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 08/19/2024

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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ: #163272, #169312, #169377, #169743, #16992, #170134, #172165, #172213, #172240, #173547, #173469, #173492, #173639, Survey Date: 8/5/24 to 8/19/24 Census: 120 Sample: 25 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		8/30/24

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

Electronically Signed | 09/05/2024

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F 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ00172165 REFER to F610 Based on observations, interviews and record review, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) and follow facility policy and procedures for reporting for a) NJ Ex Order 26.4(b)(1) (Sampled Resident #6, unsampled Resident #25 and #54), and b) a NJ Ex Order 26.4(b)(1) with a resdient's NJ Exec Order 26.4b1 (Resident #15). The deficient practice was identified for four (4) of nine (9) residents reviewed for investigations and was evidenced by the following: 1. On 8/5/24 at 12:10 PM, the surveyor observed Resident #6 participating in conversation and eating lunch at a table with three other residents. The resident stated that they were willing to talk with the surveyor at another time.	F 609	The corrective action put in place on 8/7/2024 to rectify the deficient practice identified during the facilities annual survey was to: 1. File a report via the Novi System portal to the New Jersey Department of Health reporting the NJ Ex Order 26.4(b)(1) made by residents #6, #25, and #54 on NJ Ex Order 26.4b1 at 12:21 PM and via email to the Ombudsman office. At the time of the initial grievance, NJ Exec Order 26.4b1, the Director of Nursing removed Certified Nursing Assistants (CNA) #1 & #2 from the residents #6, #25, and #54 assignment and provided them with education on customer services and residents rights. Facility re-investigated the allegations brought forward by residents #6, #25, and #54 during the annual survey by re-interviewing the residents mentioned above and CNA #1 & #2. The	

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F 609	Continued From page 2 The surveyor reviewed the medical record for Resident #6. According to the quarterly Minimum Data Set (MDS) (an assessment tool) dated [NJ Ex Order 2], reflected that the resident had diagnoses which included but not limited to; [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26] and [NJ Ex Order 26.4(b)(1)] The MDS assessment reflected that the resident had a Brief Interview of Mental Status (BIMS) score of [NJ Ex] out of 15, which indicated an [NJ Ex Order 26.4(b)(1)]. On 8/6/24 at 10:06 AM, the surveyor reviewed a Complaint/Grievance Form, dated [NJ Ex Order 26.4], provided by the U.S. FOIA (b) (6) The form was completed by the U.S. FOIA (b) (6)) and revealed that Resident #6 reported issues and concerns with two CNAs, (CNA#1 and CNA#2). The form indicated "Resident NJ Exec Order 26.4b1 CNA#1 and CNA#2 were caring for him/her and does not want them on his/her assignment." "Resident stated NJ Exec Order 26.4b1." The form was referred to nursing and signed by the U.S. FOIA (b) (6)), who was the U.S. FOIA (b) (6)), on [NJ Ex Order 26.4]. According to the form, the corrective action taken to rectify the concern, indicated that "Education provided to CNAs regarding: NJ Exec Order 26.4b1, resident's rights, customer service and reassignment. It was signed by the [U.S. FOIA (b) (6)] . The form had a "Final Review by US FOIA (b) (6) Nature of Concern/Grievance: CNA interaction" signed by the [U.S. FOIA (b)] and [U.S. FO] and dated [NJ Ex Order 26.4] There was no indication that a report was sent to	F 609	Administrator concluded that we could not substantiate NJ Exec Order 26.4b1 and a summary and conclusion was sent to the New Jersey Department of Health on 8/15/2024. For the incident with Resident #15, a complaint was filed, the incident was reported late to the Department of Health and Ombudsman. The facility investigated the event at the time it was reported. Facility was able to locate one of the NJ Exec Order 26.4b1 and offered NJ Exec Order 26.4b1 for the [NJ Exec Order 26.4b1]. The family and resident NJ Exec Order 26.4b1. A summary and conclusion of the investigation was sent to the New Jersey Department of Health on [NJ Exec Order 26.4b1]. The re-investigation included interviews of other NJ Exec Order 26.4b1 residents who had recently had CNA #1 & #2 on their assignment. 2. The facility identified that this deficiency could impact the entire resident population. This facility also identified its grievance process needs to be updated to address and better identify the timeliness of reporting allegations of abuse and neglect to the required parties. 3. To ensure that the deficient practice was corrected, the facility Administrator in-serviced facility US FOIA (b) (6) on the grievance process and ensuring that any statements taken by a resident that include a resident feeling unsafe is immediately brought to the attention of the Administrator, Director of Nursing and/or Designee. The facility Administrator and	

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F 609	Continued From page 3 the NJDOH. Further review of the attached "Investigation Statement Form" revealed that the date of the incident was "[NJ Ex Order 26.4(b)(1)] (reported [NJ Ex Order 26.4]" and the type of investigation was "issues with CNA #1 and CNA #2." The [U.S. FO] documented follow up interviews with two [NJ Ex Ord] and [NJ Ex Order 26.4(] residents, unsampled Residents #25 and #54 on [NJ Ex Order 26.4], that were under the care of CNA #1 and CNA #2. The [U.S. FO] indicated on the form that unsampled Resident #54 made a statement that "CNA #2 is just [NJ Ex Order 26.4(b)(1)] He/She doesn't want CNA #2 on his/her assignment as he/she does [NJ Exec Order 26.4b1] with CNA #2." The unsampled Resident #54 made a statement that CNA #2 took [NJ Exec Order 26.4b1] from the resident's tray and the resident had to ask for them back. In addition, the Investigation Statement Form revealed a follow up interview with unsampled Resident #25 who, according to the statement, indicated that "CNA #1 made him/her [NJ Ex Ord] by [NJ Ex Order 26.4(b)(1)] during care." The form reflected that the unsampled Resident #25 had requested that CNA #1 not be on their assignment. There was no indication that a report was sent to the NJDOH. On 8/6/24 at 10:17 AM, the surveyor interviewed the [U.S. FOIA (b)] regarding the Complaint/Grievance Form dated [NJ Exec Order 26] for Resident #6. The [U.S. FOIA (b)] confirmed that there was no report to the NJDOH. The [U.S. FOIA (b)] stated that the incident was treated as a grievance and not reported because Resident #6 had a history of [NJ Ex Order 26.4(b)(1)] and was saying that the CNAs were [NJ Exec Order 26.4b1] and	F 609	Director of Nursing have also reviewed the Abuse policy and the reporting requirements to ensure compliance with future potential reportable incidents, updates made to the Abuse policy. The Administrator put together a memo that was text-blasted to all facility employees on reporting abuse and neglect incidents reported by a resident to reflect the changes made to the Abuse Policy. The memo included information on timeliness and who the proper contact persons are if they witness a potential event or if a resident reports an event that can be considered abuse and neglect or a missing/stolen item. The updated abuse policy & grievance policy has been added to the new staff orientation and to agency staff packet. A resident council meeting for August was held on 8/27/2024, the Administrator and Director of Nursing reviewed with the residents in attendance the importance of reporting any incidents to a staff member or a supervisor immediately and that they can do so via phone or requesting to see a supervisor or designee in person. The staff part of the management team also re-in serviced, reporting any concerns brought forward by a resident to the Administrator, Director of Nursing and/or Designee. The concerns will be initially written in a grievance form and immediately reviewed by the Administrator and/or designee. 4. To monitor the reporting of alleged violations, the facility Administrator and/or designee will review all grievances as	

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F 609	Continued From page 4 unsure what that meant because the resident had requested specific CNAs in the past. The U.S. FOIA (b) stated that both CNAs were not working on NJ Ex Order 26.4 and were immediately reported to be reassigned from all three residents. The U.S. FOIA (b) acknowledged that after reading the wording on the form, that she should have completed a report to the NJDOH. The U.S. FOIA (b) stated that the U.S. FOIA (b) (6) and U.S. FO had done the statements. The U.S. FOIA (b) stated that the U.S. FOIA (b) (6)) was currently not available and the U.S. FOIA (b) (6) was currently on leave. The U.S. FOIA (b) added that she could not recall why a report was not done and needed to do a review. On 8/6/24 at 10:49 AM, the U.S. FOIA (b) returned to discuss Resident #6 in the presence of the survey team. The U.S. FOIA (b) stated that she had not reported because Resident #6 is usually NJ Exec Order 26.4b1 with CNAs and had asked for reassignments of CNAs in the past. The U.S. FOIA (b) added that in general the NJ Ex Or and NJ Ex Order 26.4(residents on the floor were particular about who they want to care for them and it is not unusual for the residents to request certain CNAs. The U.S. FOIA (b) stated that none of the three residents had initiated a concern and Resident #6 had been told in the past to immediately report any issues. The U.S. FOIA (b) acknowledged that according to the wording on the form, the incidents should have been reported to the NJDOH. On 8/6/24 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) in the presence of the survey team. The U.S. FOIA (b) stated that the required timeframes referred to in the facility NJ Ex Order 2 Policy were to report any NJ Ex Order 26.4(b)(1) immediately within 2 hours to the NJDOH and complete a NJDOH reportable form within 24 hours.	F 609	soon as they are reported for one month and determine if a reportable report is warranted. If a reportable report is warranted, the Administrator and/or designee will call the reportable hotline immediately but no later than 2-hours after being made aware of the incident and proceed to investigate. The timeliness of the grievance response and reportable events and conclusion of those events will be reviewed during the quarterly QAPI meeting. 5. Completion date of deficient practice is 8/30/2024.	

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F 609	Continued From page 5	F 609		

On 8/13/24 at 9:13 AM, the survey team met with the U.S. FOIA (b) and U.S. FOIA (b) the U.S. FOIA (b) stated that she was responsible for reporting to the NJDOH. The U.S. FOIA (b) also stated that she could not remember back in NJ Ex Or why the incident was not reported and stated based on the wording of the report that she should have reported it.

2. The surveyor reviewed the medical record for Resident #15.

According to the Annual MDS, dated NJ Ex Order 26.4(b), the resident had diagnosis including but not limited to; NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1). The MDS reflected a BIMS score of NJ Ex indicating NJ Ex Order 26.4(b)(

On 08/06/24 at 01:38 PM, the surveyor reviewed the facility's investigation report which indicated that the resident's NJ Exec Order 26.4 reported Resident #15's NJ Ex Order was NJ Ex Order 26.4 on NJ Ex Order 26.4(b). The NJ Ex Order did not NJ Ex Order 26.4(b)(1), but did NJ Ex Order 26. Resident #15's NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A NJ Ex Order report was filed on NJ Ex Order 26.4(b).

After inquiry to the NJDOH by the facility on NJ Ex Order 26.4(b), the facility reported the above incident.

A review of the facility policy for "Grievances/Complaints, Filing" dated 6/21/24 provided by the U.S. FOIA (b) included "Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint. In

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F 609	Continued From page 6 addition, "The grievance officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under the guidelines for reporting abuse, neglect and misappropriation of property, as per state law." A review of the facility policy for "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated 10/4/23 provided by the [redacted] included to investigate and report any allegations within timeframes required by federal and state requirements. N.J.A.C. 8:39-4.1(a)(15), 9.4(f)	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		8/30/24

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F 610	Continued From page 7 This REQUIREMENT is not met as evidenced by: REFER to F609 Based on observation, interview and record review, it was determined that the facility failed to conduct a timely and thorough investigation for three (3) of nine (9) residents, (Resident #6 and unsampled Residents #25 and #54), reviewed for alleged NJ Ex Order 26.4(investigations. The deficient practice was evidenced by the following: On 8/5/24 at 12:10 PM, the surveyor observed Resident #6 participating in conversation and eating lunch at a table with three other residents. The resident stated that they were willing to talk with the surveyor at another time. On 8/6/18 at 10:06 AM, the surveyor reviewed a Complaint/Grievance Form, dated NJ Ex Order 26.4, provided by the U.S. FOIA (b) (6) The form was completed by the U.S. FOIA (b) (6)) and revealed that Resident #6 reported issues and concerns with two CNAs, (CNA#1 and CNA#2). The form indicated "Resident does NJ Ex Order 26.4(b)(1) when CNA#1 and CNA#2 are caring for him/her and does not want them on his/her assignment." "Resident stated they are NJ Ex Order and NJ Ex Order. The form was referred to nursing and signed by the U.S. FOIA (b) (6)), who was the U.S. FOIA (b) (6) , on NJ Ex Order 26.4(. According to the form, the corrective action taken to rectify the concern indicated that "Education provided to CNAs regarding: NJ Exec Orde prevention, resident's rights, customer service and was signed by the US FOIA (b) (6)). The form had a "Final Review by NJ Exec Order 26.4b1 l: Nature of Concern/Grievance: CNA interaction" signed by the U.S. FOIA (b and U.S. FOIA (b) (6) and dated NJ Ex Order 26.	F 610	The corrective action put in place on 8/7/2024 to rectify the deficient practice identified during the facilities annual survey was to: 1. File a report via the Novi System portal to the New Jersey Department of Health reporting the NJ Ex Order 26.4(b)(1) made by residents #6, #25, and #54 on NJ Ex Order 26.4b1 at 12:21 PM and via email to the Ombudsman office. At the time of the initial grievance, NJ Exec Order 26.4b1, the Director of Nursing removed Certified Nursing Assistants (CNA) #1 & #2 from the residents #6, #25, and #54 assignment and provided them with education on customer services and residents rights. Facility re-investigated the allegations brought forward by residents #6, #25, and #54 during the annual survey by re-interviewing the residents mentioned above and CNA #1 & #2. The Administrator concluded that we could not substantiate NJ Exec Order 26.4b1 and a summary and conclusion was sent to the New Jersey Department of Health on 8/15/2024. 2. The facility identified that this deficiency could impact the entire resident population. The re-investigation included interviews of other alert and oriented residents who had recently had CNA #1 & #2 on their assignment. Allegations for the past 3 months pertaining to resident to staff complaints have been re-reviewed with no additional findings, there was no need to contact the NJ Department of	

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F 610	Continued From page 8 Further review, revealed an attached "Investigation Statement Form" revealed that the date of the incident was [redacted] (reported [redacted])" and the type of investigation was "issues with CNA #1 and CNA #2." The [redacted] documented follow up interviews with two [redacted] and [redacted] residents under the care of CNA #1 and CNA #2. The [redacted] spoke with two unsampled Residents #25 and #54 on [redacted] The [redacted] indicated that the unsampled Resident #54 made a statement that "CNA #2 is [redacted]. He/She doesn't want CNA #2 on his/her assignment as he/she does [redacted] with CNA #2." The unsampled Resident #54 made a statement that the CNA #2 took [redacted] from the resident's tray and the resident had to ask for them back. In addition, the Investigation Statement Form revealed a follow up interview with unsampled Resident #25 who according to the statement indicated that "CNA #1 made him/her [redacted] by being [redacted] during care." The form reflected that the unsampled Resident #25 had requested that CNA #1 not be on their assignment. Additionally, attached with the form was another "Investigation Statement Form", dated [redacted], completed by CNA #2 which indicated that whenever CNA #2 was assigned to Resident #6 they were [redacted] and [redacted] at CNA #2. The CNA #2 included that the resident had [redacted] of not [redacted] to them. Also attached to the Grievance/Complaint Form was an "In-service: Customer Service/Resident Dignity" and an "In-Service: [redacted] Prevention" dated [redacted] and signed by both CNA#1 and CNA #2.	F 610	Health based on the findings or conduct a more comprehensive investigation. 3. To ensure that the deficient practice was corrected, the facility Administrator in-serviced facility [redacted] on the grievance process and ensuring that any statements taken by a resident that include a resident feeling unsafe is immediately brought to the attention of the Administrator, Director of Nursing and/or Designee. The facility Administrator and Director of Nursing have also reviewed the Abuse policy and the reporting requirements to ensure compliance with future potential reportable incidents. The Administrator put together a memo that was text-blasted to staff on reporting abuse and neglect incidents reported by a resident. The memo included information on timeliness of reporting and who to report the allegations to if they witness a potential event or if a resident reports an event that can be considered abuse and neglect. The management team reeducated regarding reporting to the Administrator, Director of Nursing and/or Designee, any concerns brought forward by a resident. The concerns will be initially written in a grievance form and immediately reviewed by the Administrator and/or designee. 4. To monitor the reporting of alleged violations, the facility Administrator and/or designee will review grievances as they are reported to determine if a reportable report is warranted. If warranted, the Administrator and/or designee will call the	

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F 610	Continued From page 9 On 8/6/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b) regarding the Complaint/Grievance Form dated NJ Ex Order 26.4 for Resident #6. The U.S. FOIA (b) confirmed that there was no report to the NJDOH and that the Complaint/Grievance Form was complete and there was no further follow up investigation documented. The U.S. FOIA (b) stated that the incident was treated as a grievance and not reported because Resident #6 had a history of NJ Exec Order 26.4b1 and saying that the CNAs were NJ Exec Order 26.4b1 and unsure what that meant. The U.S. FOIA (b) stated that both CNAs were not working on NJ Ex Order 26.4 and were immediately reported to be reassigned from all three residents. The U.S. FOIA (b) acknowledged that after reading the wording on the form, that she should have completed a report to the NJDOH. The U.S. FOIA (b) stated that the U.S. FOIA (b) (6) and U.S. FO had done the statements and acknowledged that further investigation documentation was needed. The U.S. FOIA (b) stated that the U.S. FOIA (b) (6)) was currently not available and the U.S. FOIA (b) (6) was currently on leave. The U.S. FOIA (b) added that she could not recall why a report was not done and needed to do a review. On 8/6/24 at 10:49 AM, the U.S. FOIA (b) returned to discuss Resident #6 in the presence of the survey team. The U.S. FOIA (b) stated that she had not reported because Resident #6 was usually NJ Exec Order 26.4b1 with CNAs and had asked for reassignments in the past. The U.S. FOIA (b) added that in general the NJ Ex Or and NJ Ex Order 26.4(residents on that floor were particular about who they want to care for them, and it was not unusual for the residents to request certain CNAs and/or request not to have certain CNAs. The U.S. FOIA (b) stated that none of the three residents had initiated an issue and	F 610	reportable hotline within the required timeline once being made aware of the incident and proceed to investigate. The timeliness of the grievance response and reportable events and conclusion of those events will be reviewed during the quarterly QAPI meeting. 5. Completion date of deficient practice is 8/30/2024.	

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 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 10	F 610		

Resident #6 had been told in the past to immediately report any issues and in general was a [NJ Ex Order 26.4(b)(1)] resident. The [U.S. FOIA (b)] acknowledged that according to the wording on the grievance form, the incidents should have been reported to the NJDOH and further investigation documentation should have been done. The [U.S. FOIA (b)] also stated that she was very familiar with Resident #25, who was a [NJ Ex Order 26.4(b)(1)] person, and the resident was educated to report any issues immediately. The [U.S. FOIA (b)] added that Resident #54 was [NJ Ex Order 26.4(b)(1)] to the facility and was also educated to report any issues immediately. The [U.S. FOIA (b)] stated that when there were reports regarding CNAs that part of the process was to investigate what had occurred. The [U.S. FOIA (b)] added that it was handled as a grievance because the residents were not in danger and that the residents were not satisfied with the care that they received. The [U.S. FOIA (b)] stated that both CNAs were reassigned immediately as per the request of the residents. The [U.S. FOIA (b)] further explained that the grievance process was used for anything not considered [NJ Ex Order 2] such as a CNA that was rushing them or the CNA was [NJ Ex Or] , and more customer service was needed. The [U.S. FOIA (b)] acknowledged that the way the grievance report read that, there should have been further documentation of the investigation completed.

On 8/6/24 at 12:34 PM, the surveyor interviewed the [U.S. FOIA (b)] and the [U.S. FO] regarding the Complaint/Grievance Form. The [U.S. FO] stated that she was the covering [U.S. FOIA (b) (6)] as of [NJ Ex Order 2]. The [U.S. FO] added that she had completed the form and remembered the discussion clearly. The [U.S. FO] stated that she was performing a quarterly care plan discussion with Resident #6 when the

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 610	Continued From page 11	F 610		

resident voiced a concern about the 2 CNAs. The U.S. FO stated that she remembered Resident #6 just had not wanted the CNAs to be assigned to them and had not thought that was odd because Resident #6 had asked in the past for certain CNAs to be assigned to them. The U.S. FO stated that she completed the form and as a follow up, randomly selected two NJ Ex Or and NJ Ex Order 26.4(residents, (unsampled Residents #35 and #54), to interview regarding the 2 CNAs. The U.S. FO was unable to speak to whether there were more NJ Ex Or and NJ Ex Order 26.4(residents on the CNA's assignments. The U.S. FO stated that she always asks the residents if they NJ Ex Order 26.4(b) and when the answer was no, then she reports that to the U.S. FOIA (b) (The U.S. FO added that Resident #25 had said NJ Ex O felt NJ Ex Order 26.4(b)(1) because they were a NJ Ex Or and does not like having to NJ Ex and the resident felt strongly that they had not wanted to NJ Ex Order 26.4(b)(1). The U.S. FO added that besides not wanting CNA #1, Resident #25 NJ Exec Order 26 . The U.S. FO added that she should have documented more. The U.S. FOIA (b) stated that the U.S. FOIA (was also part of the investigation and was returning the next day.

The surveyor reviewed the medical record for Resident #6.

According to the quarterly Minimum Data Set (MDS) (an assessment tool), dated NJ Ex Order 26.4 reflected that the resident had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) The MDS assessment reflected that the resident had a Brief Interview of Mental Status (BIMS) score of NJ Ex out of 15, which indicated an NJ Ex Order 26.4(b)(1).

On 8/6/24 at 1:46 PM, the surveyor interviewed

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 08/19/2024

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F 610	Continued From page 12	F 610		

Resident #6 who stated that they were able to NJ Ex Order 26.4(b)(1) and told the nurses which aides they wanted and which aides they did not want. The resident was able to identify two CNAs that they felt were very good and would want all the time. The resident stated that CNA #1 gives them NJ Ex Order 26. but was unable to speak to a specific incident or occurrence and stated that they just felt that CNA #1 was reluctant to help them. The resident then added that CNA #1 was NJ Exec Order 2 NJ Ex Order 26.4(b) with CNA #2 and that together they were . The resident added that as long as they did not have the aides that they did not want, then they were fine. The resident was not specific as to what the aides that they did not want had done. The resident stated, "I can just tell which aides are NJ Ex Order 26.4(b) ." The resident then stated that he/she has a tendency to get NJ Ex Order 26.4 over everything. The resident added that they NJ Ex O and was NJ Ex Order 26.4(b)(1) with the staff. The resident added that they had no recollection of any discussion with the U.S. FOO

The surveyor reviewed the medical record for Resident #25.

According to the quarterly MDS (an assessment tool) dated NJ Ex Order 26.4 reflected that the resident had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b) (NJ Ex Order 26.4(b)(1)). The MDS assessment reflected that the resident had a BIMS score of NJ Ex out of 15 which indicated an NJ Ex Order 26.4(b)(1).

On 8/6/24 at 2:05 PM, the surveyor interviewed the unsampled Resident #25, who stated that NJ Exec had nothing to say and had NJ Ex Order 26.4(b)(1). The resident added that NJ Ex O felt NJ Ex Order 26.4(b)(1) and could tell the staff their needs.

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 610	Continued From page 13	F 610		

The surveyor reviewed the medical record for Resident #54.

According to the quarterly MDS (an assessment tool) dated [NJ Ex Order 2] reflected that the resident had diagnoses which included but were not limited to; [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]. The MDS assessment reflected that the resident had a BIMS score of [NJ Ex] out of 15, which indicated an [NJ Ex Order 26.4(b)(1)].

A review of the medical record for the unsampled Resident #54 revealed that the resident had been sent to the [NJ Exec Order 26] after an [NJ Exec Order 26.4b1] on [NJ Ex Order 26.4] and [NJ Exec Order 26.4b1] to the facility.

On 8/9/24 at 10:53 AM , the surveyor interviewed the [U.S. FOIA (b)] and [U.S. FOIA] regarding the Complaint/Grievance Form. The [U.S. FOIA] stated that when CNAs were reassigned, the [U.S. FOIA (b)(6)] was informed, and assignment sheets were updated, and all supervisors were made aware and the CNA themselves were aware. The [U.S. FOIA] added that there were no changes to the assignments allowed unless approved by a supervisor. The [U.S. FOIA] added that CNA#2 was moved to the [] floor. The [U.S. FOIA] confirmed that both CNAs were inserviced prior to returning to work. The [U.S. FOIA] acknowledged that there should have been more documentation and statements included when the concerns were reported. The [U.S. FOIA] and [U.S. FOIA (b)] stated that they had been working on completing the investigations after surveyor inquiry. The [U.S. FOIA (b)] stated that Resident #25 had not wanted to discuss anything further and felt there were [NJ Ex] in their room [NJ Ex Order 26.4(b)(1)] on

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 610	Continued From page 14	F 610		

NJ Ex Order 26.4 but had not wanted to report the issue. The U.S. FOIA added that Resident #25 understood the reason was that the CNA #3 was being helped by CNA #1 because CNA #3 was very NJ Ex Or, and CNA #1 noticed some NJ Ex Order 26.4(b)(1) and asked CNA #3 to get the nurse who verified the NJ Exec Order 26.4 The U.S. FOIA (b) added that Resident #25 understood that there was 2 CNAs and a nurse trying to provide care for a medical reason and just preferred not to have CNA #1 assigned to them. The U.S. FOIA (b) and U.S. FOIA acknowledged that there was no documentation provided in the Grievance/Complaint form.

On 8/9/24 at 11:00 AM, the surveyor was provided investigations for Resident #6 and unsampled Residents #25 and #54 by the U.S. FOIA (b) (6) The U.S. FOIA (b) stated that CNA #2 removed a finished meal tray from Resident #54 containing the NJ Exec Or. Then, when the resident expressed wanting the items they were provided. The U.S. FOIA (b) acknowledged that the Grievance/Complaint Form had not explained the above.

A review of the investigations for Residents #6 and unsampled Residents #25 and #54 were completed and thorough after surveyor inquiry.

On 8/9/24 at 12:33 PM, the survey team met with the U.S. FOIA (b) and U.S. FOIA (b) The U.S. FOIA (b) stated that she felt that they had made sure all residents were safe, that the identified CNAs were reassigned as per resident requests. The U.S. FOIA added that CNA #2 was assigned to a different floor to separate the 2 CNAs.

On 8/13/24 at 9:13 AM, the survey team met with the U.S. FOIA (b) and U.S. FOIA (b) The U.S. FOIA (b) stated "Based on the wording of the report and no further

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 610	Continued From page 15 documentation of statements that there should have been a documented further investigation." A review of the facility policy for "Grievances/Complaints, Filing" dated 6/21/24 provided by the [redacted] included "Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint. In addition, "The grievance officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under the guidelines for reporting abuse, neglect and misappropriation of property, as per state law." A review of the facility policy for "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" dated 10/4/23 provided by the [redacted] included to investigate and report any allegations within timeframes required by federal and state requirements. NJAC 8:39-4.1(a)(5), 9.3(d), 13.4(c)2(i-vi)	F 610		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		8/29/24

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 759	Continued From page 16 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 8/6/24, the surveyor observed two (2) nurses administer medications to four (4) residents. There were 26 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.69 %. This deficient practice was identified for one (1) of four (4) residents, (Resident # 268), that were administered medications by one (1) of two (2) nurses. The deficient practice was evidenced as follows: On 8/6/24 at 8:57 AM, the surveyor observed the U.S. FOIA (b) (6) preparing to administer the morning medications to Resident #268. The U.S. FOIA stated that according to the electronic medication administration record (EMAR), the resident had NJ Ex Order 26.4(b)(1) The U.S. FOIA explained that the NJ Ex Order 26.4(b)(1) had to be NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) to see the NJ Ex Order 26.4(b)(1). The U.S. FOIA removed the resident's NJ Ex Order 26.4(b)(1)) from the medication cart and removed the NJ Ex Order 26.4(b)(1) and replaced the NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) and placed the NJ Ex Order 26.4(b)(1) on top of the medication cart in a horizontal position. The U.S. FOIA then removed the NJ Ex Order 26.4(b)(1) and removed the NJ Ex Order 26.4(b)(1) and replaced it with a NJ Ex Order 26.4(b)(1) and placed the NJ Ex Order 26.4(b)(1) on top of the medication cart in a horizontal position. The U.S. FOIA explained that the	F 759	The corrective action put in place on 8/6/2024 to rectify the deficient practice identified during the facilities annual survey was to: 1. The Director of Nursing (DON) assessed Resident #268 on NJ Ex Order 26.4(b)(1) for any adverse effects from the medication administration error of NJ Ex Order 26.4(b)(1) No adverse event was identified. The DON audited current residents receiving NJ Ex Order 26.4(b)(1) to ensure proper administration technique was followed. The U.S. FOIA identified during survey was re-educated on NJ Ex Order 26.4(b)(1) administration. U.S. FOIA completed a competency and a return demonstration on NJ Ex Order 26.4(b)(1) administration. 2. The facility identified that this deficiency could impact the residents receiving insulin. 3. To ensure that the deficient practice was corrected on 8/7/2024, the Staff Development (SD) re-educated the Registered nurses who was observed during survey and all other licensed staff on the proper technique for administering insulin pen injections per manufacturer guidelines, including priming the pen with 2 units while holding it vertically with the needle cap removed. The facility's "Medication Administration Guidelines: Insulin Pens" policy was reviewed and deemed appropriate; no revisions necessary. The SD/designee will conduct Insulin Administration competency 3 times per week for 4 weeks, then weekly for 2 months, to ensure insulin pens are primed and administered per manufacturer	

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 759	Continued From page 17 NJ Ex Ord had to be NJ Ex Order 26.4(b)(1) to see the NJ Ex Order 26.4(b)(1). The U.S. FC then explained to the surveyor that she was not going to be administering all the morning medications at this time because there was an NJ Ex Order 26.4(b)(1) medication and a NJ Ex Order 26.4(b)(1)) until after the resident had finished breakfast. The surveyor observed the U.S. FC preparing a total of NJ Exec Order 26.4b medications for the resident which included the NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1). The U.S. FC then showed the surveyor that she was dialing a NJ Ex Ord for the NJ Ex Order 26.4(b)(1) according to the physician's order (PO) on the EMAR. Next, the U.S. FC showed the surveyor that she was dialing a total of NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) according to a standing PO for NJ Ex Order 26.4(b)(1) plus another NJ Ex Or according to a sliding scale PO for a NJ Ex Order 26.4(b)(1) result of NJ Ex Ord On 8/6/24 at 8:40 AM, the surveyor observed the U.S. FC NJ Ex Order 26.4(b)(1)) with the NJ Ex Order 26.4(b)(1) that was dialed to NJ Ex O and then the NJ Ex Order 26.4(b)(1) that was dialed to NJ Ex Orde The surveyor had not observed the U.S. FC prime the NJ Ex Order 26 and the NJ Ex Order 26.4(b)(1) before administration. (ERROR #1 and #2) Upon returning to the medication cart, the surveyor asked the U.S. FC when she had NJ Exec Order 2 the NJ Ex Order 26.4(b)(1). The U.S. FC stated that she NJ Exec Order 2 the NJ Ex Order 26.4(b)(1) when she removed them from the medication cart and after she put on the NJ Ex Order 26 . The U.S. FC stated that she dialed the NJ Ex Ord to NJ and NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4 went NJ Ex Order 26.4(b)(1) The U.S. FC acknowledged that she had not shown the surveyor the NJ Exec Order 26 of the NJ	F 759	guidelines. Additional education will be provided for any nurses observed to deviate from proper technique. The competency will be added to the nursing orientation & new agency orientation packet. 4. To monitor the effectiveness of the audit, the DON or designee will report the results of the insulin competency audit to the quarterly QAPI committee for review and recommendations. The QAPI committee will review the Insulin Competency audits and consult the Pharmacy Consultant when necessary. 5. Completion date of deficient practice is 8/29/2024.	

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F 759	Continued From page 18	F 759		

NJ E and thought that she had done the NJ Ex Order 26.4 quickly. The U.S. FO added that she had NJ Ex Order 26 the NJ Ex Order 26.4(b)(1) when they were horizontal on top of the medication cart and with the NJ Ex Order 26.4(b)(1) on. The U.S. FO stated that the only time she removed the NJ Ex Order 26.4(b)(1) was just before she NJ Exec Order 26 the resident in their room. The U.S. FO explained that when she NJ Ex Order 26.4(b)(1) by dialing the NJ E and NJ Ex Order 26.4(b)(1), the NJ Ex Order 26.4(b)(1) returned to NJ Ex Order 26.4 and that meant NJ Ex O pen was working properly. The U.S. FO added if there was NJ Ex Order 26.4(b)(1) or the NJ Ex O had no NJ Ex Order 26.4(b)(1) then she would have to NJ Ex Order 26.4(b)(1). The U.S. FO added that she had shown the surveyor that the NJ Ex Order 26.4 was at NJ Ex Order 26.4(b) before dialing to the doses needed for each NJ Ex Order 26.4(b)(1). The NJ Ex O added that she had training on the technique for NJ Ex Order 26.4(b)(1) use but was unsure who had performed the training.

On 8/6/24 at 11:24 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that she was employed NJ Ex Or at the facility. The U.S. FOIA (b) (6) explained that she would be involved in training the nurses the proper techniques for the medication pass. The U.S. FOIA (b) (6) stated that she was familiar with the proper technique for using an NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) explained that the NJ Ex Order 26.4(b)(1) had to be NJ Ex Order 26 before NJ Ex Order 26.4(b)(1) to make sure the NJ Ex Order 26 was working, and NJ Ex Order 26.4(b)(1) were out of NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) further explained that the NJ Ex Order 26.4(b) by NJ Ex Order 26.4(b)(1), then taking the NJ Ex Order 26.4(b)(1) off and holding the NJ Ex O in the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) added that this would allow visualizing the NJ Ex Order 26.4(b)(1) come out of the NJ Ex Order 26.4 The U.S. FOIA (b) (6) added that all NJ Ex Order 26.4(b)(1)

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH	395 AMWELL ROAD HILLSBOROUGH, NJ 08844

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F 759	Continued From page 19	F 759		

[redacted] were to be [redacted] in the same method. The [redacted] stated that seeing the [redacted] return to zero was not an indication that the [redacted] was working and you would have to visualize the [redacted]

On 8/6/24 at 2:20 PM, the surveyor interviewed the [redacted] who stated that she had spoken with the [redacted]. The [redacted] also stated that she was unaware of needing to hold the [redacted] vertically and removing the [redacted] to see the [redacted] when [redacted] The [redacted] added that she thought the [redacted] was working because the [redacted] went back to zero.

On 8/6/24 at 2:45 PM, the surveyor interviewed the [redacted] via the telephone. The [redacted] stated that he had done a medication pass inservice in March but was unsure if the inservice included [redacted] technique. The [redacted] also stated that he was aware that [redacted] a [redacted] had to be done prior to [redacted]. The [redacted] also stated that it would be obvious to see the [redacted] if the [redacted] was off but thought leaving the [redacted] on would be acceptable. The [redacted] added that [redacted] thought if there was an issue while [redacted] then there would be resistance from the [redacted] and the [redacted] would not go back to zero. The [redacted] was unable to speak to whether the instructions indicated that when the [redacted] returns to zero the [redacted] was completed and would have to check.

An inservice titled "Med Pass and Expiring meds" dated [redacted] was performed by the [redacted] was provided by the [redacted]. The inservice included a handout titled "Medication Pass" and reflected for "[redacted] Administration" to "[redacted]

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F 759	Continued From page 20	F 759		

[redacted] prior to each dose."

The surveyor reviewed the medical records for Resident #268.

A review of the resident's Admission Record reflected that the resident had diagnoses which included but not limited to: [redacted]).

A review of the resident's Order Summary Report reflected the following:

- a PO with a start date of [redacted] for [redacted] in the morning for [redacted]

-a PO with a start date of [redacted] for [redacted] with meals for [redacted] in addition to [redacted]."

-a PO with a start date of [redacted] as per sliding scale: if [redacted] Call [redacted] for [redacted] greater than [redacted] or less than [redacted] before meals and at bedtime for [redacted]

On 8/7/24 at 1:13 PM, the surveyor interviewed the [redacted] who stated that she had completed a step-by-step safe administration of [redacted] via [redacted] administration inservice with the [redacted] The [redacted] had used a manufacturer's specification handout for the "Instructions For Use [redacted]).

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 759	Continued From page 21	F 759		

On 8/7/24 at 1:46 PM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)). The U.S. FOIA (b) and the U.S. FOIA acknowledged that by not following the manufacturer's specifications for NJ Ex Order 26.4 an NJ Ex Order 26.4(b)(1) or incorrectly NJ Ex Order 26.4 an NJ Ex Order 26.4(b)(1) could affect the dosage of the NJ Ex Order 26 (ERROR #1 and #2)

On 8/8/24 at 10:36 AM, the surveyor interviewed the U.S. FO who stated that he had looked into the NJ Exec Order 2 of the NJ Ex Order 26.4(b)(1) and that the NJ Ex Order 26.4(b)(1) was clear, and that the U.S. FO was able to see the NJ Ex Order 26.4(b)(1) in the cap.

At that time, the surveyor with the U.S. FO interviewed the U.S. FO who demonstrated that when the NJ Ex Order 26 were pushed with the NJ Ex Order 26.4 and the NJ Ex Order 26 was on there was liquid that was able to be seen through the NJ Ex Order 26.4(b)(1) . The NJ Ex O acknowledged that during the medication pass, neither NJ Ex Order 26.4(b)(1) was held upright and that she had not shown the surveyor the NJ Ex Order 26.4

Upon finishing the demonstration, the surveyor and the U.S. FO left the medication cart. The U.S. FO stated that NJ Ex thought resistance of the NJ Ex Order 26.4 went hand in hand with NJ Ex Order 26.4(b)(1) and thought there would be resistance when NJ Ex Order 26.4 the NJ Ex Order 26.4(b)(1) if the U.S. FO had not come out. The U.S. FO was unsure if there was documentation regarding the resistance if the U.S. FO was not visualized. The U.S. FO added that he felt the dosage disparity was not significant by not holding the NJ Ex Order 26.4(b)(1) vertical and was unsure if there was documentation supporting that. The U.S. FO acknowledged that there were specific manufacturer instructions for the use of NJ Ex Order 2

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F 759	Continued From page 22	F 759		

NJ Ex Order 26.4(b)(1) that included instructions on NJ Ex Order 26.4 and provided the surveyor with a handout on the instructions for the NJ Ex Order 26.4(b)(1). The surveyor, with the U.S. FO reviewed the handout and the U.S. FO acknowledged that the instructions were specific to hold the NJ Ex Order 26.4(b)(1) upright (vertically) when visualizing the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) The U.S. FO was unable to provide any further documentation.

A review of the NJ Exec Order 26.4b1" handout of information provided by the U.S. FO reflected that the steps required to properly administer an NJ Ex Order 26.4 included 'NJ Ex Order 26.4 before each NJ Ex Order 26.4(b)(1) 'NJ Ex Order 26.4 your NJ Ex Or means removing the NJ Ex from the NJ Ex Order 26.4 and NJ Exec Order 26.4b1 that may collect during normal use and ensures that the NJ Ex Or is working correctly. If you do not NJ Ex Order before each NJ Ex Order 26.4(b) you may get too much or too little NJ Ex Order 26.4 The handout also revealed "Step 6: To NJ Exec Order 26.4b1 your NJ Ex Or turn the dose knob to select 'NJ Step 7: Hold your NJ Ex Or with the NJ Ex Order 26.4 pointing up. Tap the NJ Exec Order 26.4b1 gently to collect NJ Ex Order 26.4(b)(1) at the top. Step 8: Continue holding your NJ Ex Or with the NJ Ex Order 26.4 pointing up. Push the NJ Ex Orde knob in until it stops, and 'NJ E is seen in the NJ Ex Orde window. Hold the NJ Ex Orde Knob in and count to 5 slowly, You should see NJ Ex Order 26.4 at the tip of the NJ Ex Order 26.4 If you do not see NJ Ex Order 26.4 repeat NJ Exec Order 26.4 steps 6 to 8."

A review of the facility policy Medication Administration Guidelines: NJ Exec Order 26.4b1, dated as effective 2/2/22, provided by the U.S. FOIA (b) reflected that 'NJ Exec Order will be administered in a safe and accurate manner." In addition, the policy reflected for 'NJ Exec Order administration: ... ...j) Remove outer then inner NJ Exec Order 26.4b1, k) NJ Exec Order 26.4b1 by dialing 'NJ units or units recommended by manufacturer,

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F 759	Continued From page 23 with needle pointing up, press [NJ Exec Order 26] button with thumb. Look for drops of [NJ Exec Order] to come out of tip of [NJ Exec Order 26] A review of "Patient & Caregiver Education" specifications for "How to use an insulin pen" revealed "Do a safety test (prime the pen). Priming the insulin pen will help you make sure your pen and needle are working like they should. This will also help you make sure that the needle fills with insulin, so you get your full dose. It's important to do a safety test before every insulin injection."	F 759		
F 812 SS=E	NJAC 8:39-11.2(b), 29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		8/29/24

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 08/05/2024 from 09:30 AM to 10:01 AM, the surveyor, accompanied by the U.S. FOIA (b) (6) [redacted]) of another facility, toured the kitchen, and observed the following: In the walk-in freezer, the surveyor observed two opened packages of biscuits with no dates or labels. The surveyor also noted a tied shut, clear plastic bag of spinach lasagna rolls with no label or dates when opened. The U.S. FOIA stated there should be opened and use by labels and dates on all opened food in the freezer. On a storage rack, the surveyor observed a stack of three "3rd pans" wet nested and a stack of four "6th pans" wet nested. The U.S. FOIA stated they should not be stacked wet. A review of facility provided undated policy titled "Food Receiving and Storage" revealed under Refrigerated/Frozen Storage: 1.All food stored in the refrigerator or freezer are covered, labeled and dated ("use by" date)" 8. Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. Frozen foods will be used by the manufacturer expiration date. If an item has been opened, and "open date"	F 812	The corrective action put in place on 8/29/2024 to rectify the deficient practice identified during the facilities annual survey was to: 1. The Food Service Director (FSD) in-serviced all dietary staff on the Labeling and dating policy which states that all food stored in the freezer is covered appropriately, labeled with a received date, opened date, and use by date. The food in the freezer was inspected by the Food Service Director and the proper labeled date stamps were added. The items found by the surveyor, two packages of biscuits and a bag of spinach lasagna rolls, were discarded on 8/6/2024. The FSD also re-educated the dietary staff, including the U.S. FOIA (b) (6) on wet nesting protocols. The “3rd pans” and “6th pans” were observed to be air dried by the FSD before being put away on 8/6/2024. 2. The facility identified that this deficiency could impact the entire resident population. 3. To ensure that the deficient practice was corrected, the FSD re-educated all of the dietary staff on the labeling process and wet nesting protocols. The unlabeled food was discarded, and the pans observed to be wet nesting were re-washed and appropriately racked. The FSD/designee will begin to do a weekly audit on the food in the freezer for proper labeling and monitoring of wet nesting. The FSD/designee will include labeling	

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F 812	Continued From page 25 label will be placed, and the item will follow the manufacturer's expiration date or discarded after 6 months of the open date. A review of facility provided policy titled "Sanitization", revised 7/23/2023 revealed: 12. Observe for wet nesting (accumulation of moisture) when pots, pans, and other kitchen products are put to dry. N.J.A.C. 8:39-17.2(g)	F 812	and wet nesting into the monthly staff education. 4. To monitor the effectiveness of the changes, the FSD/designee will audit weekly the food labeling and wet nesting for 3 months. The information will be shared in the quarterly QAPI meeting along with any corrective action that was taken if necessary. 5. Completion date of deficient practice is 8/29/2024.	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI	F 868		8/30/24

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	315510	A. BUILDING _____ B. WING _____	C 08/19/2024

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F 868	Continued From page 26 program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, the facility failed to ensure the required committee members, the [redacted], was present for one of seven Quality Assurance and Performance Improvement (QAPI) meetings and was evidenced by the following: A review of the facility provided "QAA (Quality Assessment and Assurance) Committee Information" updated 06/07/24 revealed: "Name: Vacant; Title: [redacted]." A review of the the facility provided "In-Service Attendance; Date: 7/12/24; Topic: Q 2024 QAPI Meeting" sign in sheet had not revealed the [redacted] attended the meeting. On 08/13/24 at 09:52 AM, during an interview with the [redacted]) and the [redacted]), the [redacted] stated that the required members of the QAPI committee were the [redacted] the [redacted] the [redacted] the [redacted], and 2 other	F 868	The corrective action put in place on 8/30/2024 to rectify the deficient practice identified during the facilities annual survey was to: 1. The facility identified a current employee who is a Registered Nurse (RN) that meets the qualifications of the Infection Preventionist role. The identified staff member has completed the Centers for Disease Control and Prevention (CDC) Nursing Home Infection Preventionist Training Course on [redacted]. Once the 19.75 hours were completed, the facility offered the [redacted] position of Infection Preventionist to the RN until the facility continues to hire a permanent candidate. The Interim Infection Preventionist was present at the Quarterly QAPI meeting on 7/12/2024. The Interim Infection Preventionist will attend the next quarterly QAPI meeting until a permanent Infection Preventionist is hired. 2. The facility identified that this	

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F 868	Continued From page 27 staff members. The U.S. FOIA (b) U.S. acknowledged that the had not attended the July 2024 meeting. A review of the facility's "Job Description and Performance Standards, Position Title "Infection Preventionist RN (Registered Nurse)" revealed: "The primary functions and responsibilities of this position are as follows: ...40. Provide monthly, quarterly, and annual; reports for the Quality Assurance and Performance Improvement Committee to the Administrator." A review of the facility policy "2024 Quality Assurance Performance Improvement Plan" revealed: "Governance and Leadership" ...The QAA Committee and its members provide the framework or structure for QAPI. Committee members include the administrator, director of nursing, medical director, infection preventionist ..." NJAC 8:39-33.1(a)(b)	F 868	deficiency could impact the entire resident population. 3. To ensure that the deficient practice was corrected, the facility Administrator reviewed in-house RN's that had the potential to qualify for this role upon completion of the CDC Nursing Home Infection Preventionist Training Course. Once the RN was identified and the course was completed, the interim Infection Preventionist position was reviewed and offered to the Registered Nurse on NJ Exec Order 26.4b1. The Administrator reviewed the job description and requirements of the Infection Preventionist role with the Registered Nurse. The Administrator also explained that the Infection Preventionist is responsible for attending and being on the Quality Assessment and Assurance (QAA) Committee and quarterly QAPI meetings. The facility is continuing to look for a permanent full-time Infection Preventionist while the in-house appointed interim person fulfills the role of Infection Preventionist. 4. To monitor the effectiveness of the interim Infection Preventionist, the Administrator and/or designee will be meeting with the Interim Infection Preventionist on a weekly basis for 4 weeks. After the 4-week period, the Administrator and/or designee will meet with the Interim Infection Preventionist on a monthly basis for 3 months to review the Infection Prevention Program and infection control related items. The Interim	

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F 868	Continued From page 28	F 868	Infection Preventionist will present information during the quarterly QAPI meeting and meet with the facility Medical Director/Infectious Disease medical director for guidance. The facility will continue to search for a permanent Infection Preventionist. 5. Completion date of deficient practice is 8/30/2024.	
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documents, it was determined that the facility failed to have an U.S. FOIA (b) (6)) dedicated solely to the infection prevention and control program (IPCP) who worked at least	F 882	The corrective action put in place on 8/30/2024 to rectify the deficient practice identified during the facilities annual survey was to: 1. The facility identified a current	8/30/24

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F 882	Continued From page 29 part-time and had completed specialized training in infection control and prevention (ICP) from [NJ Exec Order 26.4] to present. This deficient practice was evidenced by the following: Reference: According to the NJ Executive Directive 21-012 (revised 12/22/22) included "The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits." According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022, Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized training is required and available. 08/05/24 at 10:50 AM, during entrance conference, the [U.S. FOIA (b) (6)] stated the facility does not have an [U.S. FOIA (b) (6)]) "at the moment." She further stated that there was no	F 882	employee who is a Registered Nurse (RN) that meets the qualifications of the Infection Preventionist role. The identified staff member has completed the Centers for Disease Control and Prevention (CDC) Nursing Home Infection Preventionist Training Course on [NJ Exec Order 26.4b1]. Once the 19.75 hours were completed, the facility offered the [NJ Exec Order 26.4b1] position of Infection Preventionist to the RN until the facility continues to hire a permanent candidate. The job description and responsibilities were reviewed with the RN nurse, and she is understanding of what her requirements and expectations will be going forward. She will be responsible for the Infection Prevention and Control Program. 2. The facility identified that this deficiency could impact the entire resident population. 3. To ensure that the deficient practice was corrected, the facility Administrator reviewed in-house RN's that had the potential to qualify for this role upon completion of the CDC Nursing Home Infection Preventionist Training Course. Once the RN was identified and the course was completed, the interim Infection Preventionist position was reviewed and offered to the Registered Nurse. The Administrator reviewed the job description and requirements of the Infection Preventionist role with the Registered Nurse. The Administrator also explained that the Infection Preventionist is responsible for the Infection Prevention	

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 08/19/2024

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

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F 882	Continued From page 30 one certified in ICP. On 08/06/24 at 08:53 AM, in the presence of the survey team, the U.S. FOIA (b) confirmed that the last day of work for the U.S. was NJ Ex Order 26.4(b). On 08/09/24 at 08:57 AM, during an interview with the surveyor, the U.S. FOIA (b) stated, "I believe the U.S. FOIA (b) (6)), who does staff education for Personal Protective Equipment (PPE), COVID surveillance and testing, is ICP certified." On 08/09/24 at 12:33 PM, in the presence of the survey team, the U.S. FOIA (b) and the NJ Ex Order 26.4(b)(1)) were made aware of the concerns of no NJ E since NJ Ex Order 26.4(b). On 08/13/24 at 08:45 AM, the U.S. FOIA (b) provided the surveyor with the NS Center for Disease Control and Prevention (CDC) certification dated 5/16/23. At that time, she confirmed that the US FO was not the designated U.S. F A review of the facility's job description for the US FOIA (b) (6))" revealed: "Purpose of this position: The US FOIA (b) (6) shall be responsible for contributing to the development of policies, procedures, and training curriculum for the long-term care facility staff based on best practices and clinical expertise. They shall monitor the implementation of infection prevention and control policies and recommending disciplinary measure for staff who routinely violate those policies. The US F will assess the facility's infection prevention and control program by conducting internal quality improvement audits."	F 882	and Control Program. The facility is continuing to look for a permanent full-time Infection Preventionist while the in-house appointed interim person fulfills the role of Infection Preventionist. 4. To monitor the effectiveness of the interim Infection Preventionist, the Administrator and/or designee will be meeting with the Interim Infection Preventionist on a weekly basis for 4 weeks. After the 4-week period, the Administrator and/or designee will meet with the Interim Infection Preventionist on a monthly basis for 3 months to review the Infection Prevention Program and infection control related items. The Interim Infection Preventionist will present information during the quarterly QAPI meeting and meet with the facility Medical Director/Infectious Disease medical director for guidance. The facility will continue to search for a permanent Infection Preventionist. 5. Completion date of deficient practice is 8/30/2024.	

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F 882	Continued From page 31 A review of the facility's policy, "Surveillance for Infections" reviewed on 01/10/24, revealed: "Policy Statement: Surveillance is an essential component of an effective Infection Prevention Control Program. The facility performs surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection." NJAC 8:39-19.1 (b), 19.4(d) (e)	F 882		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315510 Y1	A. Building B. Wing Y2	9/19/2024 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 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	F0609	Correction	ID Prefix	F0610	Correction	ID Prefix	F0759	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.12(c)(2)-(4)	Completed	Reg. #	483.45(f)(1)	Completed
LSC		08/30/2024	LSC		08/30/2024	LSC		08/29/2024
ID Prefix	F0812	Correction	ID Prefix	F0868	Correction	ID Prefix	F0882	Correction
Reg. #	483.60(i)(1)(2)	Completed	Reg. #	483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. #	483.80(b)(1)-(4)	Completed
LSC		08/29/2024	LSC		08/30/2024	LSC		08/30/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/19/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315510	A. BUILDING **01** B. WING _____	**08/19/2024**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/16/24 and 8/19/24, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The Bridgeway Rehabilitation and Care Center facility is a 3-story building with a basement, that was built in 2012. It is composed of Type I fire resistant construction. The facility is divided into 12- smoke zones. The generator does 100% of the facility.	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		9/4/24

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

Electronically Signed | 09/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 1 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/19/24 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) it was determined the facility failed ensure fire sprinkler system sprinkler heads were maintained in accordance with NFPA 101: 2012 edition, Sections 9.7.5, 19.3.5.1 and, NFPA 25: 2011 edition. This deficient practice had the potential to affect all residents and was evidenced by: An observation between 10:40 AM and 1:30 PM, revealed the following: 1. The fire sprinkler escutcheon plates were missing on 1 sprinkler head in the corridor closet ceiling by room 319 and 1 sprinkler head in the kitchen ceiling by the dishwashing area entrance. In an interview at the time, the U.S. FOIA (b) confirmed the observations. 2. The 3rd floor spa had 1 of 4 sprinklers hanging down 2 inches from its proper position in the sheet rock ceiling. In an interview at the time, the U.S. FOIA (b) and U.S. FOIA (b) (6) confirmed the observation. 3. A sprinkler head in a physical therapy closet above electrical panel EP-IN had open space around the sprinkler in the drop ceiling where 15 wires passed through the ceiling around the sprinkler into the space above. In an interview at the time, the U.S. FOIA (b) confirmed	K 353	1. The facility corrected the deficient practice by replacing the escutcheon plate in the 1 sprinkler head in the corridor closet ceiling by room 319 and 1 sprinkler head in the kitchen ceiling by the dishwashing area entrance. This was fixed on 8/20/2024. The 3rd floor spa sprinkler hanging down 2 inches from its proper position was fixed on 9/4/2024 by the maintenance worker. The sprinkler head in the physical therapy closed above the electrical panel EP-IN was also corrected by the maintenance director to remove the open space around the sprinkler on 9/3/2024. 2. The deficient practice had the potential to affect all residents. 3. The Director of Maintenance/designee will ensure the deficiencies will not recur by adding sprinkler checks to the monthly maintenance rounds. Sprinklers not found in place will be documented and corrected by the Director of Maintenance/designee. 4. The Director of Maintenance/designee will monitor the monthly checks for 3 months. The sprinkler checks will be reviewed at our quarterly QAPI meetings. The sprinkler checks will become part of the monthly building rounds by the Director of Maintenance/designee. 5. The completion date for this deficient practice was 9/4/2024.	

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K 353	Continued From page 2 the observations. The facility U.S. FOIA (b) (6) and U.S. FOIA (b) (6) [redacted] were informed of the concerns during the Life Safety Code exit conference at 2:00 PM. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the	K 363		8/20/24

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K 363	Continued From page 3 smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/19/24 in the presence of the U.S. FOIA (b) (6) [redacted]) it was determined the facility failed to ensure corridor doors resist the passage of smoke in accordance with NFPA 101: 2012 edition, Sections 8.3.3, 8.5, 19.3.6.3, 19.3.6.3.3 and NFPA 80: 2010 edition. This deficient practice had the potential to affect all first floor residents and was evidenced by: An observation at 11:25 AM, revealed the double smoke doors to the physical therapy room had a 1/4-inch gap between the two door leaves running the vertical length of the door, measured with a standard tape measure. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. The facility U.S. FOIA (b) (6) and U.S. FOIA (b) (6) [redacted] were informed of the concerns during the Life Safety Code exit conference at 2:00 PM. NJAC 8:39-31.2(e) NFPA 80	K 363	1. The facility corrected the deficient practice by adding a Nylon Brush Perimeter Seal on 8/20/2024 to the double smoke doors to the physical therapy room closing the 1/4-inch gap between the doors. 2. This deficient practice has the potential to affect all first-floor residents. will identify other areas having the potential to be affected by the same deficient practice by having the Director of Maintenance/Designee do monthly building rounds to identify other areas missing sprinklers. 3. The Director of Maintenance/designee installed a Nylon Brush Perimeter Seal to correct the 1/4-inch gap between the therapy fire doors. The Director of Maintenance/designee will add to the monthly facility rounds schedule a check of all fire doors focusing on any gaps that might exist between any of the fire doors. 4. The Director of Maintenance/designee will monitor the monthly door checks for 3 months. The	

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K 363	Continued From page 4	K 363	fire door checks will be reviewed at our quarterly QAPI meetings. The fire door checks will become part of the monthly building rounds by the Director of Maintenance/designee. 5. The completion date for this deficient practice was 8/20/2024.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		9/16/24

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K 918	Continued From page 5 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 8/16/24 and 8/19/24 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to ensure the Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test and failed to ensure the emergency power supply system (EPSS) was exercised once every 36 months at 30% of its nameplate KW rating for 3 hours and at 75% of its KW nameplate rating for 1 hour totaling 4 continuous hours in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Section 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect all residents and was evidenced by: Record review on 8/16/24 between 11:55 AM and 12:50 PM of the emergency power generator logs revealed the following: 1. The facility did not record the percentage of the EPS nameplate kW rating that the generator was exercised monthly to determine if the load met the 30% of the nameplate rating requirement or perform a 90 minute annual load bank test for the last 12 months.	K 918	1. To address the deficiency identified, the facility will take the following corrective actions: a. We will schedule a 90-minute annual load bank test and a 4-hour continuous load test with our Emergency Power Supply (EPS) provider to ensure compliance with the 36-month load requirements. The EPS is scheduled to come out on 9/12/2024 to perform the test. b. Although the emergency power supply was recently inspected and confirmed to be functioning correctly by the maintenance director and the EPS, we will continue to monitor and verity its performance regularly. 2. This deficient practice has the potential to affect all residents. 3. The Director of Maintenance/designee will ensure that the deficiency does not recur by meeting with the Emergency power supply company and reviewing where the documented information of the load percentage is displayed. The Director of Maintenance/designee will then add the percentage of the load to the monthly documentation already in place. If the load test is less than the required 30% of the nameplate rating, then a 90-minute	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 6 2. The facility's generator service conducting the 4 hour test did not run the generator for 4 continuous hour during the last 36 months at the required loads specified in NFPA 110: 2012 edition with written record. The generator was run at its normal and unrecorded load for the four hour duration of the test. In an interview at the time, the [U.S. FOIA (b) (6)] confirmed the record review findings. The facility [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] were informed of the concerns during the Life Safety Code exit conference on 8/19/24 at 2:00 PM. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	annual load bank test will be performed annually. The Director of Maintenance/designee will also run and review with the Emergency Power Supply company the 4 continuous hour test run for the 36 month required loads. 4. The Director of Maintenance/designee will monitor the percentage of the nameplate rating for monthly for the next 3 months. If the nameplate rating is less than 30%, the Director of Maintenance/designee will then schedule an annual 90-minute load bank test. The Director of Maintenance/designee will also monitor and record the 4-hour continuous run test. The information will be presented at our quarterly QAPI meeting. 5. The completion date for this deficient practice was 9/16/2024	

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 01 - BRIDGEWAY @ HILLSBOROUGH B. Wing	9/19/2024

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 Reg. # NFPA 101 LSC K0353	Correction Completed 09/04/2024	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 08/20/2024	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 09/16/2024
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	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 8/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**