STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315182	A. BUILDING _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT BRIDGEWATER	270 ROUTE 28 BRIDGEWATER, NJ 08807

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F 000	INITIAL COMMENTS Complaint #: NJ00164556, NJ00151859, NJ00153370 Census: 142 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the	F 626		10/9/23

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

Electronically Signed | 10/16/2023

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F 626	Continued From page 1 requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Complaint # NJ00164556 Based on interviews, medical records review, and review of other pertinent facility documentation on 09/19/23 and 09/20/23, it was determined that the facility failed to follow their policies and procedures for a facility-initiated discharge. A resident (Resident #3) exhibited [redacted] behaviors and was sent to the hospital for a [redacted] evaluation. When the resident was discharged from the hospital, the facility would not permit a return back to the facility. The deficient practice was identified for Resident #3, 1 of 3 residents reviewed for transfer and discharge, and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #3: According to the "Admission Record," Resident #3 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]	F 626	Policy has been revised to state more clearly what will happen if resident is sent out to hospital to distinguish between [redacted] s we can't manage when considering transfer back to facility. Resident #3 no longer resides in the facility, therefore the facility is unable to take immediate corrective action for this resident. All residents who reside in the facility and are placed on therapeutic leave have the potential to be affected by the same alleged deficient practice. There are currently no additional residents in the facility effected by the transfer discharge notice or transfer discharge: emergency policy. Residents with behaviors the facility can't manage will be evaluated following the written policy for transfer and discharge: emergency and/ or transfer and discharge notice policy.	

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F 626	Continued From page 2 Disorder. Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed that Resident #3 had a Brief Interview for Mental Status score of [redacted], which indicated the resident had [redacted]. The MDS failed to indicate that Resident #3 had any [redacted] symptoms. Review of Resident #3's Clinical Census revealed that their "Primary Payer" at the facility was Medicaid-Managed Care. The 11/22/19 Pre-Admission Screening And Resident Review (PASRR) Level I Screen (a federal requirement to help ensure individuals are not inappropriately placed in nursing homes for long trem care) indicated that Resident #3 had a diagnosis of a [redacted] but that the resident did not have a [redacted] related to the diagnosis. The PASRR also indicated that Resident #3 should be admitted to the nursing facility. The care plan dated [redacted] indicated focuses for difficulty relating to staff and other residents in [redacted] due to a [redacted] use of [redacted] medications. Review of the [redacted] "Physician Note-Narrative" (PNN) written by the Attending Physician revealed that Resident #3 was [redacted] at times, was followed closely by	F 626	Review/revise existing policy/protocol to include those areas that require evaluation upon return to facility after therapeutic leave. Admissions staff will be in-serviced on the facility's transfer discharge process including use of competency test to show understanding of policy and process. Will implement our policy and monitoring will continue for all patient transfers out. All patent transfers out in which there is information which may lead to our inability to care for upon anticipated return, the facility will initiate the discharge process by obtaining more information from psychiatry, and interdisciplinary team meetings prior to taking any steps toward resident return. Our facility will notify hospital if any patient is within a 30-day window. The Director of Nursing/designee will continue to monitor and complete weekly resident audit on residents placed on therapeutic leave at time of hospital notification of intended return for 3 months. Results will be shared in the facilities quarterly Quality Assurance Performance Improvement meeting until the facility has satisfactorily met their goal of zero residents being denied permission to return to the facility.	

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F 626	Continued From page 3 [redacted] and was [redacted]. The PNN did not include any physician documentation of the specific needs that could not be met at the facility for Resident #3. Review of the [redacted] Progress Note" [redacted] completed by the Advanced Practice Nurse (APN) revealed, "[...] LTC resident with history o [redacted]. Patient is evaluated following episodes of [redacted] and [redacted]. Staff reports that pt [patient] has become a [redacted] r to others, as [he/she] is [redacted] who are venerable [vulnerable] and unable to proactively avoid contact or protect themselves from [his/her] [redacted]. At this time pt needs an emergency high level of care for [redacted]. When pt returns and if medications are not adjusted at the hospital, will recommend increasing the [redacted] medication] to [redacted] mg, and if behavior persist an in-patient admission for medication management will be appropriate [...]." The [redacted] did not include any documentation of the specific needs that could not be met at the facility for Resident #3. According to the [redacted] Nursing Note-Narrative, "[...] Due to circumstances of [redacted] and for the [redacted] of the other residents and discussion with [redacted] [...] APN, it was determined to send out 911 to ER for evaluation. Called 911. [...] Resident was picked up via stretcher at 11:15 am." According to the communication chain from the facility's Admission's Clinical Liaison to the hospital on [redacted], "Status changed to Decline.	F 626		

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F 626	Continued From page 4	F 626		

[He/She] is from our facility but [he/she] has surpassed [his/her] 10 day Medicaid bed hold. Also we are unable to take [him/her] back with the need of a [1 to 1 monitoring system] and [his/her] behaviors under control. No Bed Available."

According to the [redacted] Daily Census (census sheet), there were 151 available beds, 134 total residents, and 17 empty beds.

According to the [redacted] Consultation completed by the [redacted] Nurse Practitioner (NP) at the hospital on [redacted] "Patient does not have [redacted] symptoms, warranting [redacted] care at this time. Patient is not a [redacted] is not [redacted]. Patient required, [redacted] and responded to verbal stimuli very little[.] Patient adamantly denies any [redacted] Patient doesn't meet commitment criteria and requesting discharge. Patient can be discharged, once medically clear to SAR [sub-acute rehabilitation], or group home."

According to the communication chain from the hospital to the facility on [redacted] "Attached is patient's [redacted]. [He/she] clearly does not meet criteria for a facility with a higher level of [redacted] support. This would not be an appropriate referral. [...] It is not the responsibility of the hospital to place one of your long term care residents that has resided with you for over [redacted] years."

According to the communication chain from the facility's Director of Admissions (DOA) to the hospital on [redacted], "[He/She] could be on the wait list should [he/she] be appropriate at that time. Thank you."

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F 626	Continued From page 5	F 626		

According to the [redacted] communication chain from the hospital to the facility, "According to the law, [he/she] is to receive the NEXT available bed, not placed back on your waiting list. [...] This is where expecting the hospital to pursue alternate placement for you is unacceptable."

During an interview with the surveyor on 09/20/23 at 12:36 PM, the DOA stated the main reason for the resident's discharge from the facility was a nursing decision because of the resident's [redacted], and the [redacted] at the facility. The DOA stated that when Resident #3 was sent out, there was a 10-day bed hold in place. The resident was not safe to return to the facility before the bed hold expired. The DOA continued that once the resident's bed hold expired, the family wound have to pay to keep the bed held for longer. The DOA stated the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) would know more about the resident's discharge because it was a clinical decision.

During an interview with the surveyor on 09/20/23 at 2:03 PM, the LNHA stated that on [redacted] that the facility had denied the hospital's referral to readmit Resident #3 because of their behaviors and out of concern for the safety of the other residents. The LNHA stated that Resident #3's bed was occupied on [redacted] but there were open beds available at the facility. The LNHA continued that the facility's Admissions Clinical Liaison and DOA did not give accurate information to the hospital that no beds were available.

Review of the [redacted] census sheet revealed that Resident #3's room was documented as

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F 626	Continued From page 6 "Empty." During an interview with the surveyor on 09/20/23 at 2:58 PM, the DON stated that a resident who had a psychiatric episode would be allowed to return to the facility when they were cleared to return to the facility. A [redacted] assessment would show that they were not a danger to themselves or others, and that their treatment was managed. The DON stated that a resident would be radmitted as long as the facility had the medications and could meet the resident's needs. The DON continued that according to the [redacted] NP's assessment on [redacted] in the hospital, the resident should have been readmitted. The facility policy, "Transfer and Discharge" dated 03/22/19 indicated under the, "Policy Section," "To permit each resident to remain the facility, and not transfer or discharge the resident from the facility unless: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility... The safety of individuals in the facility is endangered due to the clinical or [redacted] l status of the resident; The health of individuals in the facility would otherwise be endangered [...]." The facility policy continued, "Residents who are sent emergently to the hospital are considered facility-initiated transfers because their return is generally expected, and will be permitted to return to the facility, unless they meet one of the criteria under which the facility can initiate discharge." The facility polices, "Admissions Policies," and "Admission Criteria" failed to address readmission to the facility following hospitalization.	F 626		

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F 626	Continued From page 7 The undated "Notice of Bed Hold Policy and Return to Facility," sent to Resident #3's resident representative indicated, "If Medicaid or Managed Medicaid, Bridgeway will reserve the resident's accommodations for up to ten (10) days, with Day 1 being the date of discharge. [...] If the therapeutic leave or transfer exceeds the bed-hold period, and payment for bed hold is not made, the resident will be allowed to return to their previous room, only if available. If the previous room is not available, they will be offered a bed in another semi-private room." NJAC 8:39 5.1(d)	F 626		

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F 626	Continued From page 8	F 626		
F 656 SS=E	gbbbbbbbbbbbbbbbbbbbbbbbbbm Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		10/9/23

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F 656	Continued From page 9 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00151859 Based on interview, medical records review, and review of other pertinent facility documentation on 09/19/23 and 09/20/23, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan (CP) for a resident with [redacted] The deficient practice was identified for Resident #2, 1 of 3 residents reviewed for CP and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #2: According to the Admission Record, Resident #2 was admitted on [redacted] with medical diagnoses which included but were not limited to [redacted] Review of the quarterly Minimum Data Set	F 656	Urinary Tract Infections/Bacteriuria □ Clinical Protocol will be considered when developing a comprehensive care plan for residents having [redacted] Resident #2 was discharged in [redacted] and therefore the facility is unable to take any corrective action for this individual. All residents who reside in the facility who are know to have or be at risk for [redacted] have the potential to be affected by the same alleged deficient practice. There is currently _1_ additional resident in the facility who has had recurrent [redacted] in the last six-months. The physician and nursing staff will review the status of individuals who are being treated for a [redacted] and adjust treatment accordingly. Review/revise existing policy/protocol to	

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F 656	Continued From page 10 (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed that Resident #2 had a Brief Interview for Mental Status Score of [redacted] which indicated the resident was cognitively intact. The MDS further revealed that the resident was [redacted] and [redacted] and required [redacted] of [redacted] staff persons for [redacted]. The MDS also indicated that the resident had a [redacted] in the last 30 days. 1. Review of Resident #2's Progress Notes (PN) revealed a [redacted] Nursing Note-Narrative (NN) that the resident's family member stated that the resident was [redacted]. The NN also indicated that the doctor was made aware and that the resident was sent to the hospital for [redacted] status. Review of Resident #2's PN revealed a [redacted] NN that a call was placed to the Emergency Department and that the resident was being admitted for a [redacted] Review of Resident #2's [redacted] "Discharge Summary" from the hospital revealed that the resident's [redacted] came back [redacted] for [redacted]) and that [redacted] were initiated. Review of Resident #2's PN revealed a [redacted] NN that Resident #2 had returned with a physician order (PO) for [redacted] milligrams (MG) and that the Advance Practice Nurse (APN) was informed. Review of the "Order Recap Report" (ORR) for [redacted] revealed a [redacted] PO for [redacted] MG Give [redacted] by mouth	F 656	include those areas that require care plan for [redacted]. Resident care staff will be in-serviced on the facility's [redacted] clinical protocol process including use of competency test to show understanding of policy and process. The Director of Nursing (DON)/designee will continue to monitor and complete resident audit on residents who have [redacted] infections. To ensure compliance, the Director of Nursing (DON)/Designee is responsible for the completion of the [redacted] infection audit tool weekly times 4 weeks, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee. If the target goal of 100% compliance is not met, the Quality Assurance and Performance Improvement (QAPI) Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 656	Continued From page 11 every [redacted] hours for [redacted] for [redacted] Days. Review of the [redacted] Medication Administration Record (MAR) revealed that Resident #2 was administered [redacted] Tablet [redacted] MG Give [redacted] tablet by mouth every [redacted] hours for [redacted] for [redacted] Days from [redacted] 2. Review of Resident #2's PN revealed a [redacted] 1 NN that the resident was noted to be more [redacted] than at baseline. The physician was made aware and gave an order to send the resident to the hospital. Review of Resident #2's PN revealed a [redacted] NN revealed that the resident was admitted to the hospital for [redacted] status. Review of Resident #2's PN revealed a 11/26/21 NN indicated that Resident #2 was readmitted to the facility from the hospital on [redacted] and that they were receiving [redacted] MG [redacted] days for a [redacted] Review of the ORR for November [redacted] revealed a [redacted] PO for [redacted] Tablet [redacted] MG Give [redacted] tablet by mouth every [redacted] hours for infection for [redacted] Days. Review of the [redacted] MAR revealed that Resident #2 was administered [redacted] Tablet [redacted] MG every [redacted] hours for [redacted] days, from [redacted] 3. Review of Resident #2's PN revealed a [redacted] NN which indicated that the resident's temperature was [redacted] ([redacted] is [redacted] °F) and that the resident did not feel	F 656		

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F 656	Continued From page 12	F 656		

well. The note also indicated that the APN was made aware.

Review of the [redacted] Physician Note Narrative indicated that the APN discussed with the MD and the nurse arranged for transport to the hospital.

Review of the [redacted] Discharge Summary from the hospital Medical Doctor (MD) indicated that Resident #2 presented to the hospital on [redacted] with reports of [redacted] The resident "was also found to have evidence of a [redacted]." The [redacted] sample [redacted] and Resident #2 was started on [redacted] for [redacted] The resident would be transitioned to [redacted] on discharge.

Review of the Clinical Physician Orders revealed a [redacted] PO for [redacted] MG Give 1 tablet by mouth two times a day for [redacted] for [redacted] Days.

Review of the [redacted] MAR revealed that Resident #2 received [redacted] MG two times a day or [redacted] days, from [redacted]

4. Review of Resident #2's PN revealed a [redacted] NN that the resident had a temperature of [redacted] and the resident had a new onset of [redacted] The physician and APN were notified and a new order was given to send the resident to the hospital.

Review of Resident #2's PN revealed a [redacted] NN that the emergency department Registered Nurse called and stated that Resident #2 was admitted to the hospital with diagnoses which included [redacted]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT BRIDGEWATER	270 ROUTE 28 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) COMPLETION DATE
F 656	Continued From page 13 ([redacted] usually caused by an infection). Review of the Resident #2's CP failed to address the resident's recurrent [redacted] include interventions to treat or prevent it's recurrence. During an interview with the surveyor on 09/20/23 at 12:55 PM, the Licensed Practical Nurse (LPN) #1 stated that a CP reflected cooperation between all the different disciplines on how to fully care for a resident. LPN #1 added that actual problems would be included on the CP. LPN #1 continued that [redacted] could be added to a care plan and that it would the Unit Manager's responsibility to add it to the care plan. During an interview with the surveyor on 09/20/23 at 1:53 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that new orders, new procedures, or new resident behaviors would be added to a resident's CP. The LPN/UM stated that a [redacted] would go on the CP. The LPN/UM continued that the purpose of putting this on the CP was so that everyone could be aware of the issue and put interventions in place to resolve it. During an interview with the surveyor on 09/20/23 at 2:58 PM, the Director of Nursing (DON) stated that the purpose of a care plan was to provide communication between the nursing team regarding the customized needs of a resident. The DON stated that a resident's [redacted] would be placed on the CP. The 11/28/17 facility policy, "Baseline and Comprehensive Care Plans" indicated under the "Procedure" section, that "The comprehensive care plan must describe the following: A. The	F 656		

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F 656	Continued From page 14 services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being [...]. All care plans will be reviewed quarterly by each discipline and interdisciplinary team members, unless needed sooner due to a significant change in condition." NJAC 8:39-11.2(f).	F 656		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00153370 Based on interview, medical record review, and review of other pertinent facility documentation on 09/19/23 and 09/20/23, it was determined that the facility failed to: a.) complete [redacted] in accordance with a physician's order and b.) follow care plan (CP) interventions for a resident with [redacted]). The resident [redacted] pounds (Lbs.) of [redacted] days and was transferred to the hospital in [redacted] where they were admitted to the [redacted] unit.	F 684	[redacted]- Clinical Protocol has been reviewed and revised to state more clearly protocol for completion of [redacted] in accordance with a physician's order and process for follow care plan (CP) interventions for a resident with [redacted] Resident #1 no longer resides in the facility, discharging in [redacted], and therefore the facility is unable to take corrective action for the individual. All residents who reside in the facility who	10/9/23

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F 684	Continued From page 15 The deficient practice was identifed for Resident #1, 1 of 5 residents reviewed for quality of care and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #1: According to the Admission Record, Resident #1 was admitted on [redacted] with diagnoses which included but were not limited to [redacted] The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated that Resident #1 had a Brief Interview for Mental Status score of [redacted] which indicated the resident had [redacted]. The MDS also revealed that the resident weighed [redacted] lbs. Review of Resident #1's CP revealed a "Focus," initiated on [redacted] Resident #1 was at risk for [redacted]. Under the "Interventions/Tasks" section, included the following interventions, initiated on [redacted]: Assess for [redacted] and notify physician of new or [redacted] and notify physician if observed and [redacted] Review of Resident #1's "Order Recap Report"	F 684	have [redacted] related to the diagnosis on [redacted] have the potential to be affected by the same alleged deficient practice. There are currently _8_ additional residents in the facility effected by the protocol for [redacted] pertaining to the diagnosis of [redacted] as per protocol. Task will be placed for residents who as per physician order require [redacted] for monitoring of [redacted] Care plan interventions are in place regarding monitoring. Review/revise existing policy/protocol to include: o the physician will help identify individuals with a history of [redacted]) and will clarify, as much as possible, its severity and underlying causes. o In collaboration with the attending physician and other members of the interdisciplinary team, the nurse will identify interventions required based on the [redacted] and individual risk for [redacted]. Resident care staff will be in-serviced on the facility's [redacted] process including use of competency test to show understanding of policy and process. The DON/designee will continue to monitor and complete weekly resident audit on residents who have [redacted] monitoring related to diagnosis of [redacted] To ensure compliance, the DON/Designee is responsible for the completion of the	

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F 684	Continued From page 16 (ORR) did not include physician's orders (PO) to assess for [redacted] and to notify the physician of [redacted] auscultate [redacted] and notify physician if [redacted] observed, or to complete daily assessment of [redacted] Review of the [redacted] Treatment Administration Records failed to include documentation of assessment for [redacted] daily [redacted], or daily assessment of [redacted]. Review of Resident #1's Progress Notes (PN) revealed a [redacted] hour] [redacted] Surveillance" note that indicated the resident was noted as having '[redacted]" The PN revealed that the resident had "[redacted] is [redacted] present when [redacted] (reported by the resident/resident representative and/or observed by staff) [redacted] is a new symptom. [...]" The PN failed did not include documentation that the nurse [redacted] the resident's [redacted] or notified the physician of the new onset [redacted] Review of Resident #1's medical record failed to reveal that Resident #1's [redacted] were [redacted] on 05/18/21, 05/19/21, 05/28/21, 05/29/21, 05/30/21, 06/01/21, 06/02/21, 06/05/21, 06/09/21, 06/11/21, 06/12/21, 06/12/21, 06/13/21, 06/14/21, 06/16/21, 06/17/21, 06/18/21, 06/19/21, 06/20/21, 06/21/21, or 06/25/21. Review of Resident #1's medical record failed to	F 684	[redacted] audit tool weekly times 4 weeks, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee. If the target goal of 100% compliance is not met, the QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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reveal that Resident #1's [redacted] was assessed on 05/18/21, 05/19/21, 05/28/21, 05/29/21, 05/30/21, 06/02/21, 06/05/21, 06/09/21, 06/11/21, 06/12/21, 06/13/21, 06/14/21, 06/17/21, 06/19/21, 06/20/21, or 06/26/21.

The CP revealed an intervention, initiated on [redacted] for daily weights and to notify the physician if [redacted] Lbs in one day or [redacted] Lbs. in one week is noted.

The ORR revealed that physician's orders for [redacted] Protocol: [redacted]." were active from [redacted] and from [redacted].

Review of the [redacted] Medication Administration Record (MAR) revealed the following weights:

05/19: [redacted] Lbs.
05/20: [redacted] Lbs.
[redacted]: Hospitalized

Review of the "Patient Care Summary" from the resident's [redacted] hospitalization indicated that Resident #1 weighed [redacted] Lbs.)

05/22: Hospitalized
05/23: Hospitalized
05/24: Hospitalized

The "Patient Care Summary" from [redacted] indicated that Resident #1 weighed [redacted] Lbs.)

05/25: Hospitalized
05/26: Hospitalized

Review of the [redacted] "Clinical Admission

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Evaluation" did not include documentation of Resident #1's readmission weight.

Review of the ORR did not include a PO for [redacted] from [redacted]

Further review of the [redacted] MARs did not include daily weights documented from [redacted] 1.

The June 2021 MAR recorded the following weight:

06/10: [redacted] Lbs.
06/11: [redacted] Lbs.
06/12: [redacted] Lbs.
06/13: [redacted] Lbs.
06/14: [redacted] Lbs.
06/15: [redacted] Lbs.
06/16: No weight recorded.
06/17: [redacted] Lbs.
06/18: [redacted] Lbs.
06/19: 1[redacted] Lbs.
06/20: Refused
06/21: No weight recorded.
06/22: No weight recorded.
06/23: [redacted] Lbs.
06/24: [redacted] Lbs.
06/25: [redacted] Lbs.

Review of the [redacted] Emergency Department Triage Hospital paperwork indicated that Resident #1 weighed [redacted] Lbs.

The [redacted] "Q8hr [redacted] Surveillance" note indicated, "[...] Yes, [redacted] is noted. [redacted] or [redacted] is present with [redacted] or [redacted]

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F 684	Continued From page 19 [redacted] is present when [redacted] (reported by the resident/resident representative and/or observed by staff). [redacted] is not a new symptom. [...]." Further review of the PN failed to indicate that the nurse [redacted] the resident's [redacted] The [redacted] Q12hr [Every 12 hour] [redacted] y Surveillance Progress Note indicated, "[...] Yes, [redacted] noted, [redacted] or [redacted] is present with [redacted] [redacted] is not a new symptom [...]." Further review of the PN failed to indicate that the nurse [redacted] the resident's [redacted] Review of the PNs revealed a 06/23/21 Physician Note-Narrative that the resident had a questionable weight gain of 31 pounds over 10 days and lower extremity edema in both legs. Review of the PNs revealed a [redacted] Physician Note-Narrative that the resident had a [redacted] of [redacted] pounds over [redacted] days, [redacted] in their [redacted]. Review of the PNs revealed a [redacted] Nursing Note-Narrative (NN) that at 12:30 PM, Resident #2's [redacted] % [redacted] is [redacted] that the doctor was called, and that the resident was ordered to be sent to the hospital. Further review of the the PNs revealed a [redacted] NN that Resident #2 was admitted to the intermediate care unit with a diagnosis of [redacted]	F 684		

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F 684	Continued From page 20 During an interview with the surveyor on 09/19/23 at 12:25 PM, the Certified Nursing Assistant/Unit Secretary (CNA/US) stated that they do daily weights on residents with [redacted]. The CNAs [redacted] the residents and would write it in a [redacted] binder or give the [redacted]t verbally to the nurse. The CNA/US added that the nurse documented the weights in the electronic medical record. The CNA/US continued that [redacted] could cause [redacted] and that the [redacted] are completed to make sure that the residents were not [redacted] During an interview with the surveyor on 09/19/23 at 1:42 PM, the Licensed Practical Nurse (LPN) #1 stated that care for a resident diagnosed with [redacted] was driven by whatever was specified by the CP. LPN #1 added that [redacted] residents were [redacted] more frequently and, in the morning, when the resident woke up. LPN #1 stated CNAs tell the nurses the [redacted]t and that the nurses put the [redacted] onto the MAR. LPN #1 stated that there could be little fluctuations with a resident's weights day to day. LPN #1 stated that drastic changed in the resident's [redacted] would be a problem. LPN #1 further stated that if a resident had new onset [redacted], the nurse would notify the Unit Manager and notify the physician to get an order for [redacted] LPN #1 added that the resident could be sent to the emergency room because shortness of breath could be an emergency. During an interview with the surveyor on 09/19/23 at 2:02 PM, the Registered Nurse (RN) #1 stated that the physician would usually with order [redacted] for residents with a [redacted] diagnosis. RN #1 stated the resident would be [redacted] in the	F 684		

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morning before breakfast and that if there was a [redacted] or [redacted] the nurse would communicate with the physician for interventions. The surveyor asked if RN #1 would expect for several weights to be exactly the same day after day. RN #1 stated that the [redacted] usually fluctuates and that, "today is different from tomorrow." RN #1 stated that it was important to monitor residents with [redacted] to prevent an [redacted] of [redacted]. RN #1 stated that if a resident is ordered [redacted] that they should be done and documented. RN #1 continued that if there was a new onset of [redacted] in a [redacted] resident, the nurse would check their [redacted], communicate with the doctor, and document the communication in the resident's PN.

During an interview with the surveyor on 09/19/23 at 2:33 PM, the Licensed Practical Nurse/UM (LPN/UM) stated that staff needed to be monitoring residents with [redacted] by following the [redacted] protocol to determine if the resident experienced any changes. The LPN/UM stated that residents with [redacted] could be ordered [redacted] and that they would have to be completed the same time and would have to be documented. The LPN/UM stated that the nurse would also monitor the resident [redacted] and would tell the doctor. The LPN/UM stated that there should not be instances on Resident #1's MAR where no [redacted]t was recorded.

During an interview with the surveyor on 09/20/23 at 12:55 PM, the Licensed Practical Nurse (LPN) #2 stated that a care plan reflected cooperation between all the different disciplines on how to fully care for a resident.

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During an interview with the surveyor on 09/20/23 at 2:58 PM, the Director of Nursing (DON) stated residents admitted with [redacted] would have a CP developed to manage their [redacted] The DON stated that the purpose of monitoring residents with [redacted] was to check for [redacted]. The DON added that "ultimately death could be caused" if a resident had too much [redacted] backed up. The DON stated that she expected [redacted] to be recorded daily for a resident who was ordered [redacted] The DON continued that if a resident had a new onset of [redacted] that she would expect to see at least a phone call to the resident's care provider. The DON stated that the purpose of a CP was to provide communication between the nursing team regarding the customized needs of a resident.

The facility policy, [redacted] Protocol" dated 11/01/2012 indicated under the Procedure section, "The nurse, in consult with the attending physician shall initiate measures to assess and manage residents who are admitted with a primary diagnosis of [redacted] or develop new onset [redacted] These may include: [redacted], Daily assessment of [redacted] [...], Daily [redacted] [...]." The policy continued, "The nurse will notify the physician at early onset if the following are present: [...] New or [redacted] [...]."

The 11/28/17 facility policy, "Baseline and Comprehensive Care Plans" indicated under the "Procedure" section, "The comprehensive care plan must describe the following: A. The services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being [...]" "All care plans will

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F 684	Continued From page 23 be reviewed quarterly by each discipline and interdisciplinary team members, unless needed sooner due to a significant change in condition." The 04/20/12 facility policy, "Weight and Height" inidcated under the "Procedure" section, "A resident's height and weight will be taken and recorded upon admission/readmission on the nursing admission assessment." NJAC 8:39-27.1(a) NJAC 8:39-11.1.	F 684		

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S 000	Initial Comments Complaint #: NJ00164556, NJ00151859, NJ00153370 Census: 142 Sample Size: 5 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00153370 Based on interview and review of other facility documentation on 09/19/23 and 09/20/23, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratio for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 11 of 42 day shifts and deficient in total staff for	S 560	The facility works to staff on a daily basis based on at a minimum the standards as set forth by the state of New Jersey as it pertains to Certified Nursing Assistants (CNA). On the dates reviewed during the annual state survey, we appeared to not have sufficient staff for the days reviewed. Not from a lack of trying, as we attempted to	10/7/23

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

Electronically Signed | 10/16/23

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	061811	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT BRIDGE	270 ROUTE 28 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
S 560	Continued From page 1 residents for 2 of 21 overnight shifts. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) 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. 1. As per the "Nurse Staffing Report" completed by the facility for the week of 06/13/21 through 06/26/21, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -06/13/21 had 8 total staff for 122 residents on	S 560	utilize staffing agencies and paid additional incentives to our staff to pick up shifts. Our staffing system posts all our open positions allowing for staff and agency personnel to pick up those shifts. We post openings to be able to satisfy, at a minimum, the 1 C.N.A to 8 residents ratio on the day shift, 1 to 10 on the evening and 1 to 14 at night. We contract with numerous agencies to fill any remaining openings. We offer incentives to our staff and those in the agency to get those shifts filled. We have a staffing coordinator dedicated to obtaining the necessary staff. Aside from that person we have other nursing supervisors and managers that help in making any necessary phone calls and outreach to get the positions filled. Our company is working tirelessly on recruiting qualified licensed personnel so that we can reduce agency usage and fill the open positions we have. We will continue to post on our schedule so that we can attempt to fulfill the need for State mandated ratios. And will monitor, bi-weekly, in perpetuity, or until the law is repealed. Staffing Coordinator/designee will monitor staffing ratios daily and will report any days where staffing is lower than recommended. Data will be tracked and reported in the facilities monthly Quality Assurance and Performance Improvement (QAPI) meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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the overnight shift, required at least 9 total staff.
-06/20/21 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs.

2. As per the "Nurse Staffing Report" completed by the facility for the weeks of 01/09/22 to 01/15/22, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows:

-01/09/22 had 8 total staff for 120 residents on the overnight shift, required at least 9 total staff.
-01/10/22 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-01/11/22 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs.
-01/13/22 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs.
-01/14/22 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs.
-01/15/22 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs.

3. As per the "Nurse Staffing Report" completed by the facility for the weeks of 05/07/23 to 05/13/23, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:

-05/11/23 had 14 CNAs for 129 residents on the day shift, required at least 16 CNAs.

4. As per the "Nurse Staffing Report" completed by the facility for the weeks of 09/03/23 to 09/16/23, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:

-09/03/23 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs.
-09/08/23 had 15 CNAs for 137 residents on the

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S 560	Continued From page 3 day shift, required at least 17 CNAs. -09/10/23 had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. -09/11/23 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. During an interview with the surveyor on 09/20/23 at 4:09 PM, the Licensed Nursing Home Administrator (LNHA) stated that he was aware of the staffing regulations. The LNHA continued that the facility was actively engaged in recruiting new staff, that they utilized staffing agencies, and that they paid people while they were taking CNA classes in addition to paying for the cost of their classes.	S 560		