STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adroit Care Rehabilitation and Nursing Center	1777 Lawrence Street Rahway, NJ 07065

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that food stored in residents' personal refrigerators was maintained in a safe and sanitary manner by failing to a.) ensure thermometers were present in residents' personal refrigerators to monitor internal temperatures, b.) routinely monitor and document refrigerator temperatures on a temperature log, c.) maintain food items at the appropriate internal temperatures, d.) discard food items in accordance with manufacturers' expiration or by the used by dates, and e.) routinely monitor and clean refrigerators.This deficient practice was identified in 6 of 6 residents' rooms (Rooms 302, 304, 314, 319, 330B, and 330C) reviewed for the use of personal refrigerators and was evidenced by the following:On 3/19/26 at 10:20 AM, in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM), the surveyor toured the rooms of residents with personal refrigerators. During the tour, the following observations were made:room [ROOM NUMBER] contained a personal refrigerator; however, no thermometer was present to monitor internal temperatures, and no temperature log was available to document routine monitoring. The surveyor and LPN/UM reviewed the contents of the refrigerator and identified multiple expired food items, including vanilla pudding (expired 2/20/26), mixed fruit (expired 3/16/26), and three turkey sandwiches (expired 3/15/26, 3/16/26, and 3/17/26).room [ROOM NUMBER] contained a personal refrigerator but lacked a thermometer to monitor internal temperatures. A medication temperature log dated 2023 was affixed to the front of the unit; however, the log was blank, indicating that routine temperature monitoring was not being performed. The refrigerator also contained spilled food and visible debris at the bottom, suggesting inadequate cleaning concerns. Inspection of the refrigerator contents revealed multiple expired food items, including Dijon mustard (expired 2/7/26), soda (expired 11/17/25), sliced cheese (expired 8/15/25), two packages of blue cheese (expired 3/13/25), cream cheese (expired 3/12/25), tomato ketchup (expired 1/18/24), French dressing (expired 10/23/23), and Dijon mustard (expired 7/3/23).room [ROOM NUMBER] revealed the presence of a personal refrigerator equipped with a thermometer to monitor internal temperature; however, no temperature log was available to document routine monitoring. At the time of observation, the thermometer displayed a temperature of 50 F., and visible residue was observed at the bottom of the unit. Inspection of the refrigerator contents revealed multiple expired food items, including: two (2) turkey and cheese sandwiches (expired 3/15/26 and 3/17/26), sandwich meat (expired 3/5/26), rum punch (expired 3/1/26), and lemon Jell-O (expired 3/10/26) Additionally, one (1) sandwich was observed to be undated and unlabeled.room [ROOM NUMBER] revealed the presence of a personal refrigerator with a thermometer to monitor internal temperature. The thermometer displayed a temperature of 9 F at the time of observation and the food items inside were frozen. There was no temperature log present to document routine monitoring of refrigerator temperatures. The LPN/UM stated that the resident's family adjusts the temperature control.room [ROOM NUMBER]B revealed the use of a personal refrigerator; however, no thermometer was present to monitor internal temperatures, and no temperature log was available to document routine monitoring. Inspection of the refrigerator contents revealed expired food items, including four turkey and cheese sandwiches (expired 3/15/26) and (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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	apple juice (expired 11/21/25).room [ROOM NUMBER]C contained a personal refrigerator in use; however, the unit lacked a thermometer to monitor internal temperatures, and there was no temperature log available to document routine monitoring. The interior of the refrigerator was warm to the touch, indicating a potential failure to maintain required temperature control.During the tour of residents' rooms with personal refrigerators, the surveyor interviewed the LPN/UM, who acknowledged that thermometers were not routinely placed in residents' personal refrigerators and that staff did not monitor or document temperatures. The LPN/UM also stated that residents, rather than staff, checked for expiration dates and cleaned the refrigerators. When asked about safety concerns associated with the warm internal temperatures, the LPN/UM responded by obtaining the residents' permission and discarded the hazardous food. On 3/20/26 at 12:00 PM, the surveyor interviewed the Director of Maintenance (DOM), who stated that the Certified Nursing Assistants (CNAs) were responsible for monitoring residents' refrigerators, including checking and cleaning them daily and ensuring that expired food items were discarded. On 3/23/26 at 12:17 PM, during a meeting with the Licensed Nursing Home Administrator (LNHA), Regional Clinical Nurse (RCN), and the Director of Nursing (DON), inconsistencies were identified regarding the placement of thermometers, monitoring and cleaning of residents' refrigerators, and the labeling, dating, and routine inspection of residents' food items. The LNHA stated that the facility was not responsible for residents' personal refrigerators and that no specific policy existed regarding their use. However, the RCN noted that the DOM periodically checked residents' refrigerator temperatures using thermometer guns. When asked for documentation, the RCN was unable to provide temperature logs and stated that the temperatures were not recorded. The surveyor asked the team about the expected temperature range for personal refrigerators. The RCN stated that temperatures should be maintained between 36 F and 40 F. When questioned about the appropriateness of periodic monitoring, given that temperatures outside this range were observed, the team did not provide a response and was unable to report how often the temperatures were out of range, acknowledging that this represented a safety concern. On 3/20/26 at 11:40 AM, the surveyor was provided a copy of the facility policy titled Use and Storage of Food Brought to Residents by Visitors, dated 1/3/24 and reviewed 2/7/26. Under the Procedure section, the policy indicated that: 2. All food items are to be labeled with the resident's name, room number, and date; 4.b. Food past the manufacturer's expiration date will be discarded by nursing staff; 5. Nursing staff will monitor . refrigeration units for food and beverage disposal; and 7. All resident room refrigerator units will be checked daily and cleaned weekly. A review of the facility policy titled Foods Brought by Family/Visitors, dated 6/13/22 and reviewed 1/28/26, indicated under Policy Interpretation and Implementation that nursing staff are responsible for discarding perishable foods on or before the use-by date. NJAC 8:39-17.2(g)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide residents with a clean environment by failing to a.) appropriately dispose of soiled materials and personal protective equipment (PPE) and b.) provide clean bed linen and incontinence supplies maintained in sanitary condition to prevent cross-contamination. This deficient practice was identified in room [ROOM NUMBER] and Resident #16 reviewed for environmental concerns and was evidenced by the following:1). On 3/18/2026 at 11:19 AM, surveyor #1 toured room [ROOM NUMBER] and observed the following: Enhanced Barrier Precautions (EBP) signage posted on the door. Soiled materials including bed linen with other items wrapped inside and a blue disposable chuck) disposed of on top of the garbage receptacle. A disposable glove turned inside-out and discarded on the floor. On 3/20/26 at 9:45 AM, surveyor #1 observed EBP signage posted on the door of room [ROOM NUMBER] and a pair of disposable gloves turned inside-out discarded on the floor. On 3/20/26 at 9:51 AM, surveyor #1 interviewed the Certified Nursing Assistant (CNA), who stated that the soiled bed linen should be discarded inside the trash bin, not placed on top of it. The CNA further stated that gloves and other PPE should not be discarded on the floor, but instead placed in a designated trash receptacle. The CNA also reported that proper disposal of trash and PPE is important for infection control. On 3/20/26 at 10:08 AM, surveyorc#1 interviewed the Licensed Practical Nurse (LPN), who confirmed that soiled linen should be placed inside the garbage receptacle and not on top of it. The LPN acknowledged that PPE should not be discarded on the floor and stated that used gloves and other PPE should be disposed of in a designated red trash bin for infection control purposes. On 3/20/26 at 12:00 PM, surveyor#1 interviewed the Director of Maintenance (DOM), who confirmed that it was not acceptable to place trash on top of a garbage receptacle and that all waste should be placed in a bag inside the receptacle. The DOM stated that trash is emptied daily and more frequently as needed to support proper infection control practices. On 3/20/26 at 1:05 PM, surveyor #1 interviewed the Registered Nurse/Infection Preventionist (RN/IP), who stated that staff were expected to discard used PPE in a red trash bin or in a regular trash receptacle lined with a red bag if a red trash bin was unavailable. The RN/IP further stated that staff were expected to perform hand hygiene immediately after disposal of trash. The RN/IP agreed that placing PPE on top of the trash bin and on the floor was unacceptable. The RN/IP stated that staff who failed to adhere to the facility's policy were provided with individualized, one-on-one reeducation. A review of the facility's Personal Protective Equipment policy, dated 11/29/21 and reviewed 1/28/26, included that personal protective equipment should be disposed of appropriately in designated receptacles inside residents' rooms. The Personal Protective Equipment – Using (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gloves section indicated to discard gloves in the designated waste receptacle inside the room. NJAC 8:39-31.4 (a) 2.) On 3/18/2026 at 9:18 AM, Surveyor #2 observed Resident #16 in bed. At the foot of the resident's bed was a covered red plastic trash bin. The surveyor observed the following sitting directly on top of the trash bin cover: folded blue disposable chuck, folded cream-colored incontinence brief, and several layers of folded linen and garments. There was an Enhanced Barrier Precautions (EBP) (an infection control strategy focused on reducing the spread of multidrug-resistant organisms [MDRO] in nursing homes), signage posted on the door. A plastic bin containing PPE (Personal Protective Equipment) was located along the doorway. The surveyor reviewed the medical record for Resident #16. A review of the admission Record revealed Resident #16 was admitted to the facility with diagnoses which included but not limited to local infection of the skin and subcutaneous tissue, dementia, and muscle weakness. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 1/6/2026, reflected the resident had an unhealed stage 4 pressure ulcer on the left hip. A review of the Physician Orders active as of 3/24/2026, revealed an order for Santyl 250 unit/gram topical ointment every day and as needed for the diagnosis of Other skin changes. A review of the resident's individualized comprehensive care plan effective on 1/1/2026, indicated a focus for pressure ulcer stage 4 on the left ischium (hip). One of the goals in the care plan included the following: I will show no signs of infection to site. On 3/20/2026 at 9:57 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that nursing staff cannot put clean linens on top of the trash bin for infection control. On 3/23/2026 at 10:02 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated that red trash bins are for soiled PPE of residents on EBP. The IP also stated that clean linens should be bagged and not be left on top of trash bins. A review of the facility-provided policy titled Linen Storage reviewed on 11/22/2025, did not include how clean linen should be stored inside the room of residents on EBP. N.J.A.C. 8:39 - 31.4 (a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents receiving enteral feedings were provided appropriate care and services to prevent complications by failing to complete formula labels for residents receiving feedings. This deficient practice was identified for 2 of 3 residents (Residents #49 and #114) reviewed for tube feeding. The deficient practice was evidenced by the following:1.) On 3/18/26 at 11:24 AM, Surveyor #1 observed Resident #114 lying asleep in bed while receiving a continuous tube feeding (TF). Observation revealed that the TF bag was not labeled with the resident's name, room number, date and time the feeding was initiated, or the prescribed infusion rate per hour. Surveyor #1 reviewed the electronic medical record (EMR), for Resident #114. A review of the admission Record (admission summary) indicated that the resident had diagnoses which included but were not limited to dysphagia (difficulty swallowing), aphasia (a disorder affecting communication), and gastrostomy status (presence of a tube in the stomach for the administration of nutrition, fluids, and medications). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of the resident's care, dated 1/15/26, revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating that the resident's cognition was severely impaired. Further review of Section K (Swallowing/Nutritional Status) of the MDS indicated that the resident was receiving nutrition via a feeding tube while residing in the facility. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, initiated on 8/22/24 and revised on 9/3/24, that the resident required tube feeding related to (r/t) dysphagia, failure to thrive, malnutrition, and at risk for aspiration. Interventions included providing or enteral feeding per medical doctor (MD) orders and tube feed formula and water flushes as ordered. A review of the Order Summary Report of active orders, renewed 1/15/26, included a physician's orders (PO) for enteral feeding, Peptamen 1.5 cal. liquid via gastrostomy (GT) to run at 60 mL/hr. via a pump. Total volume to be infused, 1000 mL/24 hrs. The order further directed that the feeding be initiated at 4:00 PM and discontinued when total feeding volume infused. The order directed the staff to document the feeding start time each shift and to verify and ensure the accuracy of the infusion rate and feeding each shift. On 3/20/26 at 10:08 AM, surveyor #1 interviewed the Licensed Practical Nurse (LPN), who confirmed that the TF bag should have been labeled with the resident's name, room number, date and time the feeding was initiated, and the prescribed infusion rate. The LPN further stated that proper labeling of the TF bag was important to ensure safety and accuracy, as well as to prevent contamination by ensuring the feeding bag is changed daily. On 3/20/26 at 10:53 AM, Surveyor #1 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM). When asked what information should be applied to a TF bag, the LPN/UM stated that the label should include the date, time, TF rate, as well as the resident's name and room number. The LPN/UM was unable to explain why the TF bag was missing this information. The LPN/UM further (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that labeling the TF bag with the resident's information was important for resident safety and infection control. On 3/23/26 at 12:17 PM, Surveyor #1 interviewed the Director of Nursing (DON), who confirmed that the tube feeding TF bag should have been labeled with the resident's name, room number, date and time the feeding was started, formula, and rate. The DON stated that staff were expected to apply a new label with the required information each day to ensure resident safety and adherence to infection control practices. The facility policy and procedure titled Tube Feedings, dated 6/14/21 and reviewed on 2/10/26, indicated that tube feedings will be given per physician's order. Under the Action section, step 3 directed staff to fill in information on the label (i.e. resident's name, room start time and rate) . 2.) On 03/18/2026 at 9:54 AM, during initial tour of the facility Surveyor #2 observed Resident #49 asleep in bed while receiving a continuous tube feeding (TF). At that time Surveyor #2 observed the TF bag was not labeled with the resident's name, room number, date and time the feeding was initiated, or the prescribed infusion rate per hour. A review of Resident #49's admission record revealed that Resident #49 was admitted with but not limited to Gastrostomy status (presence of a tube in the stomach for the administration of nutrition, fluids and medication). A review of Resident #49's annual Minimum Data Set (MDS) dated [DATE] revealed in Section K (Swallowing/Nutritional Status) that the resident received 51% or more of their total calories through TF while residing at the facility. A review of Resident #49's Electronic Medical Record (EMR) revealed a physician's order for tube feeding, Glucerna 1.2 at a rate of 75 milliliters per hour (ml/hr) via pump. Total volume to be infused of 1,550 milliliters. The order further directed the TF to be initiated at 5:00 PM and discontinued when the total volume infused. A review of Resident #49's Care Plan revealed that the resident included a focus area for Tube feeding effective 03/25/2025. Interventions included .will administer your feedings: as ordered. On 03/23/2026 at 12:05 PM during an interview the Director of Nursing (DON) indicated that it was necessary to have the TF bags properly labeled to ensure that the residents are receiving the correct nutrition. A review of the policy titled Tube Feedings reviewed on 2/10/2026revealed under the section Action under step 3, fill in information on the label (i.e. residents name, room, start time and rate). N.J.A.C. 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. REPEAT DEFICIENCYBased on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store medications securely inside the medication cart by keeping it locked when unattended and b.) failed to ensure that medications were stored under proper temperature controls by failing to maintain unopened insulin vials in the refrigerator. The deficient practice was identified in 2 of 5 medication carts (B side 2nd floor cart and the 2nd floor central medication cart) observed during tour of the facility and medication storage and labeling task inspection.The deficient practice was evidenced by the following: A.) On 3/18/2026 at 9:09 AM, during the initial tour of the facility, Surveyor #1 observed a medication cart labeled B- Side unlocked along the B side hallway of the 2nd floor. The lock of the cart faced the hallway. There were no medications on top of the cart. There were no residents, visitors, or staff present in the hallway. The surveyor stayed within the line of sight of the medication cart. On 3/18/2026 at 9:12 AM, the surveyor observed Registered Nurse #1 (RN #1) came out of a resident's room near the B side medication cart. RN #1 approached the unlocked medication cart and locked the cart. On 3/18/2026 at 9:14 AM, during an interview with the surveyor, RN #1 confirmed that they were in charge of the medication cart. RN #1 stated that medication carts need to be locked at all times. RN #1 apologized to the surveyor for leaving the cart unlocked. On 3/20/2026 at 9:57 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that nurses must lock the medication carts if they are not behind them because they do not want anybody to open the carts. A review of facility- provided policy titled Medication Storage reviewed on 1/28/2026, did not include keeping medication carts locked when not being attended to. B.) On 03/20/2026 at 11:50 AM, the Surveyor observed the Central Medication Cart in the presence of Licensed Practical Nurse (LPN) # 1 located on the second floor. At that time, the Surveyor observed the top drawer of the cart and found one multi-dose vial of insulin lispro 100 units, one insulin glargine 100 units/milliliter, and one unopened box of a lantus multi-dose vial 100 units. Each medication is prescribed to treat blood-sugar levels within the body. Two of the insulin multi-dose vials had the protective cap intact and the lantus multi-dose vial was still in a sealed, unopened box. At that time, the surveyor reviewed the instructions located on each box for each of the insulin multi-dose vials. The instructions revealed that, DO NOT FREEZE. Store refrigerated at 36 degrees F to 46F [2^ to 8 C] until time of use. Store in-use vials refrigerated at 36 degrees F to 46 degrees F [2* C to 8 degrees C]. If refrigeration is not possible store at room temperature (up to 88 degrees F [30 degrees C]) . The second floor medication room did contain a refrigerator for medications. At that time, the surveyor interviewed LPN # 1. LPN # 1 confirmed that the insulin multi-dose vials should be refrigerated. LPN # 1 both confirmed that the three insulin multi-dose vials were sealed by (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the protective cap and the lantus multi-dose vial box was unopened. A review of the facility policy titled Medication Storage-Insulin last reviewed 1/28/26. The policy revealed that, It is the policy of [Facility Name] to follow the manufacturer's recommendations for the proper storage and temperature controls of all medications including but not limited to INSULIN. N.J.A.C. 8:39-29.4(h) N.J.A.C. 8:39-29.4(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of medical records and other pertinent facility documents, it was determined that the facility failed to use appropriate infection control practices to prevent the spread or reduce the risk of infection in accordance with the Center for Disease Control & Prevention (CDC) guidelines and standards of clinical practice by ensuring, a.) respiratory device tubing, masks, and mouthpiece were stored in protective covering between uses identified for 1 of 5 residents (Resident #50) reviewed for respiratory care, b.) proper use of personal protective equipment (PPE) for 1 of 1 residents reviewed under contact precautions (Resident #75). This deficient practice was identified in 1 out of 2 nursing units (third floor unit) and was evidenced by the following:a.) On 03/19/2026 at 09:36AM, the surveyor observed Resident #50's bedside table had oxygen tubing hanging from the bedside table. With the permission of Resident #50, the surveyor requested a staff member to open the top draw revealing Resident #50's nebulizer (a machine that aerosolizes medications for inhalation) with the nebulizer mask on top open to air. A review of Resident 50's admission record revealed that Resident #50 was admitted with but not limited to chronic obstructive pulmonary disease (COPD), (a progressive lung disease that makes it difficult to breathe).A Review of Resident #50's annual Minimum Data Set (MDS) dated [DATE] revealed under section O that the resident received oxygen therapy. A review of Resident #50's Electronic Medical Record (EMR) revealed a physician's order for Sodium Chloride (inhalant) 0.9% solution for nebulization, inhale 1 unit four times per day for shortness of breath. A review of the Care Plan in the EMR revealed a nursing focus of respiratory disorder with intervention that included nebulizer treatments as ordered. During an interview on 03/20/2026 at 09:57 the Director of Nursing (DON) stated that when nebulizers were not in use they should be stored in a plastic bag. b.) On 03/18/2026 at 10:31 AM during initial tour, the surveyor observed signage on Resident #75's door that read Contact Precautions that included instruction to Put on gown before room entry. At that same time, a Certified Nurse's Aide (CNA) was observed entering Resident #75's room without a gown. At that time the surveyor observed the CNA remove a basin from Resident #75's room and then was observed entering another resident room. The CNA confirmed that the basin was removed from Resident #75's room and indicated that she did so because Resident #75's water took too long to warm. Review of Resident #75's EMR revealed a physician's order for Contact Precautions dated 01/07/2026. A review of the Care Plan in the EMR revealed a focus titled Contact Precautions. Etiology C. Auris (an infectious organism) swab positive 11/12/2025, with an effective date 11/14/2025. On 03/23/2026 at 10:03 AM during an interview, the Infection Preventionist (IP) indicated that PPE should be applied prior to entering the resident's room. The IP indicated that residents on contact precautions should have dedicated supplies that should not go in and out of the residents' room. Review of the policy titled Infection Prevention and Control Program last review dated 01/28/2026 revealed under the section titled Contact Precautions, that 5. Gown; a. wear a disposable gown upon enter the contact precautions room. The same policy under the section titled Contact Precautions revealed, 7. Resident-care Equipment; .dedicate the use of non-critical resident-care equipment items . to a single resident (or cohort of residents) to avoid sharing between residents.N.J.A.C. 8:39-19.4(a)