was also a concern for cross-contamination to put a dressing that fell out of the wound back into the wound bed and that he should have discarded it. The DON further stated that the nurse should only have taken what they needed into the room rather than returning the wound treatment supplies to the wound treatment cart. On 12/9/25 at 12:49 PM, the Licensed Nursing Home Administrator (LNHA) was informed of the surveyors concerns with the resident's wound treatment observation. A review of the facility's Wound Care policy, revision date October 2024, included:Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used on the clean field.Wash and dry your hands thoroughly Put on exam glove. Loosen tape and remove dressing. Pull glove over dressing and discard in appropriate receptacle. Wash and dry your hands thoroughly. Put on gloves.Use no-touch technique.Pour liquid solutions directly onto gauze sponges on their papers.Wear sterile gloves when physically touching the wound or holding a moist surface over the wound.Remove dry gauze. Apply treatments as indicated.Dress wound.Pick up sponge with paper and apply directly to the area.Be certain all clean items are on clean field.Discard disposable items in the designated container.Remove disposable gloves and discard into designated container. Wash and dry hands thoroughly.Wipe reusable supplies with alcohol as indicated (i.e., outside of containers that were touched by unclean hands,.etc., Return reusable supplies to resident's drawer in treatment cart. Take only disposable supplies that are necessary for the treatment into the room. Disposable supplies can not be returned to the cart. Wash and dry your hands thoroughly. A review of the facility's Handwashing/Hand Hygiene policy, revision date October 2023, included:The facility considers hand hygiene to be the primary means to prevent the spread of healthcare-associated infections.Indications for Hand Hygiene:Immediately before touching a resident;after contact with blood, body fluids, or contaminated surfaces;after touching a resident;after touching a resident's environment;before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal. NJAC 8:39-19.4