

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315510	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/05/2025
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NAME OF PROVIDER OR SUPPLIER BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH	STREET ADDRESS, CITY, STATE, ZIP CODE 395 AMWELL ROAD , HILLSBOROUGH, New Jersey, 08844
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(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
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F0000	<p>INITIAL COMMENTS</p> <p>COMPLAINT #: 2648245</p> <p>CENSUS: 118</p> <p>SAMPLE SIZE: 4</p> <p>THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F0000		11/30/2025
F0580 SS = G	<p>Notify of Changes (Injury/Decline/Room, etc.)</p> <p>CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in</p>	F0580	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law. For the purposes of any allegation that the facility is not in substantial compliance with respect to any state requirements as a Licensed Nursing Home, this response and plan of correction constitutes the facility's confirmation of such substantial compliance.</p> <p>The corrective action put in place on 11/30/2025 to rectify the deficient practice identified during the complaint survey was to:</p> <p>Since Resident #3 is no longer in the facility, no direct corrective action could be taken for resident. However, had the resident remained, the facility would have followed up with the Nurse Practitioner/ Physician who had seen the resident earlier with the evolving symptoms, immediately obtained appropriate orders including ██████████ management interventions, and reassessed/evaluated the effectiveness of those orders. The facility determined that Agency LPN #3 failed to follow facility protocols requiring immediate physician notification of changes in condition and failed to complete required ██████████ assessment documentation. As an immediate corrective action, Agency LPN #3 was ██████████</p>	11/30/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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
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F0580 SS = G	<p>Continued from page 1 §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15)</p> <p>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Complaint: 268245</p> <p>Based on interviews, review of medical records, and review of pertinent facility documentation, it was determined that the facility failed to notify the resident's physician of a change in condition for 1 of 3 residents (Resident #3) reviewed. This deficient practice was evidenced by the following:</p> <p>A review of Resident #3's Closed Medical Record's Admission Record revealed that Resident #3 was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	F0580	<p>Continued from page 1 from the facility agency account and is NJ Exec Order 26.4b1 in the facility.</p> <p>The facility identified that this alleged deficiency could impact the entire resident population. The facility reviewed all residents who experienced changes in condition over the last 30 days, including but not limited to falls, new onset pain, or decline in physical/mental status, to ensure physician notification was completed and documented. No additional incidents of missed physician notification were identified.</p> <p>The deficient practice for Resident #3 cannot be corrected as the resident is no longer in this facility. To mitigate the possibility of the alleged deficient practice from occurring again, the post NJ process was revised to require documentation of MD notification for any reported or observed change in condition, including new or worsening pain. All licensed nursing staff, including agency personnel, were re-educated on the Changes in Condition policy, the Pain Assessment and Management policy, and requirements for immediate physician notification. Education included scenarios beyond falls, including pain, mobility limitations, mental status changes, and any significant deviation from baseline. All agency onboarding packets were updated to include mandatory education on Change in Condition and physician notification procedures. This change has also been added to the new hire orientation packet for nurses.</p> <p>To monitor the notifications of change in conditions, the Director of Nursing (DON) and/or designee will audit 10% of change-in-condition events (including falls, new onset pain, mental status changes, and mobility limitations) weekly for 4 weeks, then monthly for 3 months, to verify: MD notification was completed and documented, pain assessment was completed, orders obtained and interventions implemented, effectiveness of interventions are reassessed. Results will be reviewed monthly by the IDT and quarterly in QAPI. Additional corrective action will be taken as identified.</p> <p>The completion date of this deficient practice is 11/30/2025.</p>	

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F0580 SS = G	<p>Continued from page 2 NJ Exec Order 26.4b1</p> <p>A review of the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 revealed that Resident #3 had a brief interview for mental status (BIMS) score of out of 15, which indicated that the resident had NJ Exec Order 26.4b1.</p> <p>A review the Care Plan (CP) for Resident #3 revealed a focus area of, "RISK FOR [Resident #3] needs [related to]: . With an initiation date of . Interventions initiated on included to administer NJ Exec Order 26.4b1 measures; administer medications as per orders; encourage reporting of NJ Exec Order 26.4b1 to staff before it monitor for complaints of and encourage reporting of before it and monitor for effectiveness of interventions and, "Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of .</p> <p>Further review of the CP for Resident #3 revealed a focus initiated on NJ Exec Order 26.4b1 that the resident had NJ Exec Order 26.4b1 related to making their and NJ Exec Order 26.4b1 others. Interventions initiated on included but were not limited to anticipating and meeting the resident's needs.</p> <p>A review of NJ Exec Order 26.4b1 Notes for Resident #3 with a date of service of NJ Exec Order 26.4b1, revealed that Resident #3 stated that they had rated as out of ten at and out of ten with . The further revealed that Resident #3 was NJ Exec Order 26.4b1 their through its NJ Exec Order 26.4b1 due to .</p> <p>A review of the Progress Notes (PNs) for Resident #3 was conducted. The PNs included a Nursing Note (NN) written by a Licensed Practical Nurse (LPN #1), dated NJ Exec Order 26.4b1 at 2:33 AM, which revealed that Resident #3 had an NJ Exec Order 26.4b1 at 1:45 AM, and . The PN further revealed that Resident #3's family and physician were notified. A late entry NN written by the Unit Manager (UM #1) dated NJ Exec Order 26.4b1 at 11:17 AM, revealed that Resident #3 complained of and it was endorsed to the resident's primary nurse to obtain</p>	F0580		

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	<p>Continued from page 3</p> <p>a physician order (PO) for [redacted] medication, and administer [redacted] medication as per doctor's orders. A PN by the Nurse Practitioner (NP #1) dated [redacted] at 2:58 PM, revealed that Resident #3 had [redacted] to their [redacted] and [redacted]s were requested. A PN by the [redacted] (b)(6) dated [redacted] at 5:06 PM, revealed that a family member of Resident #3 reported that the resident was in [redacted] that morning. The PN further revealed that Resident #3 reported [redacted] out of ten [redacted] when [redacted] to [redacted] their [redacted]. A PN written by LPN # 2 dated [redacted] at 7:32 PM, revealed that Resident #3 was sent to the hospital for [redacted] at approximately 6:00 PM. The PNs revealed no documentation that a physician was notified that Resident #3 [redacted] that [redacted] with [redacted] and [redacted] the resident's [redacted] to [redacted] their [redacted] as usual.</p> <p>A review of the Order Summary Report (OSR) for Resident #3 revealed the following POs:</p> <p>[redacted] of the [redacted] and [redacted] to rule out [redacted] [redacted] after a [redacted]. The order date was [redacted].</p> <p>Send to the emergency department for evaluation of [redacted]. The order date was [redacted].</p> <p>The OSR revealed no orders for [redacted] medications or [redacted].</p> <p>On 11/05/2025 at 1:16 PM, a telephone interview was conducted with LPN #3, the nurse assigned to care for Resident #3 on day shift on [redacted]. LPN #3 stated that on [redacted] she was assigned to give medication at the facility and was assisted by UM #1. LPN #3 stated that she did not remember details related to Resident #3.</p> <p>On 11/05/2025 at 1:35 PM, a telephone interview was conducted with the Unit Manager (UM #1). UM #1 stated that on [redacted] he evaluated Resident #3 with NP #1 in the morning and the resident seemed to be in [redacted]. UM #1 stated that he instructed LPN #3 to give [redacted] medication to Resident #3 because the resident's family member reported that the resident was in [redacted]. UM #1 stated that it was the responsibility of the resident's primary nurse to contact the resident's physician,</p>			

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F0580 SS = G	<p>Continued from page 4 inform them that the resident was in [REDACTED] and obtain POs for medication. UM #1 further stated that LPN #3 confirmed that she would notify the resident's physician that the resident was in [REDACTED] and would get an order for [REDACTED] medication.</p> <p>An interview was conducted with the [REDACTED] on 11/05/2025 at 2:24 PM. The [REDACTED] stated that it was LPN #3's responsibility to follow up with a physician about Resident #3's reports of [REDACTED]. The [REDACTED] stated that UM #1 could also have followed up with the resident's physician. The [REDACTED] stated that physician notification of the Resident #3's [REDACTED] was not documented, and no order was obtained for [REDACTED] medication. The [REDACTED] stated that LPN #3 did not follow the policies and procedures that the facility had in place. The [REDACTED] further stated that if those things were not done harm could have been caused to the resident.</p> <p>An interview was conducted with NP #1 on 11/05/2025 at 3:46 PM. NP #1 stated that although her PN was timed at 2:58 PM, she had actually seen Resident #3 and ordered an [REDACTED] in the morning. NP #1 could not recall if she had ordered [REDACTED] medication for Resident #3. NP #1 further stated that at around dinner time on [REDACTED] the [REDACTED] called to request a prescription for [REDACTED] for Resident #3, then asked her to disregard the request because the resident was going to the emergency department.</p> <p>A review of the facility policy, "Change in a Resident's Condition or Status," with a date reviewed/revised of 06/23/2025 was conducted. The facility policy revealed under "Policy Statement," that the facility promptly notifies the resident, their attending physician, and the resident representative of changes in the resident's medical/mental condition or status. Under, "Policy Interpretation and Implementation," the facility policy revealed, "1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): [...] d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; [...] 2. A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting').</p>	F0580		

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	<p>Continued from page 6</p> <p>A review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #3 had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated that the resident had [redacted].</p> <p>A review of the Care Plan (CP) for Resident #3 revealed a focus area of, "RISK FOR [redacted] [Resident #3] needs [redacted] [related to]: [redacted]". With an initiation date of [redacted]. Interventions initiated on [redacted] included to administer [redacted] measures; administer [redacted] medications as per orders; encourage reporting of [redacted] to staff before it [redacted] monitor for complaints of [redacted] and encourage reporting of [redacted] before it [redacted] and monitor for effectiveness of [redacted] interventions and, "Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of [redacted].</p> <p>Further review of the CP for Resident #3 revealed a focus initiated on [redacted] that the resident had [redacted] related to making their [redacted] and [redacted] others. Interventions initiated on [redacted] included but were not limited to anticipating and meeting the resident's needs.</p> <p>A review of the Order Summary Report (OSR) for Resident #3 revealed the following physician's orders (POs):</p> <p>[redacted] of the [redacted] and [redacted] to rule out [redacted] [redacted] after a [redacted]. The order date was [redacted].</p> <p>Send to the emergency department for evaluation of [redacted]. The order date was [redacted].</p> <p>The OSR revealed no orders for [redacted] medications or [redacted].</p> <p>A review of the [redacted] Medication Administration Record (MAR) for Resident #3 revealed no documentation that [redacted] medication was administered to Resident #3.</p> <p>A review of the [redacted] Treatment Administration</p>		<p>Continued from page 6</p> <p>medication and non-pharmaceutical interventions were administered if needed. No additional incidents of missed physician notification were identified.</p> <p>The deficient practice for Resident #3 cannot be corrected as the resident is no longer in this facility. To mitigate the possibility of the alleged deficient practice from occurring again, the post [redacted] process was revised to require documentation of MD notification for any reported or observed change in condition, including new or worsening pain. All licensed nursing staff, including agency personnel, were re-educated on the Pain Assessment and Management policy, and requirements for immediate physician notification. Education included scenarios beyond falls, including pain, mobility limitations, mental status changes, and any significant deviation from baseline. All agency onboarding packets were updated to include mandatory education on Change in Condition and physician notification procedures. This change has also been added to the new hire orientation packet for nurses.</p> <p>To monitor the notifications of change in conditions, the Director of Nursing (DON) and/or designee will audit 10% of change-in-condition events (including but not limited to falls, new onset pain, mental status changes, and mobility limitations) weekly for 4 weeks, then monthly for 3 months, to verify: MD notification was completed and documented, pain assessment was completed, orders obtained and interventions implemented, effectiveness of interventions are reassessed. Results will be reviewed monthly by the IDT and quarterly in QAPI. Additional corrective action will be taken as identified.</p> <p>The completion date of this deficient practice is 11/30/2025.</p>	

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F0697 SS = G	<p>Continued from page 7 Record (TAR) for Resident #3 revealed no documentation that NJ Exec Order 26.4b1 were provided to Resident #3.</p> <p>A review of the Progress Notes (PNs) for Resident #3 was conducted. The PNs included a Nursing Note (NN) written by a Licensed Practical Nurse (LPN #1), dated NJ Exec Order 26.4b1 at 2:33 AM, which revealed that Resident #3 had an NJ Exec Order 26.4b1 at 1:45 AM, and NJ Exec Order 26.4b1. A late entry NN written by the Unit Manager (UM #1) dated NJ Exec Order 26.4b1 at 11:17 AM, revealed that Resident #3 complained of NJ Exec and it was endorsed to the resident's primary nurse to obtain a PO for NJ Exec medication, and administer NJ Exec medication as per doctor's orders. A late entry NN written by UM #1 dated NJ Exec Order 26.4b1 at 11:20 AM, revealed that Resident #3 expressed NJ Exec in their NJ Exec Ord and it was endorsed to the resident's primary nurse to assess for NJ Exec and administer NJ Exec medication. A PN by the Nurse Practitioner (NP #1) dated NJ Exec Order 26.4b1 at 2:58 PM, revealed that Resident #3 had NJ Exec Order 26.4b1 to their NJ Exec Ord and NJ Exec Ord were requested. A PN by the US FOIA (b)(6) dated NJ Exec Order 26.4b1 at 5:06 PM, revealed that a family member of Resident #3 reported that the resident was in NJ Exec that morning. The PN further revealed that Resident #3 reported NJ Exec out of ten NJ Exec when attempting to NJ Exec Order 26.4b1. Resident #3 and their family member agreed to have the resident sent to the emergency department for evaluation. A PN written by LPN # 2 dated NJ Exec Order 26.4b1 at 7:32 PM, revealed that Resident #3 was sent to the hospital for NJ Exec Order 26.4b1 at approximately 6:00 PM. The PNs revealed no documentation that NJ Exec Order 26.4b1 medications were provided to Resident #3 after facility staff became aware that the resident complained of NJ Exec on NJ Exec Order 26.4b1 at 11:17 AM, prior to the resident's transfer to the emergency department at 6:00 PM that day.</p> <p>A review of NJ Exec Order 26.4b1 Notes (NJ Exec Ord) for Resident #3 with a date of service of NJ Exec Order 26.4b1 revealed that Resident #3 stated that they had NJ Exec Order 26.4b1 rated as NJ Exec out of ten at NJ Exec and NJ Exec out of ten NJ Exec with NJ Exec Order 26.4b1. The NJ Exec Ord further revealed that Resident #3 was NJ Exec Order 26.4b1 through its NJ Exec Order 26.4b1 due to NJ Exec.</p> <p>A telephone interview was conducted with LPN #1 on 11/05/2025 at 12:29 PM. LPN #1 stated that after Resident #3 NJ Ex in the early morning of NJ Exec Order 26.4b1 no</p>	F0697		

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F0697 SS = G	<p>Continued from page 8 orders were obtained because the resident [REDACTED]. LPN #1 stated that he did not recall who he endorsed the resident's care to the next morning but stated that he explained the resident's situation and needs.</p> <p>On 11/05/2025 at 1:16 PM, a telephone interview was conducted with LPN #3, the nurse assigned to care for Resident #3 on day shift on [REDACTED]. LPN #3 stated that on [REDACTED] she was assigned to give medication and was assisted by UM #1. LPN #3 stated that she did not remember Resident #3 or whether she gave the resident [REDACTED] medication. LPN #3 stated that if she had administered any medication, it would have been documented in the electronic medical record. LPN #3 further stated that if a medication administration was not documented in the electronic record that meant that she did not administer the medication.</p> <p>A telephone interview was conducted with UM #1 on 11/05/2025 at 1:35 PM. UM #1 stated that on [REDACTED] he instructed LPN #3 to give [REDACTED] medication to Resident #3 because the resident's family member reported that the resident was in [REDACTED]. UM #1 stated that it was the responsibility of the resident's primary nurse to contact the resident's physician, inform them that the resident was in [REDACTED] and obtain POs for medication. UM #1 further stated that LPN #3 confirmed that she would notify the resident's physician that the resident was in [REDACTED] and would get an order for [REDACTED] medication.</p> <p>An interview was conducted with a Certified Nursing Assistant (CNA #1) on 11/05/2025 at 1:55 PM. CNA #1 stated that Resident #3 was in a lot of [REDACTED] on [REDACTED] and she informed UM #1. CNA #1 stated that when she attempted to sit Resident #3 up in bed the resident was, "[REDACTED]", and informed her and UM #1 that [REDACTED] in their [REDACTED] and [REDACTED]. CNA #1 stated that throughout the day on [REDACTED], Resident #3's [REDACTED]. CNA #1 further stated that the next day Resident #3's family member informed her that the Resident #3 had [REDACTED].</p> <p>An interview was conducted with the [REDACTED] on 11/05/2025 at 2:24 PM. The [REDACTED] stated that it was LPN #3's responsibility to follow up with a physician about Resident #3's reports of [REDACTED]. The [REDACTED] stated that UM #1 could also have followed up with the resident's physician. The [REDACTED] stated that assessment of Resident</p>	F0697		

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F0697 SS = G	<p>Continued from page 9</p> <p>#3's [REDACTED] was not documented, physician notification of the resident's [REDACTED] was not documented, and no order was obtained for [REDACTED] medication. The [REDACTED] stated that LPN #3 did not follow the policies and procedures the facility had in place. The [REDACTED] further stated that if those things were not done harm could have been caused to the resident.</p> <p>A review of the facility policy, "Pain Assessment and Management," dated 09/04/2025 was conducted. Under "General Guidelines," the policy revealed, "1. The pain management program is based on a facility-wide commitment to the appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences related to pain management." Under "Pain Management:" the facility policy revealed, "1. The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain." Under, "Documentation" the facility policy revealed, "Document the resident's reported level of pain with adequate detail [...] as necessary and in accordance with the pain management program." Under "Reporting," the facility policy revealed, "Report the following to the physician or practitioner: 1. New pain or significant changes in the level of the resident's pain post incident;"</p> <p>NJAC 8:39-27.1(a)</p>	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315510	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/24/2025
NAME OF PROVIDER OR SUPPLIER BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH			STREET ADDRESS, CITY, STATE, ZIP CODE 395 AMWELL ROAD , HILLSBOROUGH, New Jersey, 08844	
(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
F0000	<p>INITIAL COMMENTS</p> <p>An on-site revisit for the facility's Plan of Correction was conducted on 12/24/2025 in relation to the 11/05/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		01/02/2026

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 reverse for further 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
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