STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315510	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH	**395 AMWELL ROAD HILLSBOROUGH, NJ 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
F 000	INITIAL COMMENTS COMPLAINT#: 165398 CENSUS: 119 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		8/16/23

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

Electronically Signed | 08/12/2023

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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	315510	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 1 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 165398 Based on interviews and review of the medical records (MR) it was determined that the facility failed to revise/update a person centered Care Plan (CP) for 1 of 3 residents sampled (Resident #2) who was wandering on another unit. The facility also failed to follow their policy "Incident Report". This deficient practice is evidenced by the following; 1. According to the facility Admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted]/15 which indicated NJ Exec Order 26.4b1, was independent with [redacted] and needed extensive assistance with most activities of daily living (ADLs). A CP, initiated [redacted] and revised on [redacted], included the resident had a history of [redacted] with behaviors which included: NJ Exec Order 26.4b1 [redacted]	F 657	This plan of correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. 1. The person-centered care plan for Resident #2 was updated on [redacted] to reflect that the patient has a tendency of NJ Exec Order 26.4b1 The DON, Unit Manager/designee is responsible for updating the care plan. 2. No other residents were affected by the deficient practice. The facility has reviewed residents with a wandering care plan and/or wandering tendencies on the second floor to ensure that no other residents have been affected by the removal of the 2nd floor door. A total of 10 resident care plans were updated. This was completed on 8/16/23 by the DON and Unit Manager. The residents with wandering tendencies are being	

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F 657	Continued From page 2 NJ Exec Orde The Goals revealed: "NJ Exec Order 26.4b1 [redacted] Interventions/Tasks included: "Intervene as necessary to protect the rights and safety of others. Divert attention. Remove from situation and take to alternate location as needed." A NJ Exec Order Physician Order Summary (POS) revealed an order, initiated on NJ Exec Order 26.4b1, for "Monitor behavior" but did not address NJ Exec Order 26.4b1 as one of the behaviors to be monitored. During an interview on 7/6/23 at 9:28 AM, the Licensed Nursing Home Administrator (LNHA) stated residents on NJ Exec Order 26 are supervised by all staff so they will NJ Exec Order 26.4b1 [redacted] and staff are instructed to redirect them. The LNHA further stated, "Resident #2 NJ Exec Order 26.4b1 [redacted] The nursing staff redirected Resident #2 back to his/her room." A review of the "Complaint/Grievance" form dated NJ Exec Order 26, noted Resident #2 was NJ Exec Order 26.4b1 [redacted] by the resident's spouse. Under "Corrective Actions Taken to Rectify Concern, Resident #2 was redirected back to his/her room with no further issues." A review of the "Summary Statement" written by the Director of Nursing (DON) noted "We will continue to closely monitor Resident #2 and redirect him/her to the NJ Exec Order 26 side of the facility. His/her care plan has been updated to reflect that he/she has the tendency to NJ Exec Order 26.4b1 [redacted]."	F 657	monitored when crossing over to the south side of the building by the nursing staff, activity staff, unit secretary and/or designee to ensure they do not enter other resident's rooms. 3. The facility interviewed alert and oriented residents on the 2nd floor and offered door "stop" signs for those that did not feel comfortable with the change of the 2nd floor door removal. Two residents accepted the signage, but the rest declined. The facility also reviewed the incident report & grievance policies and in-service staff on proper protocol of both policies on 7/7/23. 4. The facility will monitor the residents who have the potential to wander into other resident rooms by having the assigned CNA of the patients with the risk of wandering report to the DON/Unit Manager/designee incidents of patients ending up in other patient rooms. The Staff Development/designee will provide weekly in-service to the CNAs, activity staff and nurses on patient monitoring for 4 weeks and then monthly for 3 months. The DON/Unit Manager/designee will bring any urgent findings to the IDT immediately for immediate action. 5. The facility will review on a monthly basis the number of instances that wandering into other resident rooms occurring. The facility will also conduct an audit of resident care plans and review findings at the quarterly QAPI meeting.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 3 During an interview on 7/6/23 at 12:46 PM, the DON stated the Certified Nursing Assistants (CNAs) monitor residents in [NJ Exec Order 26], but they don't have a rounding schedule, it was developing at this time. The DON further stated during the overnight shift, hourly rounding was done to "make sure everyone was where they are supposed to be." However, there was no documentation to support this. The DON stated he did a written report about Resident #2 [NJ Exec Order 26.4] , for him to file and keep track. Further review of Resident #2's CP revealed no further updates to address the wandering incident on [NJ Exec Order 26]. There were also no new interventions put in place to prevent further NJ Exec Order 26.4b1 . A review of the facility policy, "Incident Report", under "11. The licensed nurse or other departmental staff member completing the incident report should also update the resident's care plan to include the issue/problem and new interventions." NJAC: 8:39-11.2 (e) (2) NJAC: 27.1(a)	F 657		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18104	A. BUILDING: _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT HILLSB(	395 AMWELL ROAD HILLSBOROUGH, NJ 08844

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S 000	Initial Comments COMPLAINT#: NJ165398 Census: 119 Sample: 3 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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: NJ#165398 Based on 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 7 out of 21 day shifts reviewed.	S 560	This plan of correction does not constitute an admission or agreement with the conclusions of the July 6, 2023, Unannounced Visit. It is being submitted solely as a matter of regulatory compliance. The facility works to staff on a daily basis based on, at a minimum, the standards as set forth by the state of New Jersey.	8/2/23

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

Electronically Signed | 08/12/23

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	18104	A. BUILDING: _____ B. WING _____	C 07/06/2023

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S 560	Continued From page 1 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 6/11/2023 to 7/1/2023 for the 7/6/2023 complaint survey at Bridgeway Care at Hillsborough, the facility was deficient in CNA staffing for residents on 7 of 21 day shifts as follows: -06/17/2023 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. -06/18/23 had 12 CNAs for 125 residents on the day shift, required 16 CNAs. -06/20/23 had 14 CNAs for 122 residents	S 560	1. On the dates reviewed during the unannounced visit, we appeared not to have sufficient staff for 6/17/23 (14 CNAs for 125 residents, 16 needed), 6/18/23 (12 CNAs for 125 residents, 16 needed), 6/20/23 (14 CNAs for 122 residents, 15 needed), 6/23/23 (12 CNAs for 120 residents, 15 needed), 6/25/23 (12 CNAs for 120 residents, 15 needed), 6/27/23 (14 CNAs for 117 residents, 15 needed), 6/30/23 (14 CNAs for 124, 15 needed). No residents were negatively affected by the deficient practice and there were no negative outcomes. 2. All residents have the potential to be affected by this deficient practice. 3. To help maintain the required staffing ratios, our company is working tirelessly on recruiting qualified licensed personnel so that we can reduce agency usage and fill the open positions we have. Our dedicated staffing coordinator and other management staff work to cover any last-minute call outs by offering incentives to in-house staff and boosting rates for agency staff. We will continue to post on our schedule so that we can attempt to fulfill the need for a 1 to 8 ratio on the day shift as identified in 2567. We attempt to utilize staffing agencies and offer/pay additional incentives to our staff to pick up shifts. Our staffing system posts all our open positions allowing for staff and agency personnel to pick up those shifts. We post openings to be able to satisfy, at a minimum, the 1 CNA to 8 residents' ratio on the day shift, 1 to 10 in the evening and 1 to 14 at night. We contract with	

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S 560	Continued From page 2 on the day shift, required 15 CNAs. -06/23/23 had 14 CNAs for 120 residents on the day shift, required 15 CNAs. -06/25/23 had 12 CNAs for 120 residents on the day shift, required 15 CNAs. -06/27/23 had 14 CNAs for 117 residents on the day shift, required 15 CNAs. -06/30/23 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. NJAC 8:39-5.1(a)	S 560	numerous agencies to fill any remaining openings. We offer incentives to our staff and those in the agency to get those shifts filled. We have a staffing coordinator dedicated to obtaining the necessary staff. Aside from that person we have other nursing supervisors and managers that help with making any necessary phone calls and outreach to get the positions filled. 4. The facility plans to have the Staffing Coordinator / designee monitor staffing ratios daily and will report any days where staffing is lower than recommended. Data will be tracked and reported in the facilities monthly QAPI meeting.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315510	A. Building B. Wing	8/17/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH	395 AMWELL ROAD HILLSBOROUGH, NJ 08844

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 F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 08/17/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
7/6/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
18104 Y1	A. Building B. Wing Y2	8/17/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH	395 AMWELL ROAD HILLSBOROUGH, NJ 08844

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/16/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 7/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			