STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315262	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrogate	400 Locust Street Lakewood, NJ 08701

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interviews and records review on 9/19/25, it was determined that the facility failed to ensure a resident (Resident #2) was free from a medication error when the medication nurse administered wrong medication to Resident #2; and the facility also failed to follow their policy for medication administration. The deficient practice was identified for 1 of 3 residents reviewed for medication administration.This was evidenced by the following.According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: Type 2 Diabetes Mellitus, Respiratory Failure, Pneumonia and Toxic Effect of Tobacco Cigarettes. According to the Minimum Data Set (MDS), an assessment tool dated 07/25/2025, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15/15, which indicated the Resident was cognitively intact.According to the facility reportable form dated 08/28/2025 at 9:10 a.m., on 08/28/2025 at 9:10 a.m. when the Registered Nurse #1 (RN #1) was administering morning medications to residents, she prepared and administered 4 units of Novolog and 16 units of Lantus Insulin to Resident #2. (The intended recipient of the insulin was resident #2's roommate. During an interview on 09/19/2025 12:00 pm, RN#1 stated she became distracted during the medication administration and gave the insulin to Resident #2 instead of giving it to the resident's roommate. RN#1 stated that she immediately realized that she had administered the insulin wrongly to Resident #2 and that she then reported the incident to the Director of Nursing. RN #1 further stated that she called Resident #2's physician who ordered blood sugar monitoring for the resident. RN#1 stated that she should have asked Resident #2 their name and why they were getting the medication and should have followed the 5 Rights of Medication Administration which is the right patient, right dose, right time, right medication and right route. RN#1 further stated that she was rushing and should have checked the resident before administration and that she was wrong in not following protocols.During an interview on 09/19/2025 at 10:30 a.m., the Director of Nursing (DON) stated that facility policy required that prior to medication administration, the nurse would do the patient identification using the name band, ask the resident state their name and also check the resident face sheet picture.During a follow up interview with the DON on 9/19/2025 at 2:pm,the DON stated that Resident #2 had no negative consequence from the wrong medication they received from the nurse.A review of the facility's policy with revision date of April 2019 titled Administering Medications under Policy Statement revealed: Medications are administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation #9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 26. Medications ordered for a particular resident may not be administered to another (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, unless permitted by state law and facility policy, and approved by the director of nursing services.NJAC 8:39-29.2 (d)