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	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BRIDGEWATER	390 US 22 BRIDGEWATER, NJ 08807

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A 000	Initial Comments Initial Comments: Type of Survey: Standard Census: 91 Sample Size: 7 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 783	8:36-7.5(e) Provision of Health Care Services (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced	A 783		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/08/25

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A 783	Continued From page 1 by: Based on interview and record review, it was determined that the facility failed to ensure that certification by a physician was completed annually to ensure that residents did not have needs which exceeded the care that the facility was capable of providing for 4 of 7 residents reviewed, Resident #'s 1, 4, 5 and 6. This deficient practice was evidenced by the following: 1. On 10/9/25 at 10:30 a.m., the surveyor reviewed Resident #1's medical record (MR) which revealed that the resident NJ Exec Order 26, 4B1 [redacted] The surveyor reviewed a document titled, "Physician's Move In Orders", that was dated [redacted] The surveyor observed that the document included a physician's certification that Resident #1's NJ Exec Order 26.4b1 in an assisted living facility and that the resident NJ Exec Order 26.4b1 [redacted]. However, surveyor review of the MR showed no further physician certifications for Resident #1 after [redacted] 2. The surveyor reviewed Resident #4's medical record (MR) which, revealed that the resident NJ Exec Order 26, 4B1 [redacted]. The surveyor reviewed a document titled, "Physician's Move In Orders", that was dated [redacted] The surveyor observed that the document included a physician's certification that Resident #1's needs NJ Exec Order 26.4b1 in an assisted living facility and that the resident NJ Exec Order 26.4b1 [redacted]. The surveyor review of the MR showed no further physician certifications for Resident #1 after [redacted]. 3. At 10:45 a.m., the surveyor reviewed Resident	A 783		

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A 783	Continued From page 2	A 783		

#5's MR, which revealed that the resident [redacted]. The surveyor reviewed a document titled, "Physician's Move In Orders", that was dated [redacted]. The surveyor observed that the document included a physician's certification that Resident #5's [redacted] in an assisted living facility and that the resident [redacted]. Further surveyor review of the MR showed no physician certifications for Resident #5 after [redacted]

4. At 11:00 a.m., the surveyor reviewed Resident #6's MR, which revealed that the resident [redacted]. The surveyor reviewed a document titled, "Physician's Move In Orders", that was dated [redacted]. The surveyor observed that the document included a physician's certification that Resident #6's [redacted] in an assisted living and that the resident [redacted] The surveyor review of the MR showed no further physician certifications for Resident #6 after [redacted].

Surveyor review of the resident's Electronic Medical Record and the residents' paper charts revealed no documentation to reflect that an annual certification by the physician was completed after admission, to ensure that Resident #'s 1, 5 and [redacted] the care the facility was capable of providing.

At 12:05 p.m. the surveyor interviewed the Resident Care Director (RCD) who stated that she was the acting RCD and that the facility was in the process of hiring a new RCD. The RCD

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A 783	Continued From page 3 stated that annual physicals were completed on the residents, but that the physician certification was only obtained upon move in. On 10/10/25 at 11:00 a.m. the surveyor interviewed the Regional Director of Resident Care (RDRC) and inquired about the physician certifications for the residents. The RDRC stated that the physician certifications should be done annually. The surveyor reviewed a facility policy titled, "Assessing and Evaluating Residents", with a last revision date of 5/15/25 which revealed, "...The ED/RCD/designee will ensure medical assessments/reassessments are completed by the resident's physician/practitioner as required by state ... guidelines."	A 783		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.	A 891		

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A 891	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain food service areas, equipment, and utensils in a clean and sanitary condition and failed to ensure that food was labeled, dated, and handled properly in accordance with N.J.A.C. 8:36-10.5(a) and N.J.A.C. 8:24-6.5, which require that food service operations be conducted in compliance with the New Jersey Sanitation Code. This deficient practice was evidenced by the following: On 10/09/25 at approximately 10:36 a.m., the surveyor observed in the kitchen that the can opener blade had metal shavings and a food substance adhered on the openers blade. On 10/9/25 at 12:25 p.m., during the kitchen tour and observation of the lunch meal service, the surveyor observed multiple sanitation, labeling, and handling concerns were identified: 1. The ice cream freezer contained a heavy buildup of ice and brown/black debris in the corners. 2. All five containers of ice cream inside were open and had visible freezer burn. 3. A sheet pan with undated cookies was observed on a rack with sticky residue between the tray and the pan. 4. The main walk-in refrigerator contained racks with black debris in the crevices. 5. The juice machine tray had sticky residue and gnats flying around it.	A 891		

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A 891	Continued From page 5 6. The microwave was visibly soiled. 7. The shelf beside the microwave contained debris and open containers of cereal and potato chips that were not labeled or dated. 8. A wire rack with condiments contained two expired bottles of syrup-one chocolate and one caramel-both with expiration dates of October 2025. Containers of honey and syrup were observed with product dripping down the sides of the bottles and pooling on the shelf. The containers were unlabeled and undated. 9. The ice machine interior contained black/brown residue, and the ice scoop handle had a hardened brown crust. 10. On the cook line, open, unlabeled, and undated containers of farina, oatmeal, bacon, turkey burgers, and hot dogs were observed. Two salt and pepper shakers with visible debris inside were also observed on the cook's line. 11. The server reach-in refrigerator contained debris in the interior corners, as well as undated salads, juices, fruits, puddings, and multiple open, unlabeled containers. 12. Sanitizer test results ranged from 848 to 1130 ppm (parts per million), exceeding the manufacturer's required range of 272-700 ppm. During lunch service, the surveyor observed multiple servers handling ready-to-eat foods such as sandwiches and chips with gloved hands, then clearing dirty plates and returning to serve food and take orders without changing gloves between tasks.	A 891		

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A 891	Continued From page 6 At 12:00 p.m., the surveyor interviewed the dishwasher, in the presence of the Cook, he stated that he was responsible for preparing sanitizer buckets but was unaware of the required concentration levels or proper use of the product. He stated that he did not remember if he had been trained and acknowledged completing the sanitation logs that day. In the same interview, the surveyor interviewed the cook about the dishwasher sanitizer, he stated he did not know how to test the sanitizer and deferred to the dishwasher staff. At 1:00 p.m., the surveyor interviewed the Dining Services Coordinator (DSC) regarding the unsanitary conditions, labeling practices, and sanitizer procedures. The DSC stated that all staff were responsible for labeling and day-dotting food items and that it was his responsibility to ensure these tasks were completed. He stated that the opening cook or server should be changing the sanitizer every two hours or whenever debris was present. The DSC stated that he believed the sanitizer requirement was 200 ppm. He stated that he did not know if the dishwasher had been trained prior to his arrival and that the dishwasher had been employed before he started. He explained that he had been employed at the facility for approximately [redacted] months. During continued surveyor interview with the DSC, he stated that he checked the cleaning schedules but had not verified them recently. He stated that he checked the dishwasher area daily but did not follow up on the server staff's cleaning responsibilities, as they were expected to check with one another. He stated that he primarily focused on the cooks' duties and had not followed up with the servers. The DSC stated that	A 891		

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A 891	Continued From page 7	A 891		

he conducted an in-service with staff in August 2025 that reviewed their duties, including cleaning schedules. He also stated that the last time the ice machine was cleaned was in November 2024, as written on the side of the machine. He confirmed that the ice machine was not listed on the cleaning schedule and that he had not followed up to ensure it had been cleaned.

On 10/10/25 at 1:18 p.m., the surveyor interviewed the Executive Director (ED) to determine if he was aware of the ongoing sanitation and food safety issues in the kitchen. The surveyor asked if he was aware that there were unlabeled and undated products on the line, food not being served at the proper temperatures, cross-contamination by servers not changing gloves, and unclean equipment including the ice machine, ice cream freezer, and walk-in shelves and reach in refrigerators he stated he was not aware of the food safety issues in the kitchen.

In the same interview, the surveyor also inquired if the ED had followed up on the Sanitary Inspection Report, dated 8/5/25 which, although marked "satisfactory," cited that the walk-in shelves had a black and white mold-like substance and that the person in charge, the DSC stated that the shelves would be power washed and the ice machine cleaned more frequently. The ED stated that he was not aware that the issues from the Sanitary Inspection report were not corrected in the kitchen but that he has been working with the DSC to organize and correct issues in the kitchen and that he would continue to spend more focused time addressing these areas to ensure the kitchen was maintained in a safe and sanitary manner.

Surveyor review of an undated facility document

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A 891	Continued From page 8	A 891		

titled,"Daily cleaning schedule," revealed that specific areas were listed for cleaning on multiple days during the week; however, these areas had not been cleaned as required, as evidenced by the conditions observed during the inspection..."

Surveyor review of a facility job description dated October 2023, "Cook - US, BC job description revealed, Essential Duties...ensures high standards for food taste and quality are upheld at all times...utilizes production sheets to accurately record food production quantities and cooking, holding, and cooling temperatures...Completes assigned cleaning duties and ensures accuracy of daily and weekly cleaning logs. Cleans assigned kitchen equipment, including but not limited to stoves, ovens, fryers, microwaves, mixers, slicers, refrigerators, freezers, worktables, prep sinks, ice makers, coffee machines, hoods, and ventilation screens..."

Surveyor review of a facility job description dated November 2023, "Dishwasher - US, BC job description revealed, Essential Duties...Performs dishwashing tasks to properly wash and sanitize all dishes and china, silverware, glassware, utensils, and cookware... Completes assigned kitchen cleaning duties and ensures accuracy of daily and weekly cleaning logs...Maintains accurate dish machine and pot and pan sink temperature and sanitation logs...Assists in the receiving, storage, dating, labeling, and rotation of food and non-food supplies..."

Surveyor review of a facility job description updated June 2016, "Server-US, BC, revealed, Position Summary...Responsible for handling all foods in accordance with sanitary procedures and standards and complies with all federal, state and local regulatory procedures regarding food

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A 891	Continued From page 9 service...Essential Duties: General Dining Service Duties...Follows all, local, state and federal policies regarding food handling. Maintains standards of cleanliness, hygiene and health standards...Essential Duties: Food Safety and Sanitation...Safe food handling is practiced at all times to prevent an outbreak of food borne illness...Maintains all work areas in a healthful and safe condition..." Surveyor review of a facility job description dated November 2023, "Dining Services Coordinator, -US, ON,QC, revealed, Role Summary...The Dining Services Coordinator is responsible for providing customer service, overall leadership, and management of the dining and hospitality operations in the community...ensuring proper sanitation and safe food handling...Essential Duties...Completes and utilizes production sheets to control food quality and portions. Ensures adherence to modified diets, correct portioning of food, and proper serving methods...Prepares and serves meals on time and at the correct temperature...Ensures all food in the Bistro and/ or other common areas is fresh,covered,labeled, and dated as applicable...Food Safety, Sanitation and Maintenance: Ensures compliance with local health department regulations... Practice safe food handling always to prevent contamination and/or an outbreak of food borne illness. Maintains a clean,organized, and clutter-free kitchen environment. Completes and maintains accurate sanitation and cleaning records, including refrigeration and freezer logs, cleaning logs, and dining room/bistro opening and closing checklists....Training, Leadership, and Team Member Development: Develops a working knowledge of state regulations and ensures compliance..."	A 891		

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A 901	Continued From page 10	A 901		
A 901	8:36-10.5(c)(4) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure that the current menus with portion sizes were posted in the food preparation area and was not in compliance with N.J.A.C. 8:36-10.5(a), which requires facilities to maintain food service operations in accordance with the Sanitation in Retail Food Establishments and Food and Beverage Vending Machines Code (N.J.A.C. 8:24). Specifically, N.J.A.C. 8:24-6.5 requires that menus be made available and followed to ensure consistency and accuracy in meal service. This deficient practice was	A 901		

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A 901	Continued From page 11 evidenced by the following: On 10/9/25 at 11:00 a.m., the surveyor toured the facility kitchen and observed that no menu was posted in the food preparation area that indicated portion sizes. At 11:20 a.m., the surveyor interviewed a Cook in the kitchen regarding how portion sizes were determined when serving food. The Cook stated that "everyone gets 2 oz (ounces)," and that most residents ordered a sandwich, and if they do not. He continued to say that they tell the kitchen how much they want so they don't eat too much. At 12:15 p.m., the surveyor interviewed the Dining Services Coordinator (DSC) regarding the absence of a posted menu with portion sizes. The DSC stated that he was unaware that menus indicating portion sizes were required to be posted in the food preparation area and that in other communities he had worked, menus with portions were not posted. Surveyor review of a facility job description dated October 2023, titled, "Cook - US, BC" revealed, Role Summary: The Cook uses their knowledge and experience in food production to ensure the proper, timely, and safe preparation and service of food according to established recipes, while adhering to all food safety and sanitation requirements and maintaining a safe and orderly kitchen. Responsible to effectively manage all food production in the absence of the Dining Services Coordinator. Essential Duties ... Prepares and serves meals in a timely manner and in accordance with established standardized recipes and menus. Utilizes production sheets to accurately record food production quantities and cooking, holding, and cooling temperatures..."	A 901		

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A 913	8:36-10.5(c)(10) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 10. All meals shall be served at the proper temperature and shall be attractive when served to residents. Place settings and condiments shall be appropriate to the meal; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that hot and cold foods were maintained and served at safe and palatable temperatures in accordance with N.J.A.C. 8:24-3.4(a) and N.J.A.C. 8:36-10.5(a), which require food service operations to comply with the New Jersey Sanitation Code. This deficient practice was evidenced by the following: On 10/9/25 at 12:25 p.m., the surveyor, accompanied by the Dining Services Coordinator (DSC), conducted a temperature check of foods on the serving line in the kitchen during lunch service. The following temperatures were recorded: Food Item Required Temperature Observed Temperature Turkey burger patty >135°F (hot holding) 142°F Soup > 135°F (hot holding)	A 913		

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A 913	Continued From page 13 131°F Shrimp salad < 41°F (cold holding) 62°F pasta salad < 41°F (cold holding) 57°F At the time of the temperature check observation, the surveyor interviewed the Cook about checking the food temperatures, the Cook stated that he did not check food temperatures prior to service and that the food had been placed on the serving line approximately one hour earlier. In continued surveyor interview, the cook stated that the salads were stored in the walk-in refrigerator before being removed to the line to prepare for service. The surveyor observed that the cold salads were not placed in an ice bath or on refrigeration units, and the containers were filled to capacity without visible means of temperature control. At the time of the temperature check observation, the DSC stated that he did not know why the food was not at the correct temperatures and that the cook was aware he should be checking food temperatures before service. Failure to maintain foods at required hot and cold holding temperatures created a potential for bacterial growth and foodborne illness, placing all residents at risk. Surveyor review of a facility job description dated October 2023 titled, "Cook - US, BC" revealed, ... Essential Duties ... Prepares and serves meals in a timely manner and in accordance with established standardized recipes and menus. Utilizes production sheets to accurately record food production quantities and cooking, holding, and cooling temperatures ... Stocks, rotates,	A 913		

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	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

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SUNRISE OF BRIDGEWATER	390 US 22 BRIDGEWATER, NJ 08807

(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) COMPLETE DATE
A 913	Continued From page 14 dates, and stores product according to food safety standards and regulations..." Despite these requirements, the cook did not check food temperatures prior to service and placed foods on the serving line approximately one hour before meal service without temperature control.	A 913		
A1095	8:36-16.5(b) Automatic Fire Detection System (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101.. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 10/09/25 and 10/10/25 in the presence of the facility's Maintenance Coordinator (MC), it was determined that the facility failed to ensure smoke detection sensitivity was checked every other year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2.	A1095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BRIDGEWATER	390 US 22 BRIDGEWATER, NJ 08807

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A1095	Continued From page 15 This deficient practice was identified for 1 of 1 fire alarm systems, which could affect the 91 Residents who resided in the facility and was evidenced by the following: On 10/09/25 at 10:05 a.m., during the survey entrance, a request was made to the Administrator (Admin) and MC to provide all mandatory inspections from 01/01/24 through to 10/08/25, and to provide a copy of the last smoke detector sensitivity testing for review. At 12:38 p.m., a review of the facility provided mandatory inspections for the previous 18 months performed. The surveyor reviewed the following Semi-Annual (every 6 months) Fire Alarm and Detection system inspections: 1. On 04/16/24, no documentation of sensitivity testing performed. 2. On 10/11/24, no documentation of sensitivity testing performed. 3. On 04/09/25, no documentation of sensitivity testing performed. 4. On 10/09/25, no documentation of sensitivity testing performed. Surveyor review of the testing reports revealed no reference to a smoke detection sensitivity testing performed for the smoke detectors in the facility. On 10/09/25 at 1:20 p.m., a request was made to the Admin to place a telephone call to the Contracted Fire Alarm Inspection Vendor (CFAIV) for the Fire Alarm and Detection System and request to get a copy of the last smoke detector sensitivity testing. On 10/10/25 the facility could not provide evidence of a smoke detector sensitivity testing.	A1095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

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SUNRISE OF BRIDGEWATER	390 US 22 BRIDGEWATER, NJ 08807

(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) COMPLETE DATE
A1095	Continued From page 16 The Admin informed the surveyor that they spoke to the CFAIV and there was an additional charge for the smoke detector sensitivity testing. At 10:40 p.m., the Administrator and MC were informed of the above concern during the Life Safety Code survey exit. NFPA 72.	A1095		
A1169	8:36-16.15(a) Fire Extinguisher Specifications (a) Fire extinguishers shall comply with National Fire Protection Association (NFPA) 10, Standards For Portable Fire Extinguishers, 2002 edition, incorporated herein by reference, as amended and supplemented, available from: NFPA, One Batterymarch Park, Quincy, MA, 02169- 7471, http://www.nfpa.org, 1-800-344-3555. This REQUIREMENT is not met as evidenced by: Based on observation and record review on 10/09/25 and 10/10/25 in the presence of the facility's Maintenance Coordinator (MC), it was determined that the facility failed to perform the Six (6) Year Maintenance of 1 of 14 fire extinguishers observed. The deficient practice was evidenced by the following: Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, 1). 4- 4.3 Six Year Maintenance, Every 6 years, stored-pressure fire extinguishers shall require a	A1169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BRIDGEWATER	390 US 22 BRIDGEWATER, NJ 08807

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A1169	Continued From page 17 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halo agent fire applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall be from that date. 2). 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. On 10/9/25 at 9:36 a.m., in the presence of the MC a tour of the facility was conducted. During the tour the surveyor observed the following: At 10:53 a.m., an inspection on the "Penthouse" level, the surveyor observed on the tag attached to one (1) ABC type fire extinguisher was last annually inspected October 2022. Hand written on the tag read, "6 Year Maintenance." At 10:40 p.m., the Administrator and MC were informed of the above concern during the Life Safety Code survey exit. Fire Safety Hazard.	A1169		
A1249	8:36-17.7 Building and Grounds Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from	A1249		

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	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1249	Continued From page 18 fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 10/09/25 and 10/10/25 in the presence of the facility's Maintenance Coordinator (MC), it was determined that the facility failed to maintain 3 of 6 fire rated corridor stairwell access doors in proper working condition. The deficient practice had the potential to affect the 91 Residents who resided in the facility and was evidenced by the following, Reference: NJAC 5:23 Uniform Construction Code, International Building Code, 715.3.7 Door closure. Fire doors shall be self-closing or automatic-closing in accordance with this section. 715.3.7.1 Latch required. Unless otherwise specifically permitted, single fire doors, and both leaves of pairs of doors of side-hinged swinging fire doors shall be provided with an active latch bolt that will secure the door when closed. On 10/09/25 at 10:05 a.m., during the survey enterance, a request was made to the Administrator and MC to provide a copy of the	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BRIDGEWATER	390 US 22 BRIDGEWATER, NJ 08807

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A1249	Continued From page 19 facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the lay-out identified the facility was a three (3) story building with two (2) exit stairwells that Residents, Visitors and Staff could use in the event of an emergency. On 10/9/25 at 9:36 a.m., in the presence of the MC a tour of the facility was conducted. During the tour the surveyor observed and tested six (6) fire rated stairwell exit access doors with the following findings: At 11:50 a.m., the surveyor observed a closure test of the 3rd floor Stairwell #1 corridor exit access door performed. The MC entered the code to release the magnetic hold closed device and the surveyor was able to push the door open. The door did not latch into its frame as required by code. The test was repeated two additional times with the same results, which would allow fire, smoke and poisonous gasses to enter the exit stairwell in the event of a fire. On 10/10/25 at 10:42 a.m., the surveyor observed during a closure test of the 2nd. floor Stairwell #1 corridor exit access door performed. The MC entered the code to release the magnetic hold closed device and the surveyor was able to push the door open. The door did not latch into its frame as required by code. The test was repeated two additional times with the same results, which would allow fire, smoke and poisonous gasses to enter the exit stairwell in the event of a fire. At 11:14 a.m., the surveyor observed during a closure test of the 1st. floor Stairwell #3 corridor exit access door when it closed into its frame. The surveyor observed, measured and recorded	A1249		

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	18A111	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1249	Continued From page 20 a 3/8 of an inch gap between the door and frame along the right side of the door. Code required no more than a 1/8 of an inch gap along where the door meets the door frame. This would allow fire , smoke and poisonous gasses to enter the exit stairwell in the event of a fire. At 10:40 p.m., the Administrator and MC were informed of the above concern during the Life Safety Code survey exit. Fire Safety Hazard.	A1249		

POC # 2 Received 12/12/24
Accepted

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Sunrise of Bridgewater_ Plan of Correction GE611

Name of Facility: Sunrise Senior Living of Bridgewater
Address of Facility: 390 US Highway 22 E. Bridgewater, NJ 08807
License number: [redacted]
Inspection date(s): 10.10.2025
Name and Title of Legal Entity Representative Signing the Plan of Correction: [redacted], Administrator
Signature of Sunrise Representative: [redacted]
Date of Submission: 12/12/2025

A783 8:36-7.5 (e) Provision of Health Care Services

Target completion date: 12/31/2025

1. Resident #1 was seen by their Primary Care Physician on [redacted] and a new annual [redacted] was completed. Residents #4, #5 and #6 were seen by their Primary Care Physician on [redacted] and their [redacted]s were completed. The documented [redacted]l has determined that the care of the residents does not exceed the care capabilities in the community.

2. All residents at the facility have the potential to be affected by this deficient practice.

3. The Senior Resident Care Director will hold an in-service for Registered Nurses, and Licensed Practical Nurse regarding annual recertification by the resident's Primary Care Physician and regulation 8:36-7.5€. On 12/8/25 the Senior Resident Care Director will initiate an audit of the medical records to ensure all residents residing in the community have a current and documented annual physical examination by their Primary Care Physician to certify that their care needs do not exceed the care capabilities in the community. This audit will be completed by 12/12/25. Any resident's certification that is out of compliance will be given to physicians to have completed by 12/31/25.

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BRIDGEWATER

4. Starting on 12/8/25 the Registered Nurse will conduct monthly audits of the charts for 3 months to ensure the completion of the certifications. Plan of correction will be discussed and evaluated quarterly for two quarters by the Executive Director / Admin Designee / Coordinators at the Quality Assurance Performance Improvement meeting to verify it is still effective. If it is not effective, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify the violation does not occur again. QAPI meeting scheduled for January 14, 2026, by the Administrator with the Registered Nurse.

5. Completion Date: December 31, 2025

Accepted 12/12/25

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BRIDGEWATER

A891 8:36-10.5 (a) Dining Services

Target completion date: 12/16/2025

1. The Dining Services Coordinator and Dining Staff corrected the citations through targeted cleaning and since the visit, all areas noted in the citation; have been cleaned and are within state regulations. The can opener has been cleaned, the ice cream freezer has been defrosted and cleaned, all built and ice cream containing freezer burn has been discarded, all cookies and food without dates have been discarded, the walk in refrigerator has been cleaned, the juice machine has been cleaned, the shelf behind the microwave and microwave have been cleaned, the ice machine, and condiment shelves have been cleaned. The server reach-in refrigerator has been cleaned and food discarded on 10/16/25. The Sanitizer buckets have maintained accepted parts per million since 10/16/2025 and checked daily.

2. All residents at the facility have the potential to be affected by this deficient practice.

3. On 12/8/2025 the Dining Services Coordinator will hold documented in-service for dining staff regarding the failure to maintain food service areas, equipment and utensils in a clean and sanitary condition. This in-service will also review the use of gloves when preparing food and cleaning dishes and will be completed by 12/8/25. The Executive Director conducted an audit of dining cleaning logs on 12/2/25 and concluded that they are within required standings. Through the online NJ Exec Order 26.4b1, an online training course on food safety fundamentals will be assigned by the Executive Director on 12/8/2025 to be completed by 12/15/2025 for dining staff.

4. The Dining Services Coordinator will hold monthly meetings for the next 3 months with dining staff. Next meeting to be held on December 16, 2025. The meetings shall include food safety, sanitation concerns and areas of improvement pertaining to cleanliness and workflow. Plan of correction will be discussed and evaluated quarterly for two quarters by the Executive Director / Designee / Coordinators at the Quality Assurance Performance Improvement (QAPI) meeting to verify it is still effective. If not effective, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify the violation does not occur again. QAPI meeting scheduled for January 14, 2026, by the Administrator with the Dining Services Coordinator and Department Heads.

5. Completion Date: December 16, 2025 Accepted 12/2/25

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A901 8:36-10.5 (c4) Dining Services

Target completion date: 12/16/2025

1. On 10/12/2025 the Dining Services Coordinator posted the menus with portion sizes in the kitchen accessible to staff. On 10/12/25 and current menus with portion sizes are clearly posted in the food area. Menus are changed every 6 months and the postings will change every 6 months as well.

2. All residents at the facility have the potential to be affected by this deficient practice.

3. The Dining Services Coordinator will hold an in-service for dining staff regarding the findings which will be initiated on 12/8/25 with a completion date of 12/15/25. This in-service will review the need to have menus and portion sizes posted in both the food preparation area and kitchen area. The Executive Director will conduct an audit of required menu postings, this audit was completed on 12/2/2025, no concerns. Menu items with food portion sizes were posted in the dining are in both memory care and assisted living neighborhoods on 12/2/25 audit and ongoing.

4. Beginning 12/16/2025, the Dining Services Coordinator will hold monthly meetings with dining staff for 3 months. Meetings shall include food safety, sanitation concerns, correct menu postings with portion sizes and areas of improvement pertaining to cleanliness and workflows. The Plan of Correction will be discussed and evaluated quarterly for two quarters by the Executive Director / Admin Designee / Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again. QAPI meeting scheduled for January 14, 2026, by the Administrator with the Dining Services Coordinator and Department Heads.

5. Completion Date: December 16, 2025

Accepted 12/12/25

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SENIOR LIVING

BRIDGEWATER

A913 8:36-10.5 (c10) Dining Services

Target completion date: 12/16/2025

1. The Dining Services Coordinator counseled and trained the dining staff on proper food temperatures on 10/12/2025. Since the visit the food temperatures have been checked and recorded daily by the dining staff and are within state-required temperatures.

2. All residents at the facility have the potential to be affected by this deficient practice.

3. The Dining services Coordinator will hold an in-service for dining staff regarding the findings which will be initiated on 12/8/25 with a completion date of 12/15/25. An audit of posted temperature logs was conducted on 12/2/25 by the Executive Director, temperatures recorded are within required temperature. A training course "food safety fundamentals" will be assigned by Executive Director for cooks and servers regarding temperature control will be initiated on 12/8/25 and completion date will be 12/15/25. An online training course on food safety fundamentals will be assigned by the Executive Director to the dining staff to be completed by 12/15/2025.

4. The current Dining Services Coordinator will continue to hold monthly meetings with dining staff. Next meeting to be held on December 16, 2025, and continue for 3 months. Meetings shall include food safety, sanitation concerns, correct menu postings w/ portion sizes, and a review of temperature and cleaning logs. The Plan of Correction will be discussed and evaluated quarterly for two quarters by the Executive Director / Admin Designee / Coordinators at the Quality Assurance and performance Improvement (QAPI) meeting to verify it is still effective. If it is not effective, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. QAPI meeting scheduled for January 14, 2026, by the Administrator with the Dining Services Coordinator and Department Heads.

5. Completion Date: December 16, 2025

Accepted 12/12 KS

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A1095 8:36-16.5 (b) Automatic Fire Detection System

Target completion date: 12/15/2025

1. The Maintenance Coordinator and the licensed vendor conducted the smoke sensitivity test on 10/17/2025 and since the visit this test was completed there with no deficiencies.

2. All residents at the facility have the potential to be affected by this deficient practice.

3. A smoke sensitivity test was completed at the community by the licensed vendor between 10/17/25 – 10/23/25 and all are within required regulations. A biannual work order for sensitivity testing will be placed in the community's electronic building maintenance system on 12/15/25 by the Executive Director. This will ensure that our Maintenance Coordinator conducts these tests as required in accordance with NFPA 72 national Fire Alarm and signaling code Section 14.4.5.3.2.

4. The Maintenance Coordinator will utilize our electronic building maintenance program to maintain and monitor all required testing, including smoke sensitivity biannual checks. The Plan of Correction will be discussed and evaluated quarterly for two quarters by the Executive Director / Admin Designee / Coordinators at the Quality assurance Performance Improvement (QAPI) meeting to verify it is still effective. If it is not effective, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. QAPI meeting scheduled for January 14, 2026, by the Administrator with the Maintenance Coordinator and Department Heads.

5. Completion Date: December 15, 2025

Accepted 12/12/25

SUNRISE
SENIOR LIVING

BRIDGEWATER

A1169 8:36-16. 15 (a) Fire Extinguisher Specifications

Target Completion Date: 12/15/2025

1. The Maintenance Coordinator replaced the "penthouse" fire extinguisher in question and since 10/11/25 the extinguishers are up to date with their inspections.

2. All residents at the facility have the potential to be affected by this deficient practice.

3. A new fire extinguisher was placed in the penthouse on 10/11/2025 by the Maintenance Coordinator and is in working order. A specific monthly work order will be placed in the community's electronic building services monitoring program by the Executive Director on 12/15/2025 to identify penthouse fire extinguishers to ensure that all fire extinguishers on site will be evaluated and remain in working order.

4. The Maintenance Coordinator will utilize our electronic building monitoring program to maintain and monitor all required testing, including fire extinguishers. The plan of correction will be discussed and evaluated quarterly for two quarters by the Executive Director / Admin Designee / Coordinators at the Quality Assurance Performance Improvement (QAPI) meeting to verify it is still effective. If not effective, it will be amended, and a new Plan of Correction training will be implemented and monitored to verify the violation does not occur again. QAPI meeting scheduled for January 14, 2026, by the Administrator with the Maintenance Coordinator and Department Heads.

5. Completion Date: December 15, 2025

Accepted 12/12/25

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BRIDGEWATER

A1249 8:36-167.7 Building and Grounds Maintenance

Target completion date: 12/15/2025

1. On 10/24/2025, the Maintenance Coordinator corrected the infraction by adjusting the door latches and closures and since the correction, the 3 identified doors are in working order as of 10/24/2025

2. All residents at the facility have the potential to be affected by this deficient practice.

3. Repairs to the stairwell doors were completed at the community by the Maintenance Coordinator on 10/24/25. The Maintenance Coordinator determined that stairwell doors were in working order and latching properly. By 12/15/25 A specific work order will be placed in the community's electronic building monitoring program by the Administrator to maintain stairwell latch closures by our Maintenance Coordinator monthly.

4. The Maintenance Coordinator will utilize our electronic building monitoring program to maintain and monitor all required testing of stairwell doors. The plan of correction will be discussed and evaluated quarterly for two quarters by the Executive Director / Admin Designee / Coordinators at the Quality Assurance Performance Improvement (QAPI) meeting to verify it is still effective. If it is not effective, it will be amended, and a new Plan of Correction and training will be implemented and monitored to verify that the violation does not occur again. QAPI meeting scheduled for January 14, 2026, by the Administrator with the Maintenance Coordinator and Department Heads.

5. Completion Date: December 15, 2025

Accepted 12/12/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
18A111 Y1	A. Building B. Wing Y2	12/12/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF BRIDGEWATER	390 US 22 BRIDGEWATER, NJ 08807

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 A0783	Correction	ID Prefix A0891	Correction	ID Prefix A0901	Correction
Reg. # 8:36-7.5(e)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-10.5(c)(4)	Completed
LSC	12/31/2025	LSC	12/16/2025	LSC	12/16/2025
ID Prefix A0913	Correction	ID Prefix A1095	Correction	ID Prefix A1169	Correction
Reg. # 8:36-10.5(c)(10)	Completed	Reg. # 8:36-16.5(b)	Completed	Reg. # 8:36-16.15(a)	Completed
LSC	12/16/2025	LSC	12/15/2025	LSC	12/15/2025
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/15/2025	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?
10/10/2025	☐ YES ☐ NO