STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT BRIDGEWATER	270 ROUTE 28 , BRIDGEWATER, New Jersey, 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
F0000	INITIAL COMMENTS Complaint NJ #'s: 163198, 172409, 177346, and 184362 Survey Dates: 3/25/25 to 3/31/25 Census: 150 Sample size: 30 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated	F0609	• The summary and conclusion for the NJ Exec Order 26.4b1 incident involving Resident #74 and Resident #195 was completed on NJ Exec Order 26.4b1 and submitted to the Department of Health on NJ Exec Order 26.4b1 when requested. Resident #74 was NJ Exec Order 26.4b1 [redacted]. The resident remains NJ Exec Order 26.4b1 [redacted] related to the incident. Resident #195 was care planned for NJ Exec Order 26.4b [redacted] and was being NJ Exec Order 26.4b1. Interventions were added. Staff directly involved in the incident were counseled and educated on timely reporting protocols. All department heads were educated on the abuse reporting timeline and protocol by the U.S. FOIA (b)(6) [redacted] on April 17, 2025. The following department heads were educated:U.S. FOIA (b)(6) [redacted]	05/15/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY CARE AND REHAB CENTER AT BRIDGEWATER	270 ROUTE 28 , BRIDGEWATER, New Jersey, 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
F0609 SS = D	Continued from page 1 representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Complaint #: NJ177346 Based on interview, record review, and review of facility documents, it was determined that the facility failed to report the results of an [NJ Exec Order 26.4b1] [redacted] to the New Jersey Department of Health (NJDOH) within five working days for 2 of 2 residents (Resident #74 and Resident #195) reviewed for [NJ Exec Orde] [redacted]. This deficient practice was evidenced by the following: On 3/25/25 at 10:42 AM, the surveyor observed Resident #74 who was seated in a wheelchair with a transfer pad beneath of him/her and the resident was engaged in a group activity. When interviewed at that time, the [U.S. FOIA (b)(6)] stated that the resident [NJ Exec Order 26.4b] [redacted]. On 3/25/25 at 1:09 PM, the surveyor reviewed the medical record of Resident #74. A review of the Admission Record, and admission summary, revealed that the resident had diagnoses which included, but were not limited to, [NJ Exec Order 26.4b] [redacted]. A review of the the resident's quarterly Minimum Data Set (MDS) , an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4] included the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Exec Order 26.4b1] which indicated that the resident's NJ Exec Order 26.4b1. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [NJ Exec Order 26.4]	F0609	Continued from page 1 • All residents are considered potentially at risk for abuse and neglect. A facility-wide review of reportable events from the past 90 days was conducted to verify timely submission and identify any similar reporting delays. • A standardized “Abuse Reporting Checklist” will be used for each reported allegation to track the 5-day submission timeline. The Director of Nursing will ensure this checklist is initiated and completed for every incident. Education was provided to all nursing, administrative, and department head staff on April 18, 2025, by the Administrator. All new hires will receive education on abuse reporting protocols during orientation. • The DON or designee will audit the Abuse Reporting Checklist for all incidents weekly x 3 months, then monthly x 3 months. Audit results will be reviewed during the Quarterly QAPI meetings to identify trends and discuss any missed timelines. QAPI meets quarterly and includes leadership from all departments.	

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F0609 SS = D	Continued from page 2 which indicated that the resident had a [redacted] Interventions included: providing a program of activities that was of interest and accommodated the resident's status. A review of the resident's Progress Notes (PN) included an entry dated [redacted] which revealed that while the [redacted]) propelled the resident back to his/her room, they passed by Resident #195. Resident #195 [redacted] that he/she [redacted] Resident #74's [redacted]. The supervisor was made aware of the incident and a [redacted] was done with [redacted] noted. Resident #74 was wearing a long sweat shirt at the time of the incident and [redacted]. On 3/26/25 at 10:18 AM, the surveyor requested and reviewed a copy of the [redacted] investigation which included a Reportable Event Record (RER). The RER indicated that on [redacted], the facility notified the NJDOH of a [redacted] event that occurred on [redacted], which involved both Resident #74 and Resident #195. Further review of the RER revealed that as Resident #74 was being brought back to their room, Resident #195 [redacted] Resident #74 on the [redacted] he/she [redacted]. Interventions included that the residents were separated with supervision, a [redacted] was conducted and the [redacted] and [redacted] were notified. At that time, the surveyor noted that there were no employee statements included in the investigation and notified the [redacted]. The [redacted] stated that he had the employee statements in his email account and he agreed to provide them. On 3/26/25 at 11:57 AM, the [redacted] provided the surveyor with two employee statements that were written by both Registered Nurse (RN) #1 and RN #2 that were sent to the [redacted] via email on [redacted]. A review of the email that was written by RN #1, dated [redacted] 11:58 PM, indicated that Resident #195 [redacted] Resident #74 [redacted] when Resident #74 was [redacted] as Resident #195 was [redacted] in his/her wheelchair. Resident #195 told	F0609		

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F0609 SS = D	Continued from page 3 Resident #74 to NJ Exec Order 26 as Resident #195 NJ E Resident #74 NJ Exec Order 26.4b1 Further review of the investigation revealed an undated "Summary of NJ Exec Order 26.4b1 Investigation" related to Resident #74 and Resident #195. A review of the undated Summary included the conclusion: After investigation it was concluded that the NJ Exec Order 26.4b1 On 3/31/25 at 9:38 AM, the surveyor interviewed the U.S. FOIA (b and asked him if he sent a copy of the summary and conclusion of the NJ Exec Order 26.4b1 that occurred on NJ Exec Orde between Resident #74 and Resident #195 to the Department of Health, and the U.S. FOIA (b stated that he waited until he had all of the information that was requested and sent it to the DOH on NJ Exec Order 26.4b1 days later. When the surveyor asked the U.S. FOIA (b what the required time frame was to submit a summary and conclusion was, he stated that he was required to submit the summary and conclusion within five days of the reportable event submission. A review of the facility's policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" revised April 2021, included: Investigate and report any allegations within timeframes required by federal requirements. NJAC 8:39-9.4(e)(2)	F0609		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F0812	• The outdated chicken salad sandwich and unidentified food items were discarded. Personal staff food was removed from resident-designated refrigerators. • All residents who receive food from the kitchen have the potential to be affected by this deficient practice. A full inspection of kitchen refrigerators, dry storage, and food labeling practices was conducted immediately after the survey to ensure safety of all food provided to residents. • All refrigerated and dry foods will be labeled with "open" and "use-by" dates.	04/28/2025

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F0812 SS = E	Continued from page 4 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to handle potentially hazardous food to prevent food-borne illness. This deficient practice was evidenced by the following: On 3/25/25 from 9:58 AM until 10:51 AM, the surveyor observed the following in the kitchen in the presence of the U.S. FOIA (b)(6)): 1. In the "bay marine" refrigerator, on a shelf, there was a chicken salad sandwich labeled with a use-by date of 3/21/25. The U.S. FOIA stated that the sandwich can be stored for three (3) days after it was prepared and should be discarded by the "Use by" date. The U.S. FOIA stated that she would discard the chicken salad sandwich. 2. In the same refrigerator, there was an unlabeled large block of a white, round, solid food item wrapped in white paper on the shelf. The U.S. FOIA was unable to identify the food item. At that time, the U.S. FOIA (b)(6) approached the surveyor and U.S. FOIA and stated that it was a block of cheese that belonged to the kitchen staff. The U.S. FOIA stated that staff were not supposed to store their personal food in the "bay marine" refrigerator. The U.S. FOIA removed the cheese. 3. In the dry food storage area, there was a bag of tricolor pasta that did not have an opened date. At that time, the U.S. FOIA stated that the tricolor pasta was no longer on the menu because they were now using a different menu for the summer. She further stated that the pasta should have been dated when it was opened and that she would discard the pasta.	F0812	Continued from page 4 All dietary staff were educated on proper food safety, labeling, and storage procedures by the Food Service Director on April 18, 2025. Staff are prohibited from storing personal food in any resident-designated refrigerator. Food storage policies were reviewed and updated to reflect regulatory expectations. • The Dietary Supervisor or designee will audit all refrigerators three times per week for 3 months, then weekly for 3 months. Audit results will be documented and brought to the quarterly QAPI meeting for review. QAPI meets quarterly and includes representatives from dietary, nursing, administration, and other department heads.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

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F0812 SS = E	Continued from page 5 On 3/31/25 at 11:41 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that staff members' personal food items should not be stored in the kitchen refrigerator designated for resident food. He also stated that prepared foods should not be kept for longer than 3 days and should be discarded if not consumed by the use-by date. A review of the facility's "Food Receiving and Storage" policy, revised November 2022, revealed, "Dry Food Storage 4. Dry foods that are stored in bins are removed from original packaging, labeled and dated ("use by" date)," and, "Refrigerated/Frozen Storage 7. Refrigerated foods are labeled, dated and monitored so they are used by their "use-by" date, frozen, or discarded." NJAC 8:39-17.2(g)	F0812		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315182 Y1	A. Building B. Wing Y2	5/21/2025 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 05/15/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
315182 Y1	Y2	5/21/2025 Y3

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

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ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 05/15/2025	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 04/24/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/31/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/26/2025 and 03/27/2025. Bridgeway Care and Rehab was found to be in NON-COMPLIANCE with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Bridgeway Care and Rehab building construction was stated to be in 1981, with no current major renovations. It is a one story building Type II (000) construction and is fully sprinklered. The facility added a wing of the same construction type called the "Pavilion" in the 2000's. The facility utilizes 2-generators, one diesel 500 KW that powers 100% of the main building and one natural gas 100 KW that powers the Pavilion wing. There is supervised smoke detection located in the corridors, spaces open to the corridors and battery operated smoke detectors in approximately 80% of resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting, and life safety components utilized for preservation of life.	K0000		
K0211 SS = F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K0211	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our egress meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - The table/chairs and equipment blocking egress were removed immediately. - Maintenance and department heads were educated on NFPA 101 requirements for clear pathways by the U.S. FOIA (b)(6)	04/24/2025

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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K0211 SS = F	Continued from page 1 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 3/26/2025 and 3/27/2025 in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that passageways, corridors, exit discharges, exit locations, and access were in accordance with Chapter 7 and the means of egress of egress was continuously maintained free of all obstructions to full use in case emergency in accordance with NFPA 101:2012 Edition, Sections 7.1.10.1, 19.2.1 and 19.2.2 through 19.2.11. These deficient practices had the potential to affect all residents and was evidenced by the following: An observation on 3/26/2025 at 1:53 PM revealed that a table and chairs were impeding access to the emergency exit, reducing the clearance to approximately 3-feet in the sitting room of the pavilion building. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. An observation on 3/27/2025 at 12:13 PM revealed that a battery powered floor scrubber and its charger were being stored in the exit access corridor. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation and stated that although the floor cleaning equipment was not charging at the time, it is typically stored and charged in that location. An observation at 12:15 PM revealed that the latching hardware on the laundry room fire door was sticking, preventing the door from positive latching when closed. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 3/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0211	Continued from page 1 - Weekly rounds initiated by Maintenance Supervisor to identify and correct obstructions. - Random monthly audits to be conducted by the Safety Committee. - Quarterly audit of egresses added to Maintenance Preventative Maintenance checklist. - Audits findings will be brought back to QAPI committee for review	
K0222	Egress Doors	K0222	- All current residents have the potential to be	04/24/2025

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K0222 SS = F	Continued from page 2 CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in	K0222	Continued from page 2 affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our egress meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Thumb-turn locks were immediately removed. - Approved hardware installed per NFPA guidelines. - Maintenance staff educated on proper locking mechanisms for egress doors by the[redacted] - All doors reviewed to confirm compliance. - Quarterly audit of doors added to Maintenance Preventative Maintenance checklist and will be reviewed in quarterly QAPI meeting.	

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K0222 SS = F	Continued from page 3 accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 03/27/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that doors in a required means of egress were not equipped with a lock or latch. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:43 PM revealed that the exit door between the pavilion dining room and corridor was equipped with thumb-turn lock door handle, which restricted egress from the dinning when locked and tested by the U.S. FOIA (b) In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0222		
K0225 SS = F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K0225	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our doors meet the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice.- Panic/fire exit hardware installed on identified stairway doors. - Maintenance staff educated on proper requirements for	04/24/2025

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K0225 SS = F	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 3/27/2025 in the presence of the[U.S. FOIA (b)(6) redacted] it was determined that the facility failed to ensure that exit stairway enclosure doors were provided with fire exit hardware in accordance with NFPA 101:2012 Edition, Section 7.2 ,19.2.2.3, 19.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:37 PM revealed that the exit stairway enclosure door across from the conference room was not provided with panic or fire exit hardware. An observation at 12:43 PM revealed that the exit stairway enclosure near the employee exit was equipped with a delayed egress locking arrangement. The delayed egress feature did not activate unless the door handle was turned and unlatched beforehand. Additionally, the door was not provided with panic or fire exit hardware. The facility's[U.S. FOIA (b)(6) redacted] was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0225	Continued from page 4 egress doors by the[U.S. FOIA (b)(6) redacted]. - All stairways inspected to ensure no other locations lacked proper hardware. - Monthly inspections initiated results will be brought to the quarterly QAPI meeting for review.	
K0233 SS = F	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 03/27/2025 in the presence of the[U.S. FOIA (b)(6) redacted] and the[U.S. FOIA (b)(6) redacted], it was determined that	K0233	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our exits meet the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Doors not providing 32 inches clearance to be replaced with compliant doors. - Project scheduled with contractor and Maintenance Department. - Maintenance educated regarding door width regulations by the[U.S. FOIA (b)(6) redacted] - Completion of replacement will be verified by Administrator/designee. - Progress will be reviewed in the quarterly QAPI	05/31/2025

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K0233 SS = F	Continued from page 5 the facility failed to ensure that where a pair of door leaves were provided in a means of egress, one door leaf provided not less than a 32-inch clear width opening in accordance with NFPA 101:2012 Edition Section 7.2.1.2.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:43 AM revealed that the dining room contained a swinging pair of exit doors. Each door only provided a 26-inch clear width opening. In an interview at the time, the [U.S. FOIA] confirmed the observation. The facility's [U.S. FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0233	Continued from page 5 meeting	
K0281 SS = F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 03/26/2025 and 03/27/2025 in the presence of the [U.S. FOIA (b)(6)] [redacted]), it was determined that the facility failed to ensure that illumination of the means of egress was provided at exits, exit doors and exit discharges in accordance with NFPA 101:2012 Edition, Sections 7.8 and 19.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 03/26/2025 and 03/27/2025 revealed the following exit doors were provided with single bulb fixtures:	K0281	- All current residents have the potential to be affected by an outdated or incomplete Emergency Preparedness Plan. Therefore, a comprehensive review was conducted to ensure that the emergency lighting meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Identified lighting fixtures corrected for continuous or automatic operation. - Emergency lighting replaced as needed. - Maintenance educated on illumination requirements by the [U.S. FOIA (b)(6)] [redacted] - Weekly inspections added to Maintenance checklist. - Inspection results will be reviewed in the quarterly QAPI committee.	04/24/2025

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K0281 SS = F	Continued from page 6 Near W-29, near W-12, near E-25, near E-9, near P-4, Physical Therapy and the Pavilion Day room. Observations on 03/26/2025 and 03/27/2025 revealed emergency lighting that was not continuously in operation or capable of automatic operation without manual intervention. The following areas contained emergency lighting that was controlled by a switch on the wall that when in the "OFF" position, would not provide illumination in an emergency: Milltown Lounge exit door, exit door near P-4, physical therapy exit door, Pavilion basement stairway enclosure, kitchen exit door, and the Atrium near the dining room. Observations on 03/26/2025 and 03/27/2025 revealed that the following exit discharge areas were not provided with emergency illumination: Approximately 40-foot exit access ramp near W-12, approximately 20-foot exit access ramp from the West Wing courtyard, East Wing courtyard access-controlled exit door keypad, West Wing courtyard access-controlled exit door keypad and approximately 20 feet at both ends of the exit access corridor in the basement. In interviews at the time, the U.S. FOIA confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0281		
K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting	K0291	- All current residents have the potential to be affected by an outdated or incomplete Emergency Preparedness Plan. Therefore, a comprehensive review was conducted to ensure that the emergency lighting meets the needs of all residents, including those with mobility impairments, cognitive impairments, and	04/24/2025

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K0291 SS = F	Continued from page 7 Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 03/27/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that emergency lighting was provided in accordance with NFPA 101:2012 Edition, Section 7.9, 19.2.9.1 and NFPA 110. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 12:20 PM and 12:54 PM revealed that 2 of 2 emergency generator sets were not provided with automatic emergency lighting of at least 1-1/2 hours. In interviews at the time, the U.S. FOIA confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 110	K0291	Continued from page 7 specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Corrective maintenance completed on emergency lighting. - All fixtures checked for automatic operation. - Monthly testing added to maintenance rounds. - Maintenance educated on emergency lighting standards by the U.S. FOIA (b)(6) . - Monthly testing will be reviewed quarterly by the facilities QAPI committee.	
K0293 SS = F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K0293	- All current residents have the potential to be affected by an outdated or incomplete Emergency Preparedness Plan. Therefore, a comprehensive review was conducted to ensure that the exit signage is identifiable for all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Exit signage installed where identified (atrium, courtyard, fire doors). - Maintenance staff educated regarding exit signage visibility requirements by U.S. FOIA (b)(6) . - Monthly exit signage inspection implemented. - Inspection results will be reviewed in quarterly QAPI	04/24/2025

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K0293 SS = F	Continued from page 8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 03/26/2025 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that exit and directional signs were displayed in accordance with NFPA 101:2012 Edition, Section 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 03/26/2025 from 12:06 PM to 12:52 PM revealed: 1. The swinging fire door assembly near the west side nurses' station was not provided an exit sign on the egress side. When the doors swing closed, they block the view of any exit pathway signs beyond them, making it hard to locate the exit. 2. The swinging fire door assembly near room E-27 was not provided an exit sign on the egress side. When the doors swing closed, they block the view of any exit pathway signs beyond them, making it hard to locate the exit. 3. When exiting the stairway enclosure, the fenced in courtyard area on the west wing was not provided with directional exit signage to the nearest exit. Additionally, the fenced in area contained 2 gates and was not provided with an exit sign at the designated exit. 4. An exit sign was not provided at the exit of the fenced in courtyard area on the east side. In interviews at the time, the U.S. FOIA confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0293	Continued from page 8 meeting	
K0345 SS = F	Fire Alarm System - Testing and Maintenance	K0345	- All current residents have the potential to be	04/24/2025

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K0345 SS = F	Continued from page 9 CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview on 03/26/2025 in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure A) that smoke detectors were inspected for sensitivity and B) Battery powered smoke and carbon monoxide detectors were inspected, tested, and maintained in accordance with the manufacture provided user manuals and NFPA 101:2012 Edition, Section 9.6.1.5, NFPA 70 and NFPA 72:2010 Edition, Section 14.4.4.3.1. These deficient practices had the potential to affect all residents and was evidenced by the following: A record review on 03/26/2025 revealed that the provided report for smoke detector sensitivity testing did not indicate the current sensitivity range of the detectors nor did it indicate whether the smoke detectors were within range or needed calibration. In an interview at the time, the U.S. FOIA (b) confirmed the observation and stated that they were told the smoke detectors were self-reporting, and that the report that was provided for review was the report that was provided to them when they requested sensitivity testing. A record review on 03/26/2025 revealed that battery powered smoke and carbon monoxide detectors were inspected monthly and only in resident rooms. A review of the provided manufacturer recommendations indicated that weekly testing was required. An observation on 03/26/2025 at 12:06 PM revealed that the battery powered smoke detector in the employee	K0345	Continued from page 9 affected by an outdated or incomplete Emergency Preparedness Plan. Therefore, a comprehensive review was conducted to ensure that smoke and carbon monoxide testing equipment is functional to ensure the safety of our residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Smoke detector sensitivity testing completed by licensed contractor. - Battery-operated detectors inspected and documented. - Maintenance and Life Safety staff re-educated on NFPA 72 requirements by the U.S. FOIA (b)(6) [redacted]. - Semi-annual and annual testing schedules updated. - Review testing in quarterly QAPI	

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K0345 SS = F	Continued from page 10 lounge contained an installation sticker that was not filled out. In an interview at the time, the survey asked the U.S. FOIA if they had Inspection, Testing and Maintenance (ITM) documentation for the detector in the employees lounge. The U.S. FOIA confirmed that battery operated smoke and carbon monoxide detectors were only inspected monthly and stated that only battery powered smoke detectors in resident rooms were documented. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 70, 72	K0345		
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by:	K0351	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our sprinkler system meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Exposed CPVC piping protected. - Sprinkler heads corrected per smoke compartment requirements. - Awning fire protection addressed with sprinkler coverage. - Facility-wide sprinkler head review completed. - Education of the Maintenance Staff conducted by the U.S. FOIA (b)(6) on Sprinkler compliance. - Quarterly inspections scheduled with vendor. - Quarterly inspection results to be reviewed in the quarterly QAPI meeting	04/24/2025

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K0351 SS = F	Continued from page 11 Based on observations and interviews on 03/26/2025 and 03/27/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that sprinkler system installation was in accordance with NFPA 101:2012 Edition, Section 19.3.5.1 and NFPA 13. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 03/26/2025 at 12:31 PM revealed that the north branch lounge contained quick response and standard response sprinkler heads in the same smoke compartment. An observation at 12:06 PM revealed that the nourishment room contained exposed, unprotected CPVC sprinkler piping. An observation at 1:18 PM revealed that the electrical room contained exposed, unprotected CPVC sprinkler piping. Additionally, pendent sprinkler heads were installed where sidewall sprinkler heads were required. An observation at 1:23 PM revealed that the Pavilion entrance contained a 6-foot by 6-foot awning that was attached to the building and constructed of combustible material. Sprinkler protection was not provided. An observation at 1:39 PM revealed that the rehab gym contained quick response and standard response sprinklers in the same smoke compartment. An observation on 03/27/2025 at 11:51 AM revealed that the kitchen area contained different temperature rated sprinkler heads in the same smoke compartment. In interviews at the time, the US FOIA [redacted] confirmed the observations. The US FOIA [redacted] provided documentation for the exposed {Brand Name Redacted} CPVC sprinkler piping. {Brand Name Redacted} Technical Manual, Listings & Approvals, Pg. 6-7 requires the CPVC piping to have minimum protection of either 3/8" gypsum wallboard, ½" plywood soffits, or a suspended membrane ceiling with lay-in panels or tiles having a weight of 0.35 pounds per sq ft.	K0351		

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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) COMPLETION DATE
K0351 SS = F	Continued from page 12 The facility's U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 13	K0351		
K0363 SS = F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K0363	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our fire doors meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Rolling fire door repaired for full closure and positive latch. - All corridor doors inspected for compliance. - Monthly audits initiated. - Maintenance and Safety Committee educated on requirements by the U.S. FOIA (b)(6) - Audit results to be reviewed in the facility Quarterly QAPI meetings	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

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K0363 SS = F	Continued from page 13 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 03/27/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that doors protecting corridor openings could resist the passage of smoke in accordance with NFPA 101:12 Edition, Section 19.3.6.3 and NFPA 80. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:51 AM revealed that there was a rolling fire door between the kitchen and the corridor that was used for serving food. The rolling fire door was not able to fully close and did not contain positive latching hardware. In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 80	K0363		
K0364 SS = F	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed	K0364	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our corridor windows meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Non-fixed windows replaced with fixed fire-rated assemblies. - Maintenance educated on NFPA requirements by the U.S. FOIA (b)(6) . - Quarterly inspections scheduled. - Inspections to be reviewed with the QAPI committee in its quarterly meeting	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

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K0364 SS = F	Continued from page 14 window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/27/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that windows in corridor walls were installed in fixed window assemblies in accordance with NFPA 101:2012 Edition, Sections 19.3.6.5.2 and 8.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 03/27/2026 at 12:10 PM revealed that there were 2 non-fixed window assemblies inbetween the Atrium and corridor. In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	K0364		
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K0761	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our fire door assemblies meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Fire door inspection program implemented per NFPA 80. - Annual vendor inspection contracted. - Maintenance re-educated on inspection requirements by the U.S. FOIA (b)(6) . - Annual review monitored by U.S. FOIA (b)(6)	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

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K0761 SS = F	Continued from page 15 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on record review and interview on 03/26/2025 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that fire door assemblies were inspected, tested and maintained (ITM) annually in accordance with the minimum requirements of NFPA 80:2010 Edition, Section 5.2.1 and 5.2.4.2 (1) - (11). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 03/26/2025 revealed that the facility identified 10 pair of swinging fire doors on their evacuation plan. Documentation of annual fire door assembly's ITM could not be found in the documentation that was provided for review. In an interview at the time, the U.S. FOIA [redacted] confirmed that fire door assemblies were not inspected annually in accordance with the minimum requirements of NFPA 80 and stated that the fire alarm company did inspect and document the testing of the releasing devices of the fire doors in their semiannual fire alarm reports. The facility's U.S. FOIA (b)(6) [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 80	K0761	Continued from page 15 - Inspections to be reviewed quarterly with the QAPI committee	
K0911 SS = F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This	K0911	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our gas provider meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice.	04/24/2025

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K0911 SS = F	Continued from page 16 information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and interview on 03/26/2025 and 03/27/2025 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to demonstrate reliability regarding fuel supply for its natural gas emergency generator in accordance with NFPA 99: 2012 Edition Chapter 6 and NFPA 110: 2010 Edition, Section 5.1.4. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review on 03/27/25 revealed that a letter of reliability from the natural gas provider only stated that the supply of gas cannot be interrupted and that the account was under contract until December 2025. Reliability letters from the natural gas vendor regarding fuel supply must contain all the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. In an interview at the time, the US FOIA (b [redacted] confirmed the observation.	K0911	Continued from page 16 - Updated letter from gas provider obtained. - Staff educated regarding required documentation by the U.S. FOIA (b)(6) [redacted]. - Letter to be updated annually. - Compliance will be reviewed annually in the quarterly QAPI meeting	

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K0911 SS = F	Continued from page 17 The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 110	K0911		
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 03/27/2025 in the presence of the [redacted], it was determined that	K0918	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our generator meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - Monthly electrolyte testing initiated. - Maintenance educated on requirements by the [redacted] - Monthly logs implemented. - Logs will be reviewed in the quarterly QAPI meetings	04/24/2025

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K0918 SS = F	Continued from page 18 the facility failed to ensure that inspection, testing and maintenance of essential electric systems were in accordance with NFPA 110:2012 Edition, Sections 7.3.1 and 8.3.7.1. These deficient practices had the potential to affect all residents and was evidenced by the following: An observation on 03/27/2025 at 12:19 PM revealed that the emergency diesel generator contained a lead acid battery. In an interview at the time, the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid battery. The [redacted] confirmed that the battery was not a sealed lead-acid battery and stated that monthly testing was not conducted. The facility's [redacted] was informed of the deficient practices at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 110	K0918		
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are	K0921	- All current residents have the potential to be affected by this deficient practice. Therefore, a comprehensive review was conducted to ensure that our patient care related equipment meets the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - PCREE testing completed on all equipment. - Missed items inspected and documented. - Policy revised and staff educated by the [redacted] - QAPI committee to review testing and inspection results quarterly.	04/24/2025

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K0921 SS = F Bldg. 01	Continued from page 19 legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review, observations and interviews on 03/26/2025 and 03/27/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance (ITM) of Patient Care Related Electrical Equipment (PCREE) was in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 03/26/2025 revealed that the provided PCREE inspection report did not indicate what was inspected, tested and maintained on the PCREE. An observation at 11:48 AM revealed that 2 of 2 patient care beds in resident room [redacted] did not have a PCREE inspection stickers. In an interview at the time, the [redacted] confirmed the observation and stated that the beds were checked by a vendor periodically and they would reach out to them for documentation. An observation at 11:50 AM revealed that 2 vital sign machines were in the west wing corridor near room [redacted]. PCREE inspection stickers indicate that the last inspection was conducted on 09/13/2023 and 08/14/2023. In an interview at the time, the [redacted] confirmed the observation and stated that they must have missed these on the last inspection. No further documentation was provided regarding PCREE inspections of patient care beds.	K0921		

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K0921 SS = F Bldg. 01	Continued from page 20 The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 03/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K0921		

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E0000	Initial Comments This facility is in NON-COMPLIANCE with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E0000		
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	- All current residents have the potential to be affected by an outdated or incomplete Emergency Preparedness Plan. Therefore, a comprehensive review was conducted to ensure that the EPP reflects the needs of all residents, including those with mobility impairments, cognitive impairments, and specialized care needs. No adverse outcomes were identified as a result of the deficient practice. - The facility's Emergency Preparedness Plan (EPP) was immediately reviewed and updated following survey. - Administrator/designee will conduct an annual review every January to ensure ongoing compliance. - A calendar reminder has been implemented and maintained in the Administrators calendar. - All department heads were educated by the U.S. FOIA (b)(6) on CMS requirements for EPP annual review. - QA Committee will audit EPP review annually.	04/24/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315182	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2025

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E0004 SS = F	Continued from page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on record review and interview on 3/27/2025, in the presence of the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that the Emergency Preparedness Program (EPP) was reviewed and updated annually. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed that documentation of annual review and update could not be located in the EPP. In an interview at the time, the U.S. FOIA (b)(6) confirmed the record review. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/27/2025 at 2:00 PM. N.J.A.C 8:39-31.2 (e)	E0004		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315182 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/3/2025 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix / Reg. # NFPA 101 / LSC K0211	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0222	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0225	Correction Completed 04/24/2025
ID Prefix / Reg. # NFPA 101 / LSC K0233	Correction Completed 05/31/2025	ID Prefix / Reg. # NFPA 101 / LSC K0281	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0291	Correction Completed 04/24/2025
ID Prefix / Reg. # NFPA 101 / LSC K0293	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0345	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0351	Correction Completed 04/24/2025
ID Prefix / Reg. # NFPA 101 / LSC K0363	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0364	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0761	Correction Completed 04/24/2025
ID Prefix / Reg. # NFPA 101 / LSC K0911	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0918	Correction Completed 04/24/2025	ID Prefix / Reg. # NFPA 101 / LSC K0921	Correction Completed 04/24/2025

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 3/31/2025

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