

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2025
NAME OF PROVIDER OR SUPPLIER  Bridgeway Care and Rehab Center at Bridgewater		STREET ADDRESS, CITY, STATE, ZIP CODE 270 Route 28 Bridgewater, NJ 08807	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Complaint #: 2648621 Based on interviews, medical record review, and review of other pertinent facility documentation on 10/23/2025, it was determined that the facility failed to implement their abuse policy to ensure all residents were protected from abuse, when Resident #2 alleged the Certified Nursing Assistant (CNA #1) physically abused them, and CNA #1 was taken off the resident's assignment, but remained on that nursing unit assisting other residents as well as having access to Resident #2. This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #2) and had the potential to affect all residents. On 10/19/2025 at approximately 6:00 PM, Resident #2 reported to the facility's Nursing Supervisor (NS#1) that CNA #1 pulled their arms and punched them. NS #1 removed CNA #1 from Resident #2's care and reassigned another CNA. CNA #1 remained on that nursing unit providing care to other residents as well as having access to Resident #2 until the end of the shift at 11:00 PM that same evening. On 10/23/2025 at 9:51 AM, an interview was conducted with Resident #2, who stated an aide was rough with them, so the resident told the people in charge. An interview with NS #1, on 10/23/2025 at 1:00 PM, revealed that Resident #2 did approach her about the alleged abuse by CNA #1 and she did re-assign another CNA to provide care to the resident. CNA #1 was not sent home after the allegation of abuse and continued to care for other residents for the remainder of that shift. An interview with the Director of Nursing (DON) on 10/23/2025 at 1:37 PM, revealed that she became aware of the abuse allegation on 10/20/2025 and according to the facility policy, CNA #1 should have been sent home, pending the completion of the investigation. The facility's failure to implement their abuse policy and to protect residents from potential abuse, by not immediately removing CNA#1, who continued to work having access to Resident #2 and other residents until an investigation was completed, placed Resident #2 and all residents at risk for abuse. This posed the likelihood of serious physical and psychosocial harm, or impairment which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 10/19/2025 at approximately 6:00 PM, after Resident #2 informed NS #1 that they were punched and had their arms pulled by CNA#1. The facility Administration was notified of the IJ on 10/23/2025 at 4:02 PM. The facility submitted a Removal Plan (RP) on 10/30/2025 at 2:00 PM. The Surveyor verified the implementation of the RP on-site during a continuation survey on 10/30/2025. The evidence was as follows: The facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with a revised date of April 2021, was reviewed. Under, Policy Interpretation and Implementation, the policy revealed, The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; This section of the facility policy further revealed 2. Develop and implement policies and protocols to prevent and identify a. abuse or mistreatment of residents; [ ] 10. Protect residents from further harm during investigations. A review of the Facility Reportable Event (FRE) dated 10/20/2025, revealed the following: On 10/19/2025 at approximately 6:00 PM, Resident #2 made an accusation to facility staff that CNA #1 hurt them and does not help them. The FRE included that the accused CNA was removed from the assignment pending investigation. According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: heart failure (condition where the heart muscle does not pump blood as well as it should); bipolar disorder (mental health condition that causes extreme mood swings); low back pain; depression (mood disorder that causes a persistent feeling of sadness and loss of interest); anxiety disorder (intense, excessive and persistent worry and fear about everyday situations); and fracture of superior rim of the left pubis (broken bone in the pelvis). According to the Minimum Data Set (MDS), an assessment tool dated 09/03/2025, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident's cognition was intact. The MDS further revealed that Resident #2's speech was clear, and the resident had the ability to make their ideas and wants understood. A Progress Note (PN) written by Registered Nurse #1 (RN #1), dated 10/19/2025 at 11:44 PM, was reviewed. The PN revealed that Resident #2 complained to the Supervisor on duty (NS #1) that CNA #1, hurt and doesn't help them. The PN revealed that CNA #1 was removed from Resident #2's care and replaced with a different CNA (CNA #2). The PN further revealed that a skin assessment was performed on Resident #2 which revealed no visible injuries but showed the presence of old bruising to the resident's upper extremities. An undated facility Investigation Summary and Conclusion: document was reviewed. Under Investigation Summary, the document revealed that on</p>		