

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Continuing Care at Lantern Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 537 Mountain Avenue New Providence, NJ 07974	

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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2690327Based on interviews and review of pertinent facility documents on 12/18/25, it was determined that the facility failed to protect a resident (Resident #1) from a significant medication error when the Licensed Practical Nurse, LPN #1, administered intravenous (IV) Zosyn [antibiotic] to Resident #1 and administered IV Meropenem [antibiotic] to Resident #2. Resident #1 had a physician's order for Meropenem 1-gram intravenous solution every eight hours for their heel wound infection [osteomyelitis] and Resident #2 had a physician order for Zosyn 4.5-gram intravenous solution every eight hours for thirty-two days for their wound infection [toe infection]. The Medical Doctor (MD) was notified immediately and ordered to monitor the residents closely. Resident #1 vomited one time at lunchtime, face flushed, felt cold with chills. MD was present and administered IV Benadryl [antihistamine medication for allergic reactions]. Resident #1 was transferred out to hospital emergency room (ER) by 911 [emergency services] and was admitted .On 12/3/25, it was found that LPN #1 administered 6:00 AM dose of IV 1 gram Meropenem to Resident #2 instead of to Resident #1. Also on 12/3/25, it was found that LPN #1 administered 6:00 AM dose of 4.5 gram IV Zosyn to Resident #1 instead of to Resident #2. MD was immediately notified and the residents were closely monitored. Resident #2 was monitored with no adverse effects from one dose of IV medication. Resident #1 was monitored and noted at lunch to vomit one time, face flushed, felt cold with chills. MD administered IV Benadryl and transferred the resident out to hospital for possible side effects of allergic reaction. Resident #1 was admitted to hospital with dx [diagnosis] drug reaction, fever tachycardia (rapid, abnormal heart rate). The facility's failure to protect a resident from a significant medication error placed Resident #1 as well as other residents at risk for significant medication error. This posed the likelihood of serious physical harm injury, or death which resulted in an immediate jeopardy (IJ) situation. The IJ began on 12/3/25 at 6:00 AM when LPN #1 administered the wrong IV antibiotic medications to Residents #1 and Resident #2. The facility's Administration was notified of the IJ on 12/18/25 at 6:00 PM. The facility submitted an acceptable Removal Plan (RP) on 12/19/25 at 6:21 PM. The surveyor verified the implementation of the RP on-site during the continuation of the survey 12/23/25. The deficient practice was evidenced as follows: A review of the facility's policy on Medication Administration, Receipt, Storage & Disposal, version dated 10/2023, included under Procedure: Medication Administration/Assistance .2. Medications are administered in accordance with Nursing Standards of practice and state law; 4. Trained staff designated to administer medications will verify that he/she is administering medications using the 5 Rights of Medication Administration/Assistance and are documented immediately following completion of task for each resident: i) Right resident ii) Right medication iii) Right dose iv) Right time, v) Right route. A review of the Reportable Event Record/Report (FRE) submitted by the facility to the New Jersey Department of Health (NJDOH) on 12/8/25, included the date and time of event: 12/3/25 at 5:30 AM. The FRE further included under Narrative that on 12/3/25, it was found that LPN #1 administered 6:00 AM</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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>dose of IV 1-gram Meropenem to Resident #2 instead of Resident #1. Also, on 12/3/25, it was found that LPN #1 administered 6 AM dose of 4.5 gram IV Zosyn to Resident #1 instead of Resident #2 .Resident #1 was monitored and was noted at lunch to vomit one time, face flushed, felt cold with chills. MD administered IV Benadryl and transferred out the resident to hospital for possible side effects of allergic reaction. A review of the facility's Investigation Summary (IS) dated 12/5/25 under Incident Summary: Resident #1 .primary dx includes osteomyelitis .has a physician order for meropenem 1-gram intravenous solution every 8 hours for indication of osteomyelitis of heel. Resident #2 .primary dx includes acute osteomyelitis left ankle and foot .has physician orders for piperacillin-tazobactam [Zosyn] 4.5 gram intravenous solution every 8 hours for 32 days for indication 1st distal [outer/far] phalanx [bone of toe/finger] osteomyelitis [infection]. The IS further indicated on 12/3/25, it was found that LPN #1 administered IV Meropenem to Resident #2 and IV Zosyn to Resident #1. MD immediately notified and residents closely monitored. Resident #2 monitored with no adverse effects. Resident #1 monitored and at lunch vomited x1, face flushed, felt cold with chills. MD administered IV Benadryl .and the resident was transferred out to hospital and was admitted .Resident #1 was discharged from the hospital on [DATE] and returned to facility with new orders for Allergy to PCN [penicillin] and Zosyn .At the time of incident, LPN #1 was immediately educated by the Assistant Director of Nursing (ADON) and was suspended pending investigation. LPN #1 was terminated from employment by LNHA on 12/9/25. A review of the facility's IS included statements from staff. According to the Clinical Manager, Registered Nurse (CMRN), on the morning of 12/3/25, they heard IV pump alarms from their office. The nurse on the floor at the time was busy in another room so they decided to silence the alarms and flush lines for Resident #1 and Resident #2. Both of their IV antibiotics had finished. When the CMRN went to Resident #2's room, they noticed that Resident #1's Meropenem was hung for Resident #2. The Meropenem bag was clearly marked with Resident #1's name, medication name, and dose. Resident #2 appeared to be in good spirits and was not displaying any adverse effects. The CMRN then proceeded to Resident #1's room and discovered that Resident #2's Zosyn had been hung and was finished. This bag was also clearly marked with Resident #2's name, medication, and dose. The CMRN immediately informed LPN #1 who then did a brief assessment and immediately called the doctor for directions and orders. There were no signs of adverse reaction at this point. The CMRN further included in their statement that when hanging IV medications the pump that they used launched a red warning window as the last step in the set-up process. The CMRN stated it would take the nurse to confirm the medication being administered. A review of the statements obtained from LPN #1 dated 12/3/25. According to LPN #1, at around 5:30 AM, a medication error occurred whereby resident was administered the wrong IV medication. LPN #1 stated there were some computer issues and poor lighting and they did not give the med to the right patient. MD on call was promptly notified and instructed to closely monitor the residents. The CMRN and the ADON assisted in resolving the issues surrounding the error, provided education. The residents remained stable and showed no reactions in the immediate hours. Family was notified, PCP [primary care physician] came to follow up and reassessed.A review of the statement made and signed by the ADON. In their statement, the ADON stated they were notified of the medication error with LPN #1 administering the wrong IV antibiotic to two residents. When they interviewed LPN #1, LPN #1 stated that they were setting up IV antibiotics at Nurse Station desk top area. When questioned why, LPN #1 stated that one computer was not working and the other was not charged. LPN #1 said they prepared both residents' IV antibiotics and hung the IV infusions. The CMRN later informed the ADON that when they were going to silence the alarm from pump alerting completion of infusion to find the wrong antibiotic was hung for the two residents. The ADON further said that the CMRN</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>required assistance from staff in the completion of their activities of daily living (ADLs). The resident's MDS further revealed in Section N-Medications, under N0415. High-Risk Drug Classes: Use and Indication, that the resident was taking .F. Antibiotic and an Indication was noted. A review of Resident #2's individual HCP under 10. Medications which included a Goal and Care Plan Approaches which included but not limited to: The nurse and/or caregiver will administer my medications as prescribed and monitor for side effects daily.A review of Resident #2's Medication Administration Record (MAR) titled December 2025 Medications indicated an entry order of piperacillin-tazobactam (Zosyn) 4.5 gram intravenous solution (4.5 gm/100ml) VIAL Intravenous; Every Eight Hours for Thirty-Two Days Starting 11/13/2025 Order ID: 4005870 with Order Date:11/13/2025; Discontinued (12/03/2025); Notes: Indication: 1st distal phalanx osteomyelitis. The MAR revealed under Schedule of 6:00 am and column 03 [stands for date 12/03] showed LPN #1 initial of [redacted] indicating the nurse administered the medication. On 12/18/25 at 2:52 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The DON stated LPN #1 did not follow the facility's medication administration procedure. The DON further stated the LPN was hired around four months ago and passed her medication administration pass competencies with both the ADON and the pharmacist consultant (PC), attended the education in-services as required. DON said that when they knew of the incident on medication error on 12/3/25 with the two residents, the LPN was educated on medication administration competency.The LNHA stated LPN #1 was suspended pending investigation and was eventually terminated on 12/9/25. The DON stated LPN #1 did not follow the medication pass protocol and procedure despite education in-services that were done with her by the facility. A Removal Plan (RP) was submitted by the facility on 12/19/25 at 6:21 PM indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: On 12/3/25, LPN #1 was found to administer the incorrect IV antibiotic medications to Resident #1 and Resident #2; MD was notified immediately and both residents were closely monitored; 12/3/25 at lunchtime, Resident #1 vomited one time, face flushed and felt cold with chills, MD at bedside and the resident was transferred to the ER; Resident #2 had no adverse reactions to the medication error; on 12/3/25, nurse medication administration observation checklist was completed and LPN #1 demonstrated competency immediately after medication error was found; LPN #1 was suspended on 12/3/25 and terminated on 12/9/25; on 12/3/25, a 100% audit of all current residents that have physician order of IV antibiotics were reviewed by the assistant director of nursing (ADON) to validate the correct IV antibiotics orders and that IV medications were in the medication room; medication administration education began on 12/3/25 and IV competencies began for all nurses - all nursing staff must complete education and competencies before their next scheduled shift; all newly hired nurses will be educated on proper medication administration including return demonstration during orientation; on 12/4/25 a new process was created requiring two nurses to verify the correct IV medication before administering to residents, and random audits were being conducted monitoring nurses who were administering IVs started on 12/4/25. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 12/23/25. NJAC 8:39-29.2(d)</p>		