

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Bergen New Bridge Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE  230 E Ridgewood Ave Paramus, NJ 07652	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.  (continued on next page)

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 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Bergen New Bridge Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE  230 E Ridgewood Ave Paramus, NJ 07652	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Complaint # 2665060 Based on interviews, medical record review, and review of pertinent facility documentation, it was determined on 11/18/25, that the facility failed to ensure the Certified Nursing Assistant (CNA) flow sheets were complete and accurate. this deficient practice was identified for 2 of 3 residents reviewed for resident accuracy (Resident #1, and Resident #2).The findings were as followed: 1.A review of the admission Record (AR) revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to; pneumonia and urinary tract infection. A review of Resident #1's comprehensive Minimum Data Set (MDS), an assessment tool dated 10/28/25, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 3 of 15, indicating that the resident's cognition was severely impaired. A review of Resident #1's care plan with an original date of 5/5/25 revealed that the resident needed assistance with self care and mobility due to non-ambulatory status and impaired functional mobility related to hx (history) of [stroke] with right hemiparesis and aphasia. A review of Resident #1's CNA Flow Sheet a form utilized for Activities of Daily Living (ADL) care by the CNAs for November 2025, revealed multiple blank sections where care tasks were not recorded. These blank areas further revealed that the CNAs did not document care was provided, as follows: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing, drying face and hands (excludes baths, showers and oral hygiene) were blank on 11/1/25, 11/2/25, 11/4/25, 11/5/25, 11/6/25, 11/7/25, 11/8/25, 11/9/25, 11/10/25, 11/11/25, 11/12/25, 11/13/25, 11/14/25, 11/15/25, 11/16/25, and 11/17/25 on the day shifts. The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment were blank on 11/1/25, 11/2/25, 11/4/25, 11/6/25, 11/8/25, 11/10/25, 11/11/25, 11/12/25, 11/13/25, 11/14/25, 11/15/25, 11/16/25, and 11/17/25 on the day shift. The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment were blank on 11/5/25, 11/7/25, 11/8/25, and 11/9/25 on the night shift. The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in and out of tub and shower was blank on 11/9/25 during the night shift The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing and drying face and hands (excludes baths, showers, and oral hygiene) were blank on 11/2/25, 11/5/25, 11/7/25, 11/8/25, 11/9/25, 11/11/25, 11/12/25, and 11/17/25 on the night shift. On 11/12/25 at 10:50 AM, an interview was conducted with the CNA, who revealed that the CNAs were responsible for providing the residents with activities of daily living care. The CNA further revealed that all tasks were required to be documented in the Point of Care (POC) system. On 11/12/25 at 11:00AM, an interview was conducted with the Nurse Manager, who stated that it was the expectation that the CNAs documented in the POC and that the assigned nurses reviewed and confirmed the documentation. On 11/12/25 at 2:04 PM, an interview was conducted with the Assistant Director of Nursing (ADON) who stated that all nursing staff was responsible for the resident's care. The ADON further revealed that CNAs document all care in the POC and the ADON also confirmed that there should not be any blanks in the POC. 2.A review of Resident #2's admission Record (AR) revealed on 11/12/25, that the section designated for the resident's medical diagnoses was left blank. A review of Resident #2's Medication Administration Record for November 2025, revealed in the section designated for diagnoses that the resident had diagnoses, that included but were not limited to; disease of spinal cord and quadriplegia. A review of Resident #2's comprehensive MDS dated [DATE], revealed that the resident had a BIMS score of 15 of 15, indicating that the resident's cognition was intact. A review of Resident #2's care plan with an original date of 9/2/25, revealed that the resident had self care deficit secondary to quadriplegic status, dx. (diagnosis) disease of spinal cord, diabetes, hypertension, gastroesophageal reflux disease, polyneuropathy [nerve damage]. The resident was dependent for assistance in all ADL areas. A review of Resident #2's CNA Flow Sheet for November 2025, revealed multiple blank sections where care tasks were not recorded. These blank areas further revealed that the CNAs did not document care provided as follows: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing, drying face and hands (excludes baths, showers and oral hygiene) were blank on 11/1/25, 11/2/25, 11/4/25, 11/5/25, 11/7/25, 11/8/25, 11/10/25, 11/12/25, 11/13/25, 11/14/25, 11/15/25, and 11/16/25 on the night shift. The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing, drying face and hands (excludes baths, showers and oral</p>		