STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315269	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Point	Three David Brainerd Drive Monroe Township, NJ 08831

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint: 2809139Based on interviews, review of medical records, and review of other pertinent facility documents on 3/30/2026, it was determined that the facility failed to ensure that residents (Resident #2 and Resident #3) were free of significant medication errors. On 3/12/2026, a Nurse Trainee Licensed Practical Nurse, (LPN#1) who was assigned with a preceptor (LPN#3) administered the wrong medications to Resident #2. The resident had no adverse reaction to the wrong medications. LPN #1 was re-educated by staff that same day about medication administration. A second medication error occurred on 3/18/2026 when LPN #1 who was assigned with a preceptor LPN #2 administered wrong medications to Resident #3. This resident had a harmful adverse reaction to the wrong medications and was sent to the Emergency and admitted to the hospital. This deficient practice was identified for 2 of 5 residents (Resident # 2 and Resident #3) reviewed. The facility policy titled: Administering Medication with a revised date of 01/10/2025 was reviewed. The Policy stated that Medications will be administered in a timely manner and as prescribed by the resident's attending physician or the facility's medical director. Under Procedure 3, the policy stated that Medications must be administered in a timely manner and in accordance with the attending physician's written/verbal orders. Under procedure 7, the policy stated that the individual administering the medication must ensure that the right medication, the right dose, the right time, and right method of administration are verified before medication is administered (e.g., review of the drug label, physician orders, etc.) 14. Medication ordered for a particular resident may not be administered to another resident.According to the Facility Reportable Event (FRE) record dated 3/19/2026, which the facility submitted to the New Jersey Department of Health (NJDOH), the Nurse Trainee (LPN #1) accidentally administered Jardiance 10mg along with Metoprolol succinate 100mg, Protonix 40mg, Areds 4296mcg/90mg/226mg along with Eliquis 2.5mg to Resident #3. Resident #3's physician was notified about the error, the resident's resulting low blood pressure reading of 80/50, and symptoms of hypoxia (low blood oxygen level). The resident was transferred to the emergency room and admitted at the hospital.A review of the facility document titled Clinical Note Report (CNR), dated 3/18/2026 revealed LPN #2 documented that she was assigned as preceptor to newly oriented nurse LPN#1 during the day shift (7:00 AM to 3:00PM). At the time of medication pass, the preceptor was assisting another resident and directly observing medication administration for safety. During this time, the newly oriented nurse (LPN #1) independently administered medications to assigned residents. LPN #2 was not present at bedside at the time LPN #1 inadvertently administered the medications to Resident # 3 that were intended for Resident #1. When LPN #1 told LPN #2 about the medication error, she immediately assessed the resident and notified supervisor. The supervisor notified the physician and family. On 03/18/2026, LPN #1 administered the following medications to Resident #3. Jardiance 100 mg (used to treat diabetes), Metoprolol Succinate 100 mg (used to treat hypertension), Protonix 40 mg (used to treat gastroenteritis), Areds 4296 mcg/90 mg/226 mg (used for vision treatment) and Eliquis 2.5 mg (used as blood thinner). These medications were prescribed for Resident #1.According to the admission Record face sheet, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: muscle weakness, diabetes mellitus, (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	acute respiratory failure and epilepticus. According to the quarterly MDS dated [DATE], Resident #3 had a BIMs score of 13 out of 15, which indicated the resident's cognition intact.A review of Resident #3's Order Summary Report (OSR) active orders dated 03/01/2026 contained the following medication orders:Keppra 500mg 1 tab twice daily for seizure.Metformin 500mg 1tab daily for diabetes.Amiodarone 100mg 1 tab daily for arrhythmia.Lipitor 10mg 1 tab daily for lipids.Methimazole 5mg 1 tab daily for hyperthyroidism.Multivitamin 1 tab daily for supplement.Sitagliptin 100mg 1 tab daily for diabetes.Vitamin D25mcg 1 tab daily for supplement.Metoprolol 25mg 1 tab daily for supplement. According to the admission Record face sheet, Resident #1 was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia, chronic kidney disease, overactive bladder, major depression and presence of a cardiac pacemaker. According to the quarterly Minimum Data Set (MDS), an assessment tool dated 01/25/2026, Resident #1 had a BIMs score of 10 out of 15, which indicated the resident's cognition was moderately impaired.A review of Resident #1's OSR active orders dated 03/01/2026 contained the following medication orders:Lipitor 20mg 1 tablet (tab) daily for HLD.Multivitamin 1 tab daily for supplement.Jardiance 10mg 1 tab daily for diabetes.Synthroid 25mg 1 tab daily for hypothyroidism.Lisinopril 10mg 1 tab daily for hypertension.Norvasc 5mg 1 tab daily for hypertension.Flomax 0.4mg 1 capsule daily for urinary frequency.Aspirin 81mg1 tab daily for coronary artery disease.Melatonin 5mg 1 tab daily for insomnia.Eliquis 2.5mg 1 tab twice daily for A Fib.Metoprolol 100mg 1 tab daily for hypertension.Myrbetriq 25mg 1 tab daily for overactive bladder.Metformin 500mg 1 tab daily for diabetes.PreserVision 4296mcg-226mg-90mg 1 capsule daily.Protonix 40mg 1 tab daily for reflux.Zoloft 100mg 1 tab daily for depression. During a telephone interview with LPN #1 on 03/30/2026 at 10:37 AM, she stated that she was in training (orientation) on 03/12/2026 and 03/18/2026. On 03/12/2026, she went into the room shared by Resident #2 and Resident #4 to administer medications. She asked Resident #2 to state their name. The resident stated Resident #4's name. LPN #1 stated that she did not check Resident #2's identification band to confirm their identity. At this time, Resident #2 was administered Resident 4's medications. On 03/18/2026, LPN #1 stated while she was still on orientation with her preceptor LPN #2, LPN #2 told her to go independently and administer medications to Resident #1. LPN #2 provided the name of the resident (Resident #1) to LPN #1. Resident #1 and Resident #3 are roommates. LPN#1 stated that she administered medications to Resident #3. At this time, the Certified Nursing Assistant (CNA #1) who was in the room assisting Resident #1 asked her if she was going to administer medications to this resident. She stated to the CNA that she administered Resident #1's medications, and she was pointing to Resident #3. The CNA revealed to her at this time that Resident #3 was not Resident #1 [name indicated]. LPN#1 stated at this time she immediately informed LPN #2 about the medication error. LPN #1 stated that she did not follow the facility medication policy. On 03/30/2026 at 9:11 AM, the surveyor interviewed LPN #2, who confirmed she was the preceptor for LPN #1 on 03/18/2026 during the 7:00 AM to 3:00 PM shift. LPN #2 stated that she was in the room with another resident during the time LPN #1 was conducting the medication pass. She instructed LPN #1 to independently administer medications to Resident #1. LPN #1 informed her that she had administered Resident #1's medications to Resident #3. LPN # 2 stated the resident's physician was immediately notified of the medication error. LPN #2 stated, she should have remained with the orientee during medication administration.During interview with the Unit Manager/LPN (UM/LPN) on 03/30/2026 at 11:20 AM, she confirmed that LPN #1 was on orientation and assigned with a preceptor (LPN#3) on 03/12/2026 during the 7:00Am to 3:00PM shift. The UM/LPN stated Resident #2's physician was immediately notified of the medication error. The physician ordered staff to monitor Resident #2. She stated that on 03/12/2026, the facility medication policy was not followed by LPN #1.During interview with Resident #2 on 03/30/2026 at 11:48 AM, the resident stated that on 03/12/2026, LPN #1 came into their room to administer medications. LPN #1 did not check their identification band or their name.The CNR dated 03/12/2026, identified that on 03/12/2026 at approximately 10:00 AM, a medication error (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	occurred. Resident #2 was administered medications that were prescribed for Resident #4. On 03/12/2026 a medication error was noted for Resident #2, who received medications prescribed for Resident #4. The medications administered in error included the following: Farxiga 10 mg (used to treat Diabetes), Protonix 40 mg (used to treat gastroenteritis), and Depakote 125 mg (used to treat mood disorder) The physician was notified and staff continued to monitor Resident #2 for any adverse reaction for the medications that were administered. On 03/30/2026, the Licensed Nursing Home Administrator (LNHA) provided Individual Statement Form (ISF) dated 03/12/2026 which revealed LPN #1 failed to verify Resident #2's name before administering medications. The preceptor LPN #3 In the ISF dated 3/13/2026, included that LPN#1 (trainee) is not safe to pass medications by herself and needs further training on the floor. On 03/30/2026, during interviews with LPN #2 and UM/LPN revealed Resident # 1 on 3/18/2026 and Resident #4 on on 3/12/2026 both received their received their prescribed medications. A review of sample Resident #2 medical record revealed the following: The surveyor reviewed the medical record for Resident #2. According to the admission Record face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: edema, traumatic brain injury, depression, and hypertension According to the quarterly MDS dated [DATE], Resident #2 had a BIMs score of 15 out of 15, which indicated the resident was cognitively intact. A review of Resident #2's OSR active orders dated 03/01/2026 revealed the following medication orders.Flomax 0.4mg 1 cap daily for urinary frequency.Colace 100mg daily for constipation.Centrum Complete 18mg-4400mcg 1 tab daily for supplement.Lexapro 30mg 1-tab daily for depression.Zieta 10mg 1 tab daily for lipids.Lasix 40mg 1 tab daily for edemamedroxyprogesterone 10mg 1 tab daily for hypersexuality.Senna 8.6mg 2 tabs daily for constipation.Colace 100mg 2tab daily for constipation.Potassium ER 20meq 1 tab daily for supplement. According to the admission Record face sheet, Resident #4 was admitted to the facility with diagnoses which included but were not limited to: Diabetes mellitus, muscle weakness, insomnia, and chronic kidney disease. According to the annual MDS dated [DATE], Resident #4 had a BIMs score of 9 out of 15, which indicated the resident's cognition was moderately impaired.A review of Resident #3's OSR active orders dated 03/01/2026 revealed the following medication orders.Metformin 1000mg 1 tab daily for diabetes.Farxiga 10mg 1 tab daily for diabetes.Melatonin 3mg 1 tab at daily for insomnia.Vitamin B12 1 tab daily for supplement.Gabapentin 100mg 2 tabs daily for neuropathy.Protonix 20mg 1 tab daily for reflux.Vitamin D3 25mcg 1 tab daily for supplement.Depakote 125mg 1 tab twice daily for mood.During an interview on 03/30/2026 at 1:12 PM with the Director of Nursing (DON) in the presence of the LNHA, the DON stated new nurses are paired with a preceptor during orientation phase. The DON stated LPN #1 was hired on 02/12/2026. The DON presented the surveyor with LPN #1's Licensed Nurse orientation Checklist that was blank. The facility's failure to ensure that residents were free from significant medication errors placed Resident #2 and Resident #3 and all other residents at risk for serious harm, injury/or death and resulted in an Immediate Jeopardy (IJ) situation. The facility was notified the F 760 IJ and was provided with the IJ template on 03/30/2026 at 5:35 PM.The IJ began on 03/18/2026. The facility submitted an acceptable Removal Plan (RP) on 04/01/2026 at 11:39 AM, 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 to include: on 03/18/2026 the orientee was immediately removed from providing care to any residents and terminated on 03/31/2026. The Consultant Pharmacist was immediately notified of the incident. On 03/19/2026, the DON/Unit Coordinators/Nursing Supervisors immediately initiated the following: An in-service on 5 Rights and Medication Administration. An audit of all resident photos to ensure proper identification of residents. An audit of all resident wristbands to ensure proper identification of residents. On 03/31/2026 the DON/Designee imitated the following: A mandatory in-service for all licensed Nurses on the following topics: (1) the five rights of medication administration with emphasis on resident identification verification; (2) facility policy for medication administration, including requirements for medication administration record (MAR) photo verification and two -identifier (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	confirmation; (3) preceptor responsibilities and requirement for direct observation during orientee medication passes and never to leave an orientee alone; (4) reporting obligations when a medication error occur; and (5) nurses were re-educated on how to be a preceptor. All nurses who were off duty will be re-educated when they return prior to the start of their shift. As of 04/02/2026, all licensed nurses were observed during medication administration for competency by the DON.The surveyor verified the implementation of the RP during an onsite continuation survey on 4/2/2026 at 12:25 PM. The immediacy was removed as of 04/02/2026 at 12:25PM NJAC 8:39-27.1(a)