

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Allaire Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Dutch Lane Road Freehold, NJ 07728	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2582137 Refer to F610 and F835Based on observations, interviews, and review of pertinent facility documentation on 08/05/2025, 08/06/2025, and 08/07/2025, it was determined that the facility failed to implement their abuse policy to ensure a.) residents were protected from abuse after an allegation of abuse was made on 08/05/2025, by the local police regarding Resident #8 and their caregiver, Resident Representative (RR #1). This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #8). During an interview with the Licensed Nursing Home Administrator (LNHA) on 08/06/2025, revealed that on 08/05/2025, he observed the local police at the facility, and overheard the police officer tell the facility's Receptionist that Resident #8 was being mistreated by RR #1, who was caring for the resident. The LNHA acknowledged that mistreated could be considered abuse, but at the time of the allegation, Resident #8 was on the facility's premises out on pass. The LNHA stated that the facility did not conduct an investigation including completing an incident report because Resident #8 was cognitively intact and when the LNHA asked the resident if they were okay, the resident stated they were okay, it was family drama.The facility's failure to implement their abuse policy including investigating all allegations of abuse and protecting all residents from abuse during the investigation, placed Resident #8, as well as all residents at risk for abuse. This posed the likelihood of serious physical and emotional harm or injury which resulted in an Immediate Jeopardy (IJ) situation.The IJ began on 08/05/2025, after the police notified the facility. The facility's Administrator was notified of the IJ on 08/07/2025 at 5:59 P.M. The facility submitted an acceptable Removal Plan (RP) on 08/11/2025 at 10:24 A.M. The surveyor verified the implementation of the RP on-site on 08/12/2025 at 12:45 P.M.The facility further failed to b.) protect a resident (Resident #1) from sexual and physical abuse when Resident #2 entered Resident #1's room and attempted to kiss them on their mouth and Resident #1 bit Resident #2's tongue which resulted in bleeding. In response, Resident #2 hit Resident #1 who sustained bruises to the face. This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #1). The evidence was as follows:Part A A review of the facility policy with a revision date of 01/2025, titled Abuse Prevention Program whose policy statement includes .promotes an environment that does all to prevent resident abuse, neglect, misappropriation of property through the following components: screening and training of employees, prevention, identification, investigation, protection and reporting. Under section V Investigation: an investigation is initiated for all allegations of suspected abuse, neglect or misappropriation. Further in #4 of Investigation it states that the Abuse Investigator will complete a thorough investigation inclusive of interviewing the resident, alleged abuser and any witnesses. In section VII Reporting: it states that The Abuse Investigator will be responsible to make all reports regarding abuse investigations and indicates the agencies to report to. According to the admission Record (AR), Resident #8 was admitted to the facility with the diagnoses which include but were not limited to; amyotrophic lateral sclerosis (ALS-a progressive neurodegenerative disease affecting the brain and spinal cord leading to muscle weakness and atrophy), hypertension (high blood pressure), mood disorder, and anxiety disorder. According to the Minimum Data Set (MDS), an assessment tool dated 05/27/2025, Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating that the resident was cognitively intact.A review of Resident #8's Care Plan (CP) include a focus area dated 05/03/2024, for depression and anxiety and that the resident refused to meet with psychiatry. Interventions included to monitor for depression, and to discuss concerns with [resident name's] family.On 08/06/2025 at 1:45 P.M., during an interview with the Unit Manager (UM #1), she stated that morning (08/06/2025), she became aware of an allegation of abuse involving Resident #8 and their caregiver (RR #1). UM #1 stated that the Social Worker (SW) received a call from a [community name redacted] organization regarding an allegation of abuse, and the SW spoke to Resident #8 about it. UM #1 stated that she assumed the SW investigated the allegation. UM #1 stated that RR #1 helped with Resident #8's care since the resident could be difficult with staff.On 08/06/2025, at 1:59 P. M., the surveyor observed Resident #8's bedroom door closed. The surveyor knocked on the door and RR #1 opened the door. The surveyor noted that Resident #8 was lying in bed eating lunch. There was no facility staff in the room with the resident at that time. On 08/06/2025 at 2:20 P.M., during an interview with the Licensed Practical Nurse (LPN #1), she confirmed that she was aware of the allegation of abuse. LPN #1 stated that she had not seen RR #1 abuse the resident. On 08/06/2025 at 2:34 P.M., during an interview with the SW she confirmed that a [community name redacted] organization notified her that Resident #8's RR #2</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Complaint # 2582137Based on interviews and review of other pertinent facility documentation on 08/05/2025, 08/06/2025, and 08/07/2025, it was determined that the facility failed to implement their abuse policy by thoroughly investigating an allegation of abuse to a resident (Resident #8) that the police officer reported the allegation on 08/05/2025. This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #8).During an interview with the Licensed Nursing Home Administrator (LNHA) on 08/06/2025, revealed that on 08/05/2025, he observed the local police at the facility, and heard the police officer tell the facility's Receptionist that Resident #8 was being mistreated by the Resident Representative (RR #1), who was caring for the resident. The LNHA acknowledged that mistreated could be considered abuse, but at the time of the allegation, Resident #8 was on the facility's premises out on pass. The LNHA stated that the facility did not conduct an investigation including completing an incident report because Resident #8 was cognitively intact and when he asked the resident if they were okay, the resident stated that they were okay; it was family drama.The facility's failure to implement their abuse policy by investigating all allegations of abuse placed Resident #8, as well as all resident at risk for abuse. This posed the likelihood of serious physical and emotional harm or injury which resulted in an Immediate Jeopardy (IJ) situation.The IJ began on 08/05/2025, after the police notified the facility of the allegation. The facility's Administrator was notified of the IJ on 08/07/2025 at 5:59 P.M. The facility submitted an acceptable Removal Plan (RP) on 08/11/2025 at 10:24 A.M. The surveyor verified the implementation of the RP on 08/12/2025 at 12:45 P.M. The evidence was as follows:Refer F 600, F 835 A review of the facility policy dated revised 01/2025, titled Abuse Prevention Program whose policy statement is .promotes an environment that does all to prevent resident abuse, neglect, misappropriation of property through the following components: screening and training of employees, prevention, identification, investigation, protection and reporting, Under section V Investigation: an investigation is initiated for all allegations of suspected abuse, neglect or misappropriation. Further in #4 of Investigation it states that the Abuse Investigator will complete a thorough investigation inclusive of interviewing the resident, alleged abuser and any witnesses. In section VII Reporting: it states that The Abuse Investigator will be responsible to make all reports regarding abuse investigations and indicates the agencies to report to.According to the admission Record (AR), Resident #8 was admitted to the facility with the diagnoses which include but were not limited to; amyotrophic lateral sclerosis (ALS-a progressive neurodegenerative disease affecting the brain and spinal cord leading to muscle weakness and atrophy), hypertension (high blood pressure), mood disorder, and anxiety disorder. According to the Minimum Data Set (MDS), an assessment tool dated 05/27/2025, Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating that the resident was cognitively intact.A review of Resident #8's Care Plan (CP) include a focus area dated 05/03/2024, for depression and anxiety and that the resident refused to meet with psychiatry. Interventions include to monitor for depression, and to discuss concerns with [resident name's] family.On 08/06/2025 at 1:45 P.M., during an interview with the Unit Manager (UM #1), she stated that morning (08/06/2025), she became aware of an allegation of abuse involving Resident #8 and their caregiver (RR #1). UM #1 stated that the Social Worker (SW) received a call from a [community name redacted] organization regarding an allegation of abuse, and the SW spoke to Resident #8 about it. UM #1 stated that she assumed the SW investigated the allegation. UM #1 stated that RR #1 helped with Resident #8's care since the resident could be difficult with staff.On 08/06/2025, at 1:59 P.M., the surveyor observed Resident #8's bedroom door closed. The surveyor knocked on the door and RR #1 opened the door. The surveyor noted that Resident #8 was lying in bed eating lunch. There was no facility staff in the room with the resident at that time. On 08/06/2025 at 2:20 P.M., during an interview with the Licensed Practical Nurse (LPN #1), she confirmed that she was aware of the allegation of abuse. LPN #1 stated that she had not seen RR #1 abuse the resident. On 08/06/2025 at 2:34 P.M., during an interview with the SW, she confirmed that a [community name redacted] organization notified her that Resident #8's RR #2 called them and reported that the RR #1 was abusing the resident. The SW stated that she spoke with the resident who denied the allegations. The survey continued to review Resident #8's medical record.A review of Resident #8's Progress Notes (PN) did not include documentation of the alleged abuse. The PN also did not include documentation from the SW that she received a phone call from a [community name redacted] organization alleging Resident #8 was abused.A review of the medical record also did not include any documentation that a skin assessment was conducted after the allegation of abuse was made On 08/06/2025 at 4:33 P.M. during an</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint # 2582137Census: 137Sample:12Based on observations, interviews, medical record review and review of other pertinent facility documentation on 08/05/2025, 08/06/2025 and 08/07/2025 it was determined that the facility failed to administer medications according to the acceptable practice for 1 of 4 residents (Resident #8). The facility failed to follow their policy titled Administering Medications.The deficient practice was evidenced by the following:Reference: New Jersey Statues Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means the identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen within the scope of practice of the registered professional nurse. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human responses mean those signs, symptoms, and processes which denote the individual's health need or reaction to an actual or potential health problem.The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.According to the admission Record (AR), Resident #8 was admitted to the facility with the diagnoses which include but is not limited to: Amyotrophic Lateral Sclerosis (ALS-a progressive neurodegenerative disease affecting the brain and spinal cord leading to muscle weakness and atrophy), Hypertension, Mood disorder, anxiety disorder. Review of the Minimum data Set (MDS) an assessment tool dated 05/27/2025, indicated that Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating that the resident is cognitively intact.A review of the Order Summary Report (OSR) Active as of 08/06/2025 included the following Physician Orders. (PO's):Calcium Oral Tablet 500 mg by mouth two times a day.Multiple Vitamin-Minerals Tablet give one tablet by mouth daily. Cholecalciferol Tablet 1000 Unit give one tablet twice daily.Rilutek Oral tablet 50 mg give 1 tablet by mouth two times a day for neuromuscular agent give on an empty stomach. Give one hour prior to meal or two hours after.The surveyor observed Resident #8 on 08/06/2025 at 1:59 P.M., who was lying in bed while the caretaker fed the resident lunch. The surveyor observed six pills in a medicine cup at the resident's bedside. On 08/06/2025 at 2:00P.M., the surveyor informed the Unit Manager (UM) of the medication in the cup. On 08/06/2025 at 2:04 P.M., the surveyor observed the UM remove the medication cup from the resident's bedside table and notified the Licensed Practical Nurse (LPN#1) assigned to the resident. The surveyor then interviewed the caretaker about the medication, and asked her if the medication was left for her to medicate the resident. The caretaker replied that she doesn't administer medications to Resident #8 and the resident also shook their indicating that the caretaker did not administer medications. The caretaker stated that the nurse was waiting for pudding to use in administering the medication. The survey interviewed the UM on 08/06/2024 at 2:07 P.M., and she identified the pills in the cup. When asked if it is policy to leave medications at residents' bedside, she replied, No, absolutely not. On 08/06/2025 at 2:20 P.M., the surveyor interviewed LPN #1 who confirmed that she left the medication at the resident's bedside, and stated she knows she should not have, It is not the policy. She further stated that she does not normally do that, but the resident's caretaker wanted the medications to be given in pudding so she left the medications to wait for pudding.During an interview with the Director of Nursing (DON) on 08/06/5025 at 4 2:51 P.M., she stated that it was not the policy for nurses to leave medication at bedside. The expectation would be if they do not take the medication then mark them as refused.Review of the facility policy dated 01/2025 indicated; Administering Medications under the Policy Statement, Medications shall be administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation, 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medicaitons must be administered within one (1) hour of their prescribed time, unless otherwise specified. 18. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Complaint # 2582137Based on interviews and review of other pertinent facility documentation on 08/05/2025, 08/06/2025, and 08/07/2025, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure himself, as well as staff, implemented the facility's abuse policies and procedures to ensure resident safety and well-being by a.) protecting a resident from an alleged perpetrator pending a thorough investigation and b.) thoroughly investigating an allegation of abuse.The Licensed Nursing Home Administrator (LNHA) was interviewed by the surveyor on 08/06/2025. The LNHA stated that on 08/05/2025 he observed the local police at the facility and overheard the police officer tell the facility's Receptionist that Resident #8 was being mistreated by the Resident Representative (RR #1), who was caring for the resident. The LNHA acknowledged that mistreated could be considered abuse, but at the time of the allegation, Resident #8 was on the facility's premises out on pass. The LNHA stated that the facility did not conduct an investigation including completing an incident report because Resident #8 was cognitively intact and when he asked the resident if they were okay, the resident stated they were okay; it was family drama.The facility's failure to ensure the LNHA, as well as all staff, implemented their facility policies to ensure all residents were free from abuse by not protecting a resident from abuse and not investigating an allegation of abuse posed the likelihood for serious physical or emotional harm or injury. This resulted in an Immediate Jeopardy (IJ) situation.The IJ began on 08/05/2025, after the police notified the facility of the allegation. The facility's Administrator was notified of the IJ on 08/07/2025 at 5:59 P.M. The facility submitted an acceptable Removal Plan (RP) on 08/11/2025 at 10:24 A.M. The surveyor verified the implementation of the RP on 08/12/2025 at 12:45 P.M. The evidence was as follows:Refer F 600, F 610 A review of the undated Administrator - Job Description provided by the facility included the following:Position Summary: this position is responsible to establish and maintain systems that are effective to operate the nursing home in a manner to safely meet residents' needs in accordance with federal, state, and local regulations.Essential Requirements, Duties, and Responsibilities.develop, maintain and implement operational policies and procedures to meet residents' need compliance with federal, state and local requirements.develop and enforce a monitoring program to assure compliance with federal, state, and local requirements.establish systems to enforce the facility policies and procedures.establish systems to ensure compliance with federal, state, and local regulations.observe all facility policies and procedures.A review of the facility policy that was revised on 01/2025, titled Abuse Prevention Program included policy statement .promotes an environment that does all to prevent resident abuse, neglect, misappropriation of property through the following components: screening and training of employees, prevention, identification, investigation, protection and reporting, Under section V Investigation: an investigation is initiated for all allegations of suspected abuse, neglect or misappropriation. Further in #4 of Investigation it states that the Abuse Investigator will complete a thorough investigation inclusive of interviewing the resident, alleged abuser and any witnesses. In section VII Reporting: it states that The Abuse Investigator will be responsible to make all reports regarding abuse investigations and indicates the agencies to report to.On 08/06/2025 at 1:45 P.M., during an interview with the Unit Manager (UM #1), she stated that morning (08/06/2025), she became aware of an allegation of abuse involving Resident #8 and their caregiver (RR #1). UM #1 stated that the Social Worker (SW) received a call from a [community name redacted] organization regarding an allegation of abuse, and the SW spoke to Resident #8 about it. UM #1 stated that she assumed the SW investigated the allegation. UM #1 stated that RR #1 helped with Resident #8's care since the resident could be difficult with staff.On 08/06/2025, at 1:59 P. 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The LNHA further stated that it was presented as a third-party claim of abuse and added; I went outside and spoke to them right away. When the surveyor asked about what should be done when there was an allegation of abuse of a resident the LNHA responded</p>		