STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315307	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harborage LLC	7600 River Rd North Bergen, NJ 07047

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, review of medical records, and review of pertinent facility documents on 5/18/26, it was determined that the facility failed to ensure that a cognitively impaired resident who had a tracheostomy and was ventilator dependent was free from physical abuse. On 5/10/26, the police notified the facility of an allegation of abuse by a Respiratory Therapist (RT). The Licensed Nursing Home Administrator (LNHA) was shown a video by the police that was taken by a hidden video camera that was placed in the resident's room by their family member. The RT was suspended immediately and did not return to the facility. The facility self-corrected and put themselves back in compliance to prevent serious harm from occurring or recurring on 5/11/26 when facility staff were educated on facility abuse policies.The IJ was Past Non-Compliance (PNC). This deficient practice was identified for 1 of 4 residents (Resident #1) reviewed for abuse.The deficient practice was evidenced by:A review of the facility's policy on Abuse, Neglect, and Exploitation, with a reviewed/revised date of 5/10/2026, included under Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish [.] Physical Abuse includes, but is not limited to hitting, slapping, punching [.] Staff includes [.] contractors, [.] caregivers who provide care and services to residents on behalf of the facility [.] including therapy [.]. Under Policy Explanation and Compliance Guidelines: [.] 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. Under The components of the facility abuse prohibition plan are discussed herein: [.] III. Prevention of Abuse, Neglect, and Exploitation [.] D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect [.] H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. A review of the Reportable Event Record/Report (FRE) submitted by the facility to the New Jersey Department of Health (NJDOH) on 5/11/26, included the date and time of event: 5/10/26 at 12:00 PM. The FRE further revealed under Narrative that on 5/10/26 at approximately 12:00 PM, the facility was made aware by law enforcement of an alleged staff to resident abuse. A RT was identified and immediately suspended pending investigation. The resident (Resident #1) was immediately assessed by nursing staff with no new findings. A review of the facility's Investigational Summary and Conclusion (ISC) report revealed under Description of Event: On 5/10/2026 at approximately 12 PM, the facility was made aware by law enforcement of an alleged abuse as they indicated they reviewed video footage. The ISC further revealed that the RT was interviewed and denied any abuse. Additional staff were interviewed without concerns identified. Under Conclusion the ISC revealed the RT was not returned to the facility based on the reviewed video footage as it demonstrated behaviors that are not consistent with facility policy. The surveyor reviewed the video footage from the police department. Videos were received for 4/28/26, 5/1/26, and 5/2/26. A review of footage dated 4/28/26, lasted 1:54 [1 minute and 54 seconds], revealed: - At (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11:38 PM, RT observed in view of the camera; Resident #1 in bed; RT noted on the left side of the resident's bed and appeared to be connecting the resident's tubing to their tracheostomy tube; Resident #1 raised their right hand; RT pushed the resident's hand down. - At 11:39 PM, the RT threw a towel on the resident's face; the resident removed the towel from their face with their right hand; RT threw the towel back on resident's face; the resident again removed the towel from their face with their right hand; RT threw the towel on resident's face in total of four times and each time the resident removed it with their right hand. A review of footage dated 5/1/26, lasted 1:58 [1 minute and 58 seconds], revealed:- At 11:44 PM, RT observed in view of the camera; Resident #1 noted in bed; RT noted standing on the left side of the resident's bed; RT noted pulling resident's hands by the wrists, arranged the resident's pillow, held the resident's head by the back, and let it drop on the pillow; RT was then observed using their hand to hit the resident on their left side of face and afterwards, proceeded to connect the tubing to the resident's tracheostomy; RT was then noted holding the resident's raised right hand and appeared to twist and bend the resident's hand back; Resident #1 noted with facial grimacing and pulling hand away. - At 11:45 PM, RT was observed to have held the resident's left hand by the wrist and appeared to squeeze and bend the hand; RT was then observed to push the resident's left arm down and throw a towel on the resident's face, squeezing the towel on the resident's face; Resident #1 noted to be gasping for air. - At 11:46 PM, RT was observed checking the tubing connections and seen hitting the resident on their right side of the face; RT then left and disappeared from the screen. A review of footage dated 5/2/26, lasted 15 seconds, revealed:-At 3:32 AM, RT observed in view of the camera; Resident 1 noted in bed; RT noted standing on the right side of the resident's bed; RT was then observed to have held the resident's right hand and forcibly held it down on the bed. A review of footage dated 5/2/26, lasted 31 seconds, revealed: -At 5:58 AM, RT observed in view of the camera; Resident #1 noted in bed; RT noted standing at the side of the resident's bed; Resident #1 was observed with their right hand raised and waving; RT then hit the resident on their right side of head, pushed down the resident's right hand, squeezed the fingers, and bent Resident #1's hand for 14 seconds; Resident #1 noted with facial grimacing of pain. The surveyor reviewed the medical record of Resident #1. A review of Resident #1's admission Record (AR), an admission record summary, revealed that the resident was admitted to the facility with the following diagnoses which included but are not limited to chronic respiratory failure with hypoxia (a medical condition that a specific part of body does not receive enough oxygen to function properly), chronic obstructive pulmonary disease (COPD), adjustment disorder with anxiety, tracheostomy status, and gastrostomy status. A review of the Minimum Data Set (MDS), an assessment tool dated 2/4/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated the resident's cognition was severely impaired. The MDS further revealed that the resident required total assistance from staff in the completion of their Activities of Daily Living (ADLs). A review of the resident's care plan report (CP) included the following Foci (Problem areas/needs):Resident #1 has impaired cognitive/communication function s/p (status post) CVA (cerebrovascular accident; stroke), chronic respiratory failure, initiated 6/13/24. Interventions included but were not limited to: ask yes/no questions in order to determine resident's needs; keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, and present just one thought, idea, question or command at a time.Resident #1 is at risk for developing pressure ulcers, skin breakdown, and bruising r/t (related to) holding tightly to side rail during peri care, increased agitation, swinging, decrease mobility, incontinence, and anticoagulation medications, initiated 6/13/24. Interventions included but were not limited to: report any skin redness/impaired integrity areas, resident's skin will be assessed on a weekly basis and document findings on a weekly skin assessment. monitor/document location, size and treatment of skin injury, and report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration (the softening and breaking down of tissue due to prolonged exposure to moisture), etc. to MD (physician). Resident #1 is resistive to care r/t anxiety episodes of pulling out (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	trach, initiated 2/26/25. Interventions included but were not limited to: Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care.Resident #1 uses psychotropic medications anti-anxiety meds r/t anxiety and behavior of flailing her arms and contracted hand resulting in unintentional injuries to face, arms, and hands, initiated 12/4/24. Interventions included but were not limited to: remove unnecessary environmental triggers, provide calm environment, reduce excessive noise/stimulation, and maintain calm structured environment.Resident #1 is on ventilator dependent r/t respiratory failure; resident has a trach due to respiratory failure, initiated 6/13/24. A review of Resident #1's hospital Emergency Department (ED) records dated 5/11/26 showed the admitting diagnosis of subdural hematoma (A life-threatening collection of blood between the brain and the skull's tough outer covering (Dura mater), usually caused by a head injury). Under Chief Complaint: Patient presents with: Contusion, Multiple, Face, L [left] chest, R [right] arm. The ED records further showed a CT (Computed tomography scan; an imaging test that combines a series of x-rays with computer processing to create detailed 3D cross-sectional images of bones, organs, and soft tissues) Head without contrast (dye) dated 5/11/26 at 11 PM with results which indicated, Right convexity (a curved or outward-bulging surface) subdural hematoma.On 5/18/26 at 2:24 PM, the surveyor interviewed the LNHA and the Director of Nursing (DON). The LNHA stated he only saw 1 video, which was under 1 minute, but there were more. The LNJA further stated that in the video the RT showed actions not to our expectations nor consistent with our abuse policy. The LNHA was unaware a family member had placed a camera until the police came.The facility addressed the situation by reeducated the facility staff on abuse policies and procedures, initiated 5/10/26 and completed 5/11/26; all new staff or any staff on leave to be educated prior to first shift, initiated 5/10/26; skin assessments completed on all residents, with no findings; review of all incident/accident reports; chart audits conducted on all the RT's residents from the date of hire to the present; all residents interviewed, if not cognitively intact, PHQ-2 PHQ-2 (Patient Health Questionnaire-2; a brief, 2 item tool used to identify potential major depressive disorder) conducted, with no concerns reported; audits to be conducted by interviewing 5 staff members daily x 1 week, then weekly x 4 weeks, then monthly x 2 months to ensure staff comprehension of the policy; audits to be conducted to observe staff to resident interactions, 5 staff members per unit daily x 1 week, then weekly x 4 weeks, then monthly x 2 months, and audits to be conducted by interviewing 5 residents per unit daily x 1 week, then weekly x 4 weeks, then monthly x 2 months to ensure residents feel safe within the facility and can voice any concerns. The IJ began 5/10/26 at 12 PM when the police notified the facility of the video footage.The IJ is Past Non-Compliance (PNC). The surveyor verified the implementation of the Removal Plan on-site on 5/18/26 and determined that there is sufficient evidence that the facility self-corrected the noncompliance on 5/11/26 and is in substantial compliance at the time of the current survey for the specific regulatory requirements for F 600. N.J.A.C. 8:39- 4.1(a)5

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some 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. Based on interviews, record review, and review of pertinent facility documentations on 5/18/26, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) potential abuse related to multiple incidents of resident injuries of unknown origin dated 3/21/26 and 4/16/26 for Resident #1 and dated 4/15/26 for Resident #3. This deficient practice was identified for 2 of 4 residents reviewed for abuse and neglect, Resident #1 and Resident #3.The deficient practice was evidenced by the following: The surveyor reviewed the medical record of Resident #1.A review of Resident #1's admission Record (AR), an admission record summary, revealed that the resident was admitted to the facility with the following diagnoses which included but are not limited to chronic respiratory failure with hypoxia (a medical condition that a specific part of body does not receive enough oxygen to function properly), chronic obstructive pulmonary disease (COPD), adjustment disorder with anxiety, tracheostomy status, and gastrostomy status. A review of the Minimum Data Set (MDS), an assessment tool dated 2/4/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated the resident's cognition was severely impaired. The MDS further revealed that the resident required total assistance from staff in the completion of their Activities of Daily Living (ADLs). A review of the resident's care plan report (CP) included the following Foci (Problem areas/needs):Resident #1 has impaired cognitive/communication function s/p (status post) CVA (stroke), chronic respiratory failure, initiated 6/13/24. Interventions included but were not limited to: ask yes/no questions in order to determine resident's needs; keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, and present just one thought, idea, question or command at a time.Resident #1 is at risk for developing pressure ulcers, skin breakdown, and bruising r/t (related to) holding tightly to side rail during peri care, increased agitation, swinging, decrease mobility, incontinence, and anticoagulation medications, initiated 6/13/24. Interventions included but were not limited to: report any skin redness/impaired integrity areas, resident's skin will be assessed on a weekly basis and document findings on a weekly skin assessment. monitor/document location, size and treatment of skin injury, and report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration (the softening and breaking down of tissue due to prolonged exposure to moisture), etc. to MD (physician). Resident #1 is resistive to care r/t anxiety episodes of pulling out trach, initiated 2/26/25. Interventions included but were not limited to: Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care.Resident #1 uses psychotropic medications anti-anxiety meds r/t anxiety and behavior of flailing her arms and contracted hand resulting in unintentional injuries to face, arms, and hands, initiated 12/4/24. Interventions included but were not limited to: remove unnecessary environmental triggers, provide calm environment, reduce excessive noise/stimulation, and maintain calm structured environment.Resident #1 is on ventilator dependent r/t respiratory failure; resident has a trach due to respiratory failure, initiated 6/13/24. The surveyor requested for the incidents/accidents (I/A) reports for Resident #1 from March 2026 to date of survey.A review of a facility document labeled Date of Incident reporting: 4/16/2026, Incident Investigation Summary and Conclusion revealed Resident #1 was noted to have a large bruise to the left cheek. A further review revealed that upon assessment and staff interview, it was reported that several days prior the resident attempted to pull at their tracheostomy tubing and accidentally struck themself in the face multiple times during the episode. Under Conclusion revealed no evidence of abuse, neglect, or staff misconduct was identified. A review of a facility document titled #1613 Skin Injury dated 4/16/2026 02:35 [2:35AM] revealed under Nursing Description, Resident noted with large bruise to L cheek[.]. The document further revealed under Resident Description that the resident was unable to give a description. Under Was this incident witnessed was N. A review of a PN dated 4/16/26 at 12:52 PM documented During rounds noted skin discoloration on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	left cheek down to [Resident #1's] neck [.] resident [.] can't recall what happened.The 4/16/26 incident was not reported to the NJDOH.A review of a PN dated 3/21/26 at 4:39 PM documented the resident came back to the unit from ER [emergency room] for GT [gastrostomy tube] placement via stretcher, accompanied by Respiratory Therapist (RT) and CNA (certified nursing assistant). The PN further revealed, resident noted to the L (left) side of the cheekbone ecchymosis (bruise) noted, will continue to monitor, no new order received.The 3/21/26 incident was not reported to the NJDOH.The surveyor reviewed the medical record of Resident #3. A review of Resident #3's AR, an admission record summary, revealed that the resident was admitted to the facility with the following diagnoses which included but are not limited to non-traumatic intracerebral hemorrhage (bleeding into the brain tissue; a type of stroke), atrial flutter, gastrostomy status, respiratory failure, and tracheostomy status.A review of the MDS, an assessment tool dated 2/17/26, revealed the resident had short- and long-term memory problems and had severely impaired cognitive skills. The MDS further revealed the resident required total assistance from staff in the completion of their Activities of Daily Living (ADLs).A review of the resident's care plan report (CP) included the following Foci (Problem areas/needs):Resident #3 requires tube feeding r/t dysphagia [difficulty swallowing], anoxic brain injury (a severe type of brain injury caused by a total lack of oxygen to the brain), vented tracheostomy initiated 11/7/25. Interventions included but were not limited to: NPO (nothing by mouth). Impaired gas exchange respiratory failure, mechanical ventilation initiated 11/6/25. Interventions included but were not limited to: maintain ventilator settings per orders.Resident #3 has an ADL self-care performance deficit r/t vegetative state, initiated 11/6/25. Interventions included but were not limited to: the resident is totally dependent on nursing staff for nutrition administration.Resident #3 has impaired cognitive loss due to CVA, anoxic brain, and is unable to communicate initiated 12/1/25. Interventions included but are not limited to: discuss concerns about confusion, disease process, NH (nursing home) placement with husband. Resident #3 has potential/actual impairment skin integrity r/t presence of PEG (Percutaneous Endoscopic Gastrostomy tube; a medical device inserted directly through the abdominal wall into the stomach to provide a direct route for delivering liquid nutrition, hydration, and medications to individuals who cannot safely chew or swallow), tracheostomy and impaired mobility, resident witnessed leaning on side rail, pillow added for side to help prevent bruising or injury initiated 11/6/25. Interventions included but were not limited to: report any skin redness/impaired integrity areas to my nurse.The surveyor requested the I/A reports for Resident #3 from March 2026 to date of survey. A review of a facility document labeled Date of incident 4/15/2026, Re: [Resident #3], Skin Injury Investigation revealed that during routine nursing assessment, resident was observed leaning toward the side rail of the bed with forehead resting against the rail. A small bruise/discoloration to the forehead area was noted upon repositioning. A further review revealed the investigation findings indicated the bruise was consistent with accidental contact/pressure against the side rail related to the resident's positioning behavior and anti-coagulant use.A review of a facility document titled #1611 Skin Injury dated 4/15/2026 09:00 [9:00AM] revealed under Nursing Description, Patient noted with skin area to right forehead. The document further revealed under Resident Description that the resident was unable to give a description. Under Was this incident witnessed was N and under Description: On skin assessment no open wound noted, bruising noted. The 4/15/26 incident was not reported to the NJDOH.A review of the facility's policy on Abuse, Neglect, and Exploitation, with a reviewed/revised date of 5/10/2026, included under Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under Definitions: Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source[.]. Under VII. Reporting/Response: A. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	facility will have written procedures that include:[.] 1. Reporting all alleged violations to the Administrator, state agency[.] within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.N.J.A.C. 8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on interviews, record review, and review of pertinent facility documentations on 5/18/26, it was determined that the facility failed to ensure complete and thorough investigations to rule out abuse were done for multiple incidents of resident injury dated 3/21/26 and 4/16/26 for Resident #1 and an incident dated 4/15/26 for Resident #3. This deficient practice was identified for 2 of 4 residents reviewed for abuse and neglect, Resident #1 and Resident #3.The deficient practice was evidenced by the following: The surveyor reviewed the medical record of Resident #1.A review of Resident #1's admission Record (AR), an admission record summary, revealed that the resident was admitted to the facility with the following diagnoses, which included but are not limited to chronic respiratory failure with hypoxia (a medical condition that a specific part of body does not receive enough oxygen to function properly), chronic obstructive pulmonary disease (COPD), adjustment disorder with anxiety, tracheostomy status, and gastrostomy status. A review of the Minimum Data Set (MDS), an assessment tool dated 2/4/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated the resident's cognition was severely impaired. The MDS further revealed that the resident required total assistance from staff in the completion of their Activities of Daily Living (ADLs). A review of the resident's care plan report (CP) included the following Foci (Problem areas/needs):Resident #1 has impaired cognitive/communication function s/p (status post) CVA (stroke), chronic respiratory failure, initiated 6/13/24. Interventions included but were not limited to: ask yes/no questions in order to determine resident's needs; keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, and present just one thought, idea, question or command at a time.Resident #1 is at risk for developing pressure ulcers, skin breakdown, and bruising r/t (related to) holding tightly to side rail during peri care, increased agitation, swinging, decrease mobility, incontinence, and anticoagulation medications, initiated 6/13/24. Interventions included but were not limited to: report any skin redness/impaired integrity areas, resident's skin will be assessed on a weekly basis and document findings on a weekly skin assessment. monitor/document location, size and treatment of skin injury, and report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration (the softening and breaking down of tissue due to prolonged exposure to moisture), etc. to MD (physician). Resident #1 is resistive to care r/t anxiety episodes of pulling out trach, initiated 2/26/25. Interventions included but were not limited to: Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care.Resident #1 uses psychotropic medications anti-anxiety meds r/t anxiety and behavior of flailing her arms and contracted hand resulting in unintentional injuries to face, arms, and hands, initiated 12/4/24. Interventions included but were not limited to: remove unnecessary environmental triggers, provide calm environment, reduce excessive noise/stimulation, and maintain calm structured environment.Resident #1 is on ventilator dependent r/t respiratory failure; resident has a trach due to respiratory failure, initiated 6/13/24.The surveyor requested for the incidents/accidents (I/A) reports for Resident #1 from March 2026 to date of survey.A review of a facility document labeled Date of Incident reporting: 4/16/2026, Incident Investigation Summary and Conclusion revealed Resident #1 was noted to have a large bruise to the left cheek. A further review revealed that upon assessment and staff interview, it was reported that several days prior the resident attempted to pull at their tracheostomy tubing and accidentally struck themself in the face multiple times during the episode. Under Conclusion revealed no evidence of abuse, neglect, or staff misconduct was identified. A review of a PN dated 4/16/26 at 12:52 PM documented During rounds noted skin discoloration on left cheek down to [Resident #1's] neck [.] resident [.] can't recall what happened.The I/A report did not indicate what interventions were to be put in place to prevent further injury.A review of a PN dated 3/21/26 at 4:39 PM documented the resident came back to the unit from ER [emergency room] for GT [gastrostomy tube] placement via stretcher, accompanied by Respiratory Therapist (RT) and CNA (certified nursing assistant). The PN (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	further revealed, resident noted to the L (left) side of the cheekbone ecchymosis (bruise) noted, will continue to monitor, no new order received.There was no I/A report or investigation of the 3/21/26 event given to the surveyor. The surveyor reviewed the medical record of Resident #3. A review of Resident #3's AR, an admission record summary, revealed that the resident was admitted to the facility with the following diagnoses which included but are not limited to non-traumatic intracerebral hemorrhage (bleeding into the brain tissue; a type of stroke), atrial flutter, gastrostomy status, respiratory failure, and tracheostomy status.A review of the MDS, an assessment tool dated 2/17/26, revealed the resident had short- and long-term memory problems and had severely impaired cognitive skills. The MDS further revealed the resident required total assistance from staff in the completion of their Activities of Daily Living (ADLs).A review of the resident's care plan report (CP) included the following Foci (Problem areas/needs):Resident #3 requires tube feeding r/t dysphagia [difficulty swallowing], anoxic brain injury (a severe type of brain injury caused by a total lack of oxygen to the brain), vented tracheostomy initiated 11/7/25. Interventions included but were not limited to: NPO (nothing by mouth). Impaired gas exchange respiratory failure, mechanical ventilation initiated 11/6/25. Interventions included but were not limited to: maintain ventilator settings per orders.Resident #3 has an ADL self-care performance deficit r/t vegetative state, initiated 11/6/25. Interventions included but were not limited to: the resident is totally dependent on nursing staff for nutrition administration.Resident #3 has impaired cognitive loss due to CVA, anoxic brain, and is unable to communicate initiated 12/1/25. Interventions included but are not limited to: discuss concerns about confusion, disease process, NH (nursing home) placement with husband. Resident #3 has potential/actual impairment skin integrity r/t presence of PEG (Percutaneous Endoscopic Gastrostomy tube; a medical device inserted directly through the abdominal wall into the stomach to provide a direct route for delivering liquid nutrition, hydration, and medications to individuals who cannot safely chew or swallow), tracheostomy and impaired mobility, resident witnessed leaning on side rail, pillow added for side to help prevent bruising or injury initiated 11/6/25. Interventions included but were not limited to: report any skin redness/impaired integrity areas to my nurse.The surveyor requested the I/A reports for Resident #3 from March 2026 to date of survey. A review of a facility document labeled Date of incident 4/15/2026, Re: [Resident #3], Skin Injury Investigation revealed that during routine nursing assessment, resident was observed leaning toward the side rail of the bed with forehead resting against the rail. A small bruise/discoloration to the forehead area was noted upon repositioning. A further review revealed the investigation findings indicated the bruise was consistent with accidental contact/pressure against the side rail related to the resident's positioning behavior and anti-coagulant use.The I/A report contained one staff statement from the nurse who assessed the resident. There were no other staff statements supplied to the surveyor.A review of the facility's policy on Abuse, Neglect, and Exploitation, with a reviewed/revised date of 5/10/2026, included under Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under Definitions: Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source[.]. Under Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: [.] b. Establish policies and procedures to investigate such allegations[.]. Under V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse neglect or exploitation occur.N.J.A.C. 8:39-13.4(c)2ii