STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeway Care and Rehab Center at Hillsborough	395 Amwell Road Hillsborough, NJ 08844

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, document review and policy review, the facility failed to report an allegation of injury of unknown origin for one (Resident (R) 104) of two abuse allegations reviewed in the sample of 31 residents to the State Agency (SA) immediately, but no later than 2 hours after the incident. This failure had the possibility to negatively impact residents currently residing at the facility. Findings include: Review of facility's policy titled, Investigation, Incident and Reporting, revised 02/19/25, indicated, [name of the facility] is committed to. abuse-free environment. All staff are required to report any allegation or suspicion of abuse, neglect, exploitation, or mistreatment immediately. The facility will ensure that all incidents are reported to the appropriate regulatory agencies.Policy Interpretation and Implementation: The [name of state] Department of Health.via the online reporting system or hotline, Initial report must be made within 2 hours if the incident involves serious bodily injury and/or is related to abuse/neglect.Review of R104's admission Record in the electronic medical record (EMR) under the Census tab revealed R104 was re-admitted to the facility on [DATE] with the diagnosis of dementia. Review of R104's annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/12/25 in the EMR under the MDS tab with a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating R104's cognition was severely impaired. Review Nursing Note dated 09/14/25 provided by the facility indicated, 11:20 PM: Certified Nursing Assistant [(CNA) 2] informed writer [Licensed Practical Nurse (LPN) 4] while giving report, R104 has hematoma on the left elbow. [CNA4] assigned to R104 on the 3-11 PM shift was informed and verbalized he did not see the hematoma as R104 was wearing arm sleeves on both hands. 7-3 AM nurse did not verbalize any skin changes while giving report. No evidence of injury of unknown origin is being reported to the supervisor. Review of facility provided [name of state] Department of Health Facility Information Reporting Category Long Term Care, (initial report) dated 09/15/25, indicated, .R104 was reported to have a bruise on his left elbow. R104 is unable to say what occurred. BIMS-03 [Brief Interview for Mental Status], relevant dx: dementia, muscle weakness, bone density disorder. R104 is on anticoagulant and has been care planned for risk of bruising and bleeding There is no evidence that this injury of unknown origin was reported to the SA within the two-hour timeframe. During interview on 01/20/26 at 3:00 PM, the Administrator indicated that there is a two-hour reporting timeframe to report any initial abuse allegations to the SA; however, the Administrator stated that the [name of the state] Department of Health does not include injury of unknown origin within that two hour timeframe to report unless the resident cannot tell staff what happened. Stated that [name of the state] has 24 hours to report injury of unknown origin. In addition, the Administrator said that the facility does not contact the police. Said that the facility leaves that up to the resident, and/or the family. Interview on 01/21/26 at 2:17 PM, LPN4 stated that he worked the 3-11 shift on 09/14/25, and that R104 was noticed throughout the evening shift, pulling on his Geri-sleeves. LPN4 confirmed (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	that the Supervisor was not made aware and indicated that if an incident is unwitnessed, it should be reported immediately. LPN4 stated that he spoke with the Director of Nursing (DON) the next morning. Interview on 01/22/26 at 8:45 AM, CNA2 said that upon beginning her 11-7 shift, she went to change R104 and discovered that R104 had a bruise to the left elbow area. CNA2 reported the bruise immediately to LPN4. Interview on 01/22/26 at 6:15 PM, the DON indicates that he was not unaware that an injury of unknown origin should be reported to the SA within two hours after having knowledge of the incident. NJAC 8:39-9.4(f)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and policy review, the facility failed to thoroughly investigate an allegation of an injury of unknown origin for one (Resident (R) 104) of one resident and failed to thoroughly investigate an allegation of physical abuse for R178, out of two residents reviewed for abuse in a sample of 31 residents. This failure had the potential to negatively impact all residents residing at the facility. Findings include: 1.Review of R104's admission Record in the electronic medical record (EMR) under the Census tab revealed R104 was re-admitted to the facility on [DATE] with the diagnosis of dementia. Review of R104's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/25 located in the EMR under the MDS tab with a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating R104's cognition was severely impaired. Interview on 01/19/26 at 1:40 PM, attempts to interview R104; however, R104 was confused and unable to answer any questions. During interview, observed his skin, which appeared to be paper thin. R104 was wearing Geri-sleeves on bilateral arms. Review of the facility provided Nursing Note dated 09/14/25 indicated, 11:20 PM: Certified Nursing Assistant [(CNA) 2] informed writer [Licensed Practical Nurse (LPN) 4] while giving report, R104 has hematoma on the left elbow. No evidence of injury of unknown origin was reported to the supervisor. Review of facility provided [name of state] Department of Health Facility Information Reporting Category Long Term Care, (initial report) dated 09/15/25 indicated, .R104 was reported to have a bruise on his left elbow. R104 is unable to say what occurred.R104 is on anticoagulant. Review of facility provided undated Reportable Event Summary (5-day summary) indicated, History: On 09/14/25 at around 11 PM, [CNA 2] was providing care to R104 when she noticed discoloration on his left elbow. Conclusion: A thorough investigation was conducted, including skin assessment, resident interview, review of risk factors and care plan interventions. The bruise was first noted on 09/14/25 at around 11:00 PM, and no injuries were observed the day prior during bathing, making the shower the most probable cause . Review of the investigation revealed that there was no evidence of residents' interviews, and no evidence of LPN4's interview. Interview on 01/21/26 at 2:17 PM, LPN4 stated that he worked the 3-11 shift on 09/14/25 and that throughout the evening shift, R104 was pulling on his Geri-sleeves. LPN4 indicated that he wrote a progress note after he was notified of the bruised area on R104's left elbow area. LPN4 stated that he spoke with the Director of Nursing (DON) the next morning. Interview on 01/22/26 at 8:45 AM, CNA2 said that at the beginning her 11-7 shift, she went to change R104 and discovered that R104 had a bruise to left elbow area. CNA2 reported the bruise immediately to LPN4. Interview on 01/22/26 at 6:15 PM, the DON confirmed that LPN4 was not spoken to during the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	investigation. Interview on 01/22/26 at 6:50 PM, the DON indicated since this was an injury of unknown origin, no resident interviews would be conducted. 2.Review of R178's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD). Review of R178's annual MDS with an ARD of 11/01/25 and in the EMR under the MDS tab revealed a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. Review of R178's Nurse's Note dated 01/13/26 at 7:00 PM and located in the EMR under the Notes'' tab written by Registered Nurse (RN) 4 revealed, On 1/11/25 around 7:00 PM resident has a care concerned with her CNA [CNA9]. CNA immediately removed from assignment . Review of the undated Facility's Five Day Follow Up revealed the incident was 01/11/25 at 7:00 PM, R178 reported to the supervisor that she was looking for her cell phone when the assigned aide, [CNA9] insisted on putting her to bed first, then looking for her phone. R178 stated that the aide proceeded to grab her arm and remove her dress with force. R178 started screaming that she was hurting her arm. The summary and conclusion indicated, The facility is substantiating staff to resident abuse at this time. Further review of the investigation revealed not all staff working were interviewed, there was no documentation of the roommate's interview or other residents' interviews. During an interview on 01/22/26 at 5:22 PM, the DON stated that they did not document the roommate or other residents' interviews, but they were done. He stated they did not interview additional staff since the roommate confirmed the abuse, they did not feel the need to do additional interviews. Review of the facility's policy titled, Investigation, Incident and Reporting revised 02/19/25, indicated, [name of the facility] is committed to.abuse-free environment. All staff are required to report any allegation or suspicion of abuse, neglect, exploitation, or mistreatment immediately. The facility will ensure that all incidents are. investigated promptly and thoroughly, and that corrective actions are taken, as necessary. Policy Interpretation and Implementation.3. Initiation of Investigation: The Administrator or designee will initiate a thorough investigation within 24 hours of receiving the report. The investigation may include: Interviewing the resident(s), witnesses, and involved staff Reviewing medical records, assignments, and surveillance (if available) Examining physical evidence or the environment All interviews and findings will be documented in a confidential investigation report. NJAC 8:39-9.4(f)