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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and document review, the facility failed to ensure three of three residents and their resident representatives (R)10, R159, R1 and R164) reviewed for emergent hospital transfer out of a total sample of 31 residents were provided with a written bed hold policy and transfer notice that contained the appeal process. This failure had the potential to affect the resident and their resident representative (RR) by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings include: 1.Review of R10's admission Record located under the Profile tab in the electronic medical record (EMR) revealed admitted to the facility on [DATE]. Review of R10's Progress notes dated 11/22/25 revealed R10 was transferred to the hospital due to bladder prolapse and returned to the facility on [DATE]. R10 returned to the hospital on [DATE] for repair of bladder prolapse and returned on 01/14/26 Review of R10's Medicare five-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R10's cognition was moderately impaired. 2.Review of R159's admission Record under the Profile tab in the EMR revealed admitted on [DATE]. Review of R159's Census located under the Census tab in the EMR revealed on 01/04/26 Hospital Paid Leave and on 01/16/26 returned to the facility. Review of R159's EMR located under the MDS tab revealed the admission MDS with an ARD of 11/18/25 revealed a BIMS score of 15 out of 15 indicating cognitively intact. Review of R159's Progress Note dated 01/04/26 located under the Progress Note tab of the EMR revealed R15 had altered mental status. New order received to send to hospital for evaluation and treatment. Ambulance in to transport resident. Review of Transfer/Bed Hold notice prior to Hospitalization or Therapeutic Leave provided by the facility for R10 and R159 revealed that the document did not include the appeal process. 3.Review of R1's admission Record located under the Resident tab in the EMR revealed admitted to the facility on [DATE] and readmitted on [DATE]. Review of R1's admission MDS with an ARD of 11/08/25 revealed a BIMS score of 11 out of 15 which indicated R1 was moderately cognitively impaired. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R1's Progress Note dated 12/16/25 located under the Resident tab of the EMR written by Unit Manager (UM) revealed received verbal order to send R1 to emergency room (ER) for further evaluation. Review of Notice of Emergency Transfer dated 12/27/25 revealed it did not indicate the appropriate appeal information. 4. Review of R164's Face Sheet located under the 'admissions tab revealed that R164's original admission date was 08/13/25 with a current admission date of 01/11/26. The Face Sheet indicated that R164's most recent hospital stay was from 01/01/26- 01/11/26. Review of R164's transfer notice located under the miscellaneous tab in the EMR revealed on 01/01/25, R164 was transferred to the hospital for abnormal hemoglobin. The transfer notice did not provide the appeal process. During an interview on 01/22/26 at 11:16 AM, the Admissions Director (AD) stated when a resident was transferred to the hospital she would contact their emergency contact and let them know. They would be provided with a bed hold letter, and information to reach out to the Ombudsman if they disagree with the transfer. No other information was provided to the family or resident regarding how to appeal other than the Ombudsman contact information. NJAC 8:39-4.1(a)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation record review and interview, the facility failed to ensure a resident's rights (R59) was honored when staff attempted to transfer the resident after the resident refused, causing a skin tear for one resident (Resident (R)59) of one resident reviewed for dignity in the sample of 31 residents. This had the potential to affect all residents receiving care. Findings include:Review of R59's admission Record located in the Profile tab of the electronic medical record (EMR) revealed on 11/23/25, with diagnosis of transient cerebral ischemic attack. Review of R59's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/01/26, and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of five out of 15, which indicated the resident's cognition was severely impaired.Review of R59's Other Incident Report dated 12/14/25 at 4:30 PM, written by Registered Nurse (RN)3 and Nurse's Notes dated 12/14/25, in the EMR under the Notes tab revealed, writer and 2 CNA [Certified Nurse Aides] staff was transferring the patient from bed to chair.During transfer his right hand contacted the side rail and left hand contacted the wheelchair, 5 cm [centimeter] long and 1.2 cm wide skin tear with partial flap loss.During an interview 01/21/25 4:02 PM, CNA7 Stated on 12/14/25, R59 did not want to be transferred out of the bed. CNA7 said R59 was adamant and did not want to be messed with. He wanted to be left in the bed. CNA7 said staff should have respected his right to refuse care and left him in the bed. She said nothing was reported to the nurse about his refusal and the wife's demand until R59 got hurt. During an interview on 01/21/26 at 4:20 PM, RN3 said a resident has the right to refuse care, and staff should honor that right even when a family member demanded the care be given. On 12/14/25 she heard noise coming from R59's room. When she went into the room, she observed staff trying to transfer the resident, but he was holding onto the side rails and would not let go. He was leaning back into his bed. Staff continued to transfer him out of the bed, and he hit his arm on the side rail and was injured. During an interview on 01/22/26 at 1:26 PM, CNA8 stated that all residents have the right to refuse care. When a resident refuses care, CNAs are supposed to report it to the nurse. On 12/14/25, she observed two other CNAs going into the resident's room along with the wife. She said the wife wanted R59 taken out of the bed. She overheard one of the CNAs tell a nurse that R59 did not want to get out of bed, but the wife was agitated. She went into the resident's room and observed R59 holding onto the side rails refusing to get out of the bed. She left the room. During an interview on 01/22/26 at 5:22 PM, the Director of Nursing (DON) said staff should honor a resident's right to refuse care regardless of their cognition. NJAC 8:39:4.1(a)NJAC 8:39:5.1(a)NJAC 8:39:27.1(a)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to protect the resident's right to be free from physical abuse by staff for one of five residents (Resident (R)178) reviewed for abuse out of 31sample residents. This had the potential to affect residents in the facility who were at risk for abuse. Findings include:Review of R178's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE], with diagnosis of chronic obstructive pulmonary disease (COPD).Review of R178's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/25, and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact.Review of R179's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted on [DATE], with diagnosis of heart failure.Review of R179's quarterly MDS with an ARD of 01/06/25 and located in the EMR under the MDS tab revealed a BIMS score of 15 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 concern with her CNA [Certified Nurse Aide]. CNA immediately removed from assignment. Skin assessment done, family and primary made aware of the incident.Review of the undated Facility's Five Day Follow Up indicated the incident was on 01/11/25 at 7:00 PM. Further, review revealed, R178 reported to the supervisor that she was looking for her cell phone when the assigned aide [CNA9] walked into the room for PM [evening] care. R178 told the aide that she needed to find her phone before being put into bed but that the aide 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. [CNA9] was placed on our do not return list and has been blocked to pick up further shifts. The Agency has also been made aware.During an interview on 01/21/26 at 1:45PM, CNA9 stated that on 01/11/25, at bedtime she went into R178's room. She said R178 was looking for her phone, so she helped her look for phone. She said R178's roommate [R179] was in the room. CNA9 told R178 she would put her in bed and then she would look in wheelchair for phone. At that time, the roommate [R179] yelled No, help her find her phone first and don't touch her. At that time, she left the room and found a registered nurse [(RN)4] and reported that R178 was refusing to be put in bed. RN4 told her to give R178 about forty minutes and try again. She went back and RN4 went into room with her and she told R178 that she wanted to change her and get her in bed. The roommate [R179] again yelled at her that R178 wanted her phone. RN4 closed the curtain separating the residents, and the roommate [R179] opened the curtain, and said to keep it open so she could see. At that time, CNA9 walked out of the room and RN4 came out and continued passing medications. About three minutes later, R178 came out of the room in her wheelchair and appeared to be looking around for the phone and went back into her room. RN4 went into the room at which time R178 started screaming and crying, stating that CNA9 broke her hand. The roommate [R179] was screaming that yes, she hurt her. RN4 asked CNA9 if she hurt R178. CNA9 said No. She was told not to go back into R178's room. During an interview on 01/21/26 at 3:37PM, RN4 said on the night of 01/11/25, R178 was looking for cell phone. The phone was found on the resident's wheelchair underneath R178. RN4 stated that another staff member said that R178 was upset. He spoke with R178 who appeared very emotional and she told him that CNA9 was trying to hurt her. The roommate [R179] confirmed she witnessed CNA9 hurt R178. CNA9 was taken off the floor and asked to leave. During an interview on 01/22/26 at 5:22 PM the Director of Nursing (DON) said they substantiated the staff to resident abuse. Review of the facility's policy Abuse, Neglect, Exploitation and Misappropriation PreventionProgram revised 06/23/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from.physical abuse. NJAC 8:39-4.1(a)NJAC 8:39-5.1(a)NJAC 8:39-9.4(f)NJAC 8:8:39-27.1(a)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that an accurate Preadmission Screening and Resident Review (PASARR) Level I assessment was completed for one resident (Resident (R) 9 one of resident reviewed for PASARR out of 31 sampled residents. This created a potential failure to identify what specialized or rehabilitative services the resident needed.Findings include:Review of R9's''admission Record'' located in the ''Profile'' tab of the EMR revealed R9 admitted to the facility on [DATE] with diagnoses including bipolar disorder and post-traumatic stress disorder (PTSD). Review of R9's Diagnosis List revealed bipolar disorder, and post-traumatic stress disorder (PTSD) dated 12/27/25. Review of R9's NJ [New Jersey] Department of Human Services Pre-admission Screening and Resident Review (PASRR) Level I screen dated 12/24/25 and located in the EMR under the Miscellaneous tab revealed no indication of mental illness was identified. During an interview on 01/22/26 at 9:45 AM, the Social Services Director (SSD) reviewed R9 PASARR Level I. She was unable to provide an additional Level I that was completed accurately and timely. During an interview on 01/22/26 at 5:22 PM, the Director of Nursing (DON) said he expected staff to complete assessments timely and accurately. NJAC 8:39-5.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review, the facility failed to ensure an active physician order for oxygen administration for one of one resident (Resident (R) 93) reviewed for oxygen administration of 31sample residents This failure had the potential for the residents to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen).Findings include:Review of R93's admission Record located in the Profile tab of the electronic medical record (EMR) revealed admitted on [DATE] with diagnosis of acute and chronic respiratory failure. Review of R93's admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/29/25, revealed a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated R1 was severely cognitively impaired. Review of R93's Care Plan located under the Care Plan tab of the EMR dated 12/29/25 revealed the resident was not care planned for oxygen. Review of R93's Physician Orders located under the Orders tab in the EMR, dated 01/20/25, revealed no current order for oxygen. During observations on 01/19/25 at 8:13 AM, 01/20/25 at 10:15 am and on 01/22/26 at 8:35 AM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at two liters per minute (LPM). During an interview on 01/22/25 at 8:45 AM, Registered Nurse (RN)1 confirmed R9 received oxygen and that a resident should not receive oxygen without a physician order. During an interview on 01/22/26 at 5:22 PM, the Director of Nursing (DON) stated that a resident should not received oxygen without a physician order. Review of the facility's policy titled Oxygen Administration dated 11/15/25 revealed the purpose of this procedure is to provide guidelines for safe oxygen administration'. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocolfor oxygen administration. Review the resident's care plan to assess any special needs of the resident. NJAC 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, policy review, and interviews, the facility failed to ensure that staff changed gloves when going from a soiled to a clean area while providing wound care for one of two residents (Resident (R) 78) reviewed for wound care to prevent possible cross contamination. In addition, the facility failed to ensure that staff cleansed the indwelling urinary catheter and changed gloves when going from a soiled to a clean area, for one of two residents (R78) observed for catheter care, to prevent possible urinary tract infections. Findings include: 1. During catheter observation on 01/21/26 at 9:33 AM with Registered Nurse (RN) 1, gathered all the catheter items, applied her personal protective equipment (PPE). RN1 sanitized her hands and donned gloves. RN1 unfastened R78's incontinence brief and completed peri-care; however, RN1 did not clean the catheter. Without changing her gloves, RN1 rinsed R78's perineal area, and patted dry. RN1 removed the basins, doffed the gloves, and sanitized her hands. 2. During wound care on 01/21/26 at 9:38 AM, RN1 gathered supplies and placed the items on the barrier. RN1 sanitized her hands and donned gloves. RN1 cleansed the wound, patted the wound dry and dressed the wound per physician orders, while wearing the same gloves. Afterwards, RN1 adjusted R78's bed linen and R78's incontinence brief. RN1 doffed the gloves and sanitized her hands. Interview on 01/21/26 at 5:18 PM, RN1 confirmed that she should have changed her gloves when going from a soiled to a clean area during the catheter care and wound care. RN1 said that during catheter care she mainly focused on washing the resident and not the catheter unless the catheter is visually soiled. RN1 denied R78's catheter was soiled. Interview on 01/22/26 at 9:10 AM, the Director of Nursing (DON) confirmed that gloves are to be changed when going from a dirty area to a clean area. In addition, the DON confirmed that staff are to clean the catheter when completing catheter care. Review of the facility's policy titled, Catheter Care, Urinary revised 11/15/25 indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .Steps in the Procedure .f. If indwelling catheter is in place .v. Anchor the catheter with one hand and clean the catheter where it exits the urethra by wrapping the catheter in the washcloth/wipe and using a twisting motion, vi. Move your hand to where you just cleaned and wash the reminder of the catheter to beyond where securement device will be.Review of the facility's policy titled, Personal Protective Equipment-Using Gloves revised 02/16/25 indicated, To establish guidelines for the proper use of gloves to ensure hygiene, safety, and infection control in healthcare settings.Guidelines for Glove Use.4. Use non-sterile primarily to prevent contamination of the employee's hands when treating patients or cleaning contaminated surfaces. NJAC 8:39-19.4