

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>315182</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/30/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>BRIDGEWAY CARE AND REHAB CENTER AT BRIDGEWATER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>270 ROUTE 28 , BRIDGEWATER, New Jersey, 08807</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>COMPLAINT #: 2648621</p> <p>CENSUS: 140</p> <p>SAMPLE SIZE: 5</p> <p>A complaint survey was conducted at Bridgeway Care &amp; Rehabilitation Center at Bridgewater on 10/23/2025 to determine compliance with 42 CFR Part 483 Requirements for Long-Term Care Facilities.</p> <p>During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.12(a)(1) F 600, as the facility failed to ensure residents were protected from [redacted] On [redacted] at approximately 6:00 PM, Resident #2 reported to the facility's Nursing Supervisor (NS #1) that a Certified Nursing Assistant (CNA #1) [redacted] and [redacted] them. The NS #1 removed CNA #1 from Resident #2's care and reassigned another CNA. CNA #1 remained on that nursing unit providing care to other residents as well as having access to Resident #2 until the end of the shift at 11:00 PM that same evening. On 10/23/2025 at 9:51 AM, an interview was conducted with Resident #2, who stated an "aide" was [redacted] with them, so the resident told "the people in charge". An interview with NS #1, on 10/23/2025 at 1:00 PM, revealed that Resident #2 did approach her about the [redacted] by CNA #1 and she did reassign another CNA to provide care to the resident. CNA #1 was not sent home after the [redacted] and continued to care for other residents for the remainder of that shift. During an interview on 10/23/2025 at 1:37 PM, the [redacted] (US FOIA (b)(6)) stated that she became aware of the [redacted] and according to the facility policy, a staff member who was accused of [redacted] should have been sent home, pending the completion of the investigation. The Administration was informed of the F 600 IJ and was provided with the IJ template on 10/23/2025 at 4:02 PM.</p>	F0000		11/11/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0000	Continued from page 1 An acceptable Removal Plan (RP) was submitted on 10/30/2025 at 2:00 PM, indicating the actions the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include: assessment of Resident #2; completion of the investigation; Resident #2's care plan (CP) was updated for [NJ Exec Order 26.4b1]; re-education provided to CNA #1 prior to his return to work; re-education provided to NS #1; education was provided to all staff on the facility [NJ Exec Order 26.4b1] policy and procedures for resident protection; [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] residents on CNA #1's assignment were interviewed to rule out unreported [NJ Exec Order 26.4b1] all residents with a Brief Interview for Mental Status (BIMS) score of [NJ Exec Order 26.4b1] or above were interviewed; [NJ Exec Order 26.4b1] residents on CNA #1's assignment and throughout the facility had [NJ Exec Order 26.4b1] assessments completed.  The surveyor verified the implementation of the RP on-site during the continuation of the survey on 10/30/2025 and determined that the immediacy for F 600 was removed on 10/26/2025.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation  The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;  This REQUIREMENT is NOT MET as evidenced by:  Complaint #: 2648621  Based on interviews, medical record review, and review of other pertinent facility documentation on	F0600	1. Corrective action taken for the resident(s) affected by the deficient practice  The resident was immediately assessed following the [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] identified.  The CNA was removed from any further resident contact pending the completion of the investigation.  A thorough investigation was conducted and determined the [NJ Exec Order 26.4b1] to be unsubstantiated based on the resident's recantation, [NJ Exec Order 26.4b1] and prior care-plan documentation related to making false [NJ Exec Order 26.4b1]  The resident's care plan was updated to reflect [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] assistance during ADLs.  The resident remains safe, and no further incidents have occurred.  Education provided to the accused [US FOIA] on 10/20/25.  Education provided to the [US FOIA (b)(6)] on 10/23/25.  2. How the facility will identify other residents who	11/11/2025

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F0600 SS = SQC-J	<p>Continued from page 2 10/23/2025, it was determined that the facility failed to implement their [redacted] policy to ensure all residents were protected from [redacted] when Resident #2 [redacted] the Certified Nursing Assistant (CNA #1) [redacted] them, and CNA #1 was taken off the resident's assignment, but remained on that nursing unit assisting other residents as well as having access to Resident #2. This deficient practice was identified for 1 of 3 residents reviewed for [redacted] (Resident #2) and had the potential to affect all residents.</p> <p>On [redacted] at approximately 6:00 PM, Resident #2 reported to the facility's Nursing Supervisor (NS#1) that CNA #1 [redacted] NS #1 removed CNA #1 from Resident #2's care and reassigned another CNA. CNA #1 remained on that nursing unit providing care to other residents as well as having access to Resident #2 until the end of the shift at 11:00 PM that same evening. On 10/23/2025 at 9:51 AM, an interview was conducted with Resident #2, who stated an "aide" was [redacted], so the resident told "the people in charge". An interview with NS #1, on 10/23/2025 at 1:00 PM, revealed that Resident #2 did approach her about the [redacted] by CNA #1 and she did re-assign another CNA to provide care to the resident. CNA #1 was not sent home after the [redacted] of [redacted] and continued to care for other residents for the remainder of that shift. An interview with the [redacted] (US FOIA (b)(6)) on 10/23/2025 at 1:37 PM, revealed that she became aware of the [redacted] on 10/20/2025 and according to the facility policy, CNA #1 should have been sent home, pending the completion of the investigation.</p> <p>The facility's failure to implement their [redacted] policy and to protect residents from potential [redacted] by not immediately removing CNA#1, who continued to work having access to Resident #2 and other residents until an investigation was completed, placed Resident #2 and all residents at risk for [redacted] This posed the likelihood of serious physical and psychosocial harm, or impairment which resulted in an Immediate Jeopardy (IJ) situation.</p> <p>The IJ began on [redacted] at approximately 6:00 PM, after Resident #2 informed NS #1 that they were [redacted] and had [redacted] by CNA#1. The facility Administration was notified of the IJ on 10/23/2025 at 4:02 PM. The facility submitted a Removal Plan (RP) on 10/30/2025 at 2:00 PM. The Surveyor verified the implementation of the RP on-site during a continuation survey on 10/30/2025.</p>	F0600	<p>Continued from page 2 may be affected by the deficient practice</p> <p>Because abuse allegations have the potential to affect all residents, the following facility-wide evaluations were completed:</p> <p>Alert and oriented residents assigned to the CNA were interviewed to identify any other unreported allegations.</p> <p>Completed: 10/24/25</p> <p>Skin assessments were completed on residents on the CNA's assignment who were not alert and oriented or unable to verbalize concerns.</p> <p>Completed: 10/24/25</p> <p>Additional skin assessments for all residents who were not alert and oriented were completed to ensure no other residents had been affected.</p> <p>Completed: 10/26/25</p> <p>Residents with a BIMS score of 9 or above were interviewed and no further concerns or incidents were reported.</p> <p>Completed: 10/24/25</p> <p>3. Systemic changes to ensure the deficient practice does not recur</p> <p>Whole-house education was initiated for nursing, therapy, dietary, housekeeping, and ancillary staff on:</p> <p>Facility Abuse Policy</p> <p>Immediate protection procedures</p> <p>Reporting responsibilities</p>	

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F0600 SS = SQC-J	<p>Continued from page 3</p> <p>The evidence was as follows:</p> <p>The facility's policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," with a revised date of April 2021, was reviewed. Under, "Policy Interpretation and Implementation," the policy revealed, "The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff;" This section of the facility policy further revealed "2. Develop and implement policies and protocols to prevent and identify a. abuse or mistreatment of residents; [...] 10. Protect residents from further harm during investigations."</p> <p>A review of the Facility Reportable Event (FRE) dated [REDACTED], revealed the following:</p> <p>On 10/19/2025 at approximately 6:00 PM, Resident #2 made an [REDACTED] to facility staff that CNA #1 [REDACTED] them and does [REDACTED]. The FRE included that the accused CNA was removed from the assignment pending investigation.</p> <p>According to the Admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: [REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>According to the Minimum Data Set (MDS), an assessment tool dated [REDACTED], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which indicated that the resident's [REDACTED] was [REDACTED]. The MDS further revealed that Resident #2's [REDACTED] was [REDACTED] and the resident had the ability to make their [REDACTED].</p> <p>A Progress Note (PN) written by Registered Nurse #1 (RN #1), dated [REDACTED] at 11:44 PM, was reviewed. The PN revealed that Resident #2 complained to the Supervisor on duty (NS #1) that CNA #1, [REDACTED] them. The PN revealed that CNA #1 was removed from</p>	F0600	<p>Continued from page 3</p> <p>Completed: 10/26/25</p> <p>Staff signed attendance sheets and competency attestations confirming their understanding of abuse reporting requirements.</p> <p>The facility posted visual reminders throughout the building (nursing stations, kitchen, break room, and other common staff areas) that outline:</p> <p>How to report suspected abuse, neglect, or misappropriation</p> <p>Contact information for the DON and Administrator</p> <p>Completed: 10/23/25</p> <p>The accused [REDACTED] received re-education on 10/20/25 prior to returning to work, ensuring the safety of all residents.</p> <p>4. How the facility will monitor to ensure the deficient practice does not recur</p> <p>To prevent future impact to any resident, the following measurable monitoring program has been implemented:</p> <p>The DON or designee will review all allegation reports to verify:</p> <p>Immediate protection measures are implemented</p> <p>Notifications to the DON and Administrator occur timely</p> <p>Investigations are completed within five calendar days per regulation</p> <p>Quarterly education will be provided to all staff on abuse prevention and reporting requirements.</p> <p>The DON/designee will perform monthly audits of:</p> <p>Allegation reporting practices</p> <p>Timely implementation of protection plans</p>	

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F0600 SS = SQC-J	<p>Continued from page 4 Resident #2's care and replaced with a different CNA (CNA #2). The PN further revealed that a [redacted] assessment was performed on Resident #2 which revealed [redacted] but showed the presence of old [redacted] to the resident's [redacted].</p> <p>An undated facility "Investigation Summary and Conclusion:" document was reviewed. Under "Investigation Summary," the document revealed that on [redacted] Resident #2 reported that during care, CNA #1 [redacted] and caused them [redacted]. The resident also reported that they [redacted] response and CNA #1 immediately stopped providing care. The investigation summary revealed that Resident #2 later reported the incident to NS #1, "who promptly removed [CNA #1] from [redacted] assignment pending further review." The investigation summary further revealed that the [redacted] (US FOIA (b)(6)) was notified on [redacted] and she initiated a full investigation according to facility policy. The summary revealed that CNA #1 was removed from direct care duties of Resident #2 pending outcome of the investigation.</p> <p>A facility document, Investigation Report (IR) dated [redacted] which was completed by CNA #1 was reviewed. CNA #1's written statement revealed that at approximately 6:00 PM, he assisted Resident #2 to sit up in bed. CNA #1's statement revealed that suddenly the nurse on duty informed him of Resident #2's [redacted] that he (CNA #1) was [redacted]. CNA #1's statement revealed that Resident #2 did not complain of [redacted] at the time he assisted them.</p> <p>A facility IR document completed by the Registered Nurse (RN #1), dated [redacted] was reviewed. RN #1's written statement revealed that Resident #2 went to RN #1 and requested to see the Supervisor because their CNA [redacted] and does [redacted]. RN #1's statement indicated that the Supervisor changed the assignment.</p> <p>A facility document titled: Individual Statement Form which was completed by NS #1 and dated [redacted], was reviewed. The statement revealed that Resident #2 reported that CNA #1 [redacted] the resident's [redacted] and [redacted] them. The statement further revealed that NS #1 immediately removed CNA #1 from caring for Resident #2.</p> <p>The "Pay-Period Summary," for CNA #1 for the pay period [redacted] was reviewed. The timecard revealed that on [redacted], CNA #1 punched in at 2:38 PM, and punched out at 11:00 PM.</p> <p>The surveyor conducted an interview with Resident #2 on 10/23/2025 at 9:51 AM. Resident #2 stated that an</p>	F0600	<p>Continued from page 4</p> <p>Investigation completion compliance</p> <p>QAPI Team to meet and review the items listed above: Completion 11/11/25</p> <p>Audit results and any identified trends will be reviewed quarterly in the QAPI committee, and corrective actions will be implemented as necessary.</p>	

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F0600 SS = SQC-J	<p>Continued from page 5</p> <p>"Aide" was [redacted] with them, so they told "the people in charge," and the Aide had not been back since then. Resident #2 stated that a different CNA provided their care after the [redacted] incident. Resident #2 stated that during the previous week, "...an Aide [redacted], he [redacted] when he was getting me [redacted]" Resident #2 stated that the CNA [redacted] and [redacted] while he [redacted] in bed.</p> <p>An interview was conducted with NS #1 on 10/23/2025 at 1:00 PM. NS #1 confirmed that Resident #2 approached her and told her that CNA #1 was [redacted] and [redacted] them. NS #1 stated that she obtained statements from RN #1 and CNA #1. NS #1 stated that she assigned a different CNA (CNA #2) to care for Resident #2. NS #1 stated that CNA #1 was not sent home after the [redacted] was made against him and continued to care for other residents for the remainder of that shift. NS #1 stated "I guess not," when asked if her actions followed the facility policy. NS #1 further stated, "I should have called the [redacted] I should have sent the CNA home."</p> <p>An interview on 10/23/2025 at 1:20 PM with CNA #1 confirmed that he was assigned to care for Resident #2 during the 3:00 PM to 11:00 PM shift on 10/19/2025. CNA #1 stated at approximately 5:30 PM or 6:00 PM, Resident #2 called him to assist them to the [redacted] CNA #1 stated that he assisted the resident to the edge of the bed, and then to the wheelchair and the resident did [redacted] at that time. CNA #1 stated that later in the shift he was informed that Resident #2 stated he (CNA #1) [redacted] them. CNA #1 stated that after he learned of the resident's [redacted] he provided a written statement to RN #1. CNA #1 further stated that NS #1 switched his assignment, and he cared for other residents until he finished his shift at approximately 11:00 PM on the night of the [redacted] incident.</p> <p>An interview was conducted with the [redacted] on 10/23/2025 at 1:37 PM. The [redacted] stated that the expectation when a staff member was [redacted] was that statements were obtained immediately, and the [redacted] staff member should be sent home pending investigation. The [redacted] further stated that sending the [redacted] staff home after an [redacted] was to keep residents safe. The [redacted] stated that re-assigning CNA #1 to care for other residents following an [redacted] of resident [redacted] was not in keeping with the facility's [redacted] policy. The [redacted] confirmed that CNA #1 continued caring for residents on [redacted] after the [redacted] was made against him.</p> <p>An acceptable Removal Plan (RP) was submitted on</p>	F0600		

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F0600 SS = SQC-J	<p>Continued from page 6 10/30/2025 at 2:00 PM, indicating the actions the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include: assessment of Resident #2; completion of the investigation; Resident #2's care plan (CP) was updated for [NJ Exec Order 26.4b1] care; re-education provided to CNA #1 prior to his return to work; re-education provided to NS #1; education was provided to all staff on the facility [NJ Exec Ord] policy and procedures for resident protection; [NJ Exec Order 26.4b1] oriented residents on CNA #1's assignment were interviewed to rule out unreported [NJ Exec Order 26.4b1] all residents with a Brief Interview for Mental Status (BIMS) score of [ ] or above were interviewed; [NJ Exec Order 26.4b1] residents on CNA #1's assignment and throughout the facility had [NJ Exec] assessments completed.</p> <p>The surveyor verified the implementation of the RP on-site during the continuation of the survey on 10/30/2025 and determined that the immediacy for F 600 was removed on 10/26/2025.</p> <p>NJAC 8:39-4.1(a)5</p>	F0600		



New Jersey State Department of Health

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S0560	<p>Continued from page 1 New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>For the 2 weeks of staffing prior to complaint survey from 10/05/2025 to 10/18/2025 the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows:</p> <p>-10/05/25 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs.</p>	S0560	<p>Continued from page 1 shifts daily in the electronic staffing system for internal staff and agency personnel. - Ongoing</p> <p>The facility will continue to utilize incentive programs for staff and contracted agencies to fill vacancies and maintain, at a minimum, the required staffing ratios of 1 CNA:8 residents on days, 1:10 on evenings, and 1:14 on nights. - Ongoing</p> <p>The facility maintains contracts with multiple staffing agencies to supplement internal staffing as needed. - Ongoing</p> <p>Nursing supervisors and managers will assist the staffing office with outreach calls as needed to fill open shifts. - Ongoing</p> <p>Ongoing recruitment efforts for CNAs and licensed staff have been strengthened, including daily applicant review and scheduled interviews.</p> <p>Education was provided to the staffing personnel regarding mandated State of New Jersey staffing requirements. Completed 11/11/25</p> <p>4. Monitoring to ensure ongoing compliance:</p> <p>The staffing coordinator/designee will conduct a weekly audit of staffing ratios for all three shifts to ensure compliance with NJ mandated minimums.</p> <p>Any shift that falls below minimum ratios will be reported to the Director of Nursing and Administrator immediately, along with documented efforts made to secure additional staff.</p> <p>Audit findings will be reviewed weekly by the Administrator and DON and then reported quarterly at the QAPI meeting.</p> <p>Compliance threshold is 100% staffing at or above NJ minimum standards.</p> <p>Monitoring will continue for three quarters, after which the QAPI committee will determine the need for continued auditing.</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>315182</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/16/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>BRIDGEWAY CARE AND REHAB CENTER AT BRIDGEWATER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>270 ROUTE 28 , BRIDGEWATER, New Jersey, 08807</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>An on-site revisit for the facility's Plan of Correction was conducted on 12/16/2025 in relation to the 10/30/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		12/23/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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New Jersey State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>061811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/16/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>BRIDGEWAY CARE AND REHAB CENTER AT BRIDGEWATER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>270 ROUTE 28 , BRIDGEWATER, New Jersey, 08807</b>	
(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
S0000	Initial Comments  An on-site revisit for the facility's Plan of Correction was conducted on 12/16/2025 in relation to the 10/30/2025 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		12/23/2025

Office of Primary Care and Health Systems Management

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