STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aster Creek Nursing and Rehabilitation Center	524 Wardell Road Tinton Falls, NJ 07753

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. Complaint 2962681Based on interviews, review of the medical records, and review of other pertinent facility documentation, it was determined that the facility failed to ensure that a resident (Resident #2) was free from significant medication errors on 03/21/26. On 3/21/26 at approximately 11:55 AM the LPN administered the wrong medications; Amlodipine 10 mg (milligrams) (a prescription medication to treat high blood pressure), Aspirin 81 mg, Divalproex Na 125 mg (a prescription medication used to treat certain types of seizures/epilepsy), Zoloft 50 mg (a prescription medication used to treat Major Depressive Disorder (MDD), Obsessive-Compulsive Disorder (OCD), Panic Disorder, Posttraumatic Stress Disorder (PTSD), Premenstrual Dysphoric Disorder (PMDD), and Social Anxiety Disorder), and Iron 325 mg intended for another resident (Resident #1) to Resident #2. Resident #2 was assessed and sent to the emergency room and admitted for observation, returning to the facility on 3/23/26.The facility self-corrected and put themselves back in compliance to prevent serious harm from occurring or recurring on 3/28/26 when education on Rights of Med Pass for licensed facility staff nurses was completed. The IJ was Past Non-Compliance (PNC). This deficient practice was identified for 1 of 5 residents (Resident #2) reviewed for significant medication error.The evidence was as follows:A review of the facility's policy titled, Medication Administration revised 4/2025, included under Policy, It is the policy of the Nursing Department to administer medications to residents in a timely (within one hour of prescribed time) and accurate manner (observing 5 rights in giving medications) and to ensure that all medications are prescribed by a physician and administered by a licensed nurse. Under Purpose: To provide a safe, effective medication administration process. Under Procedure: 4. The licensed nurse is to identify the resident to whom he/she is to administer medications before commencing administration. This can be accomplished by checking the resident's name band.A review of the Facility Reportable Event (FRE) dated 3/21/26, submitted to the New Jersey Department of Health (NJDOH) included the following:On March 21, 2026, an agency nurse [initials redacted] asked Staff Registered Nurse (RN #1) [initials redacted] to identify Resident #1. RN #1 identified Resident #1 as the resident seated at the end of the table in the dayroom with grey hair in a ponytail. Shortly thereafter, the agency nurse reported that he believed he had administered medications intended for Resident #1 to the wrong resident, identified as Resident #2, who was seated in the middle of the table.The facility provided a summary of the investigation related to the FRE, which stated that the Certified Nursing Aide (CNA #1) had observed the agency nurse who was a Licensed Practical Nurse (LPN) administering medications to Resident #2. CNA #1 questioned the LPN as she knew that Resident #2 was not in his assignment. After being questioned by the CNA, the LPN reported himself to RN #1 and stated he believed he administered medications to the wrong resident.According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia (significant, progressive decline in memory) and dysphagia (difficulty swallowing).According to the Minimum Data Set (MDS), an assessment tool dated 2/9/26, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated that the resident's cognition was moderately impaired.Resident #2's CP included the following:Under Focus date initiated 9/11/23: I [Resident #2] have impaired cognitive function/dementia. Under Goal: I [Resident #2] will develop (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	skills to cope with cognitive decline and maintain safety by the review date. Under Interventions: Communication: Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Provide the resident with necessary cues - stop and return if agitated.A review of Resident #2's Order Summary Report (OSR) revealed the following physician's orders (PO):-Amlodipine Besylate Tablet 2.5 MG Give 1 tablet by mouth one time a day related to essential (primary) hypertension (HTN) (high blood pressure that has no single, distinct, or underlying medical cause) hold if Systolic Blood Pressure (SBP) less than 110.A review of Resident #2's vital signs indicate that at 3/21/26 at 12:10 PM, Resident #2 had a blood pressure of 137/60. On 3/21/26 at 12:37 PM, Resident #2's blood pressure was 99/47 before Resident #2 was transported to the hospital.According to the AR, Resident #1 was admitted to the facility with diagnoses which included but were not limited to: essential (primary) hypertension, kidney transplant status, and weakness.According to the MDS, an assessment tool dated 2/3/26, Resident #1 had a BIMS score of 15 out of 15 which indicated that the resident was cognitively intact.Resident #1's CP included the following:Under Focus date initiated 2/1/26: The resident has hypertension (HTN) r/t (related to) lifestyle choices, Smoking. Under Interventions: Give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a sudden, significant drop in blood pressure that occurs when standing up from a sitting or lying position) and increased heart rate (Tachycardia) and effectiveness.A review of Resident #1's OSR revealed the following PO:- Amlodipine Besylate Tablet 10 MG Give 1 tablet by mouth one time a day for HTN.A review of the electronic Medication Administration Records (eMAR) showed that Resident #2 received their prescribed 2.5 mg of Amlodipine and due to the medication error, received another 10 mg dose of Amlodipine (for a total of 12.5 mg), as well as Aspirin 81 mg, Divalproex Na 125 mg (a prescription medication used to treat certain types of seizures/epilepsy), Zoloft 50 mg (a prescription medication used to treat Major Depressive Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Posttraumatic Stress Disorder, Premenstrual Dysphoric Disorder and Social Anxiety Disorder), and Iron 325 mg prescribed for Resident #1. On 5/13/26 at 10:11 AM, the surveyor interviewed CNA #2 who stated that to identify a resident there is a name tag on the resident's door, a staff member could simply ask the resident themselves or if the resident is unable to respond staff can check the resident's wristband or can check with another coworker.On 5/13/26 at 10:25 AM, the surveyor interviewed RN #2. RN #2 reported that to identify residents there are pictures of residents in Point Click Care (PCC), that resident names are outside the door of their rooms, to check wristbands, or to confirm with another staff member the resident's identity.On 5/13/26 at 10:50 AM, the surveyor interviewed the Unit Manager (UM) for Unit 4 of the facility. The UM stated that her expectations for staff at her facility, when it comes to med pass, is that medications are given in a safe and respectful manner which follows the guidelines for the policies and practices that are put in place. She further stated that she expects her staff to give the right medications to the right residents. On 5/13/26 at 11:11 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and the LNHA in training. The DON stated she was notified by her UM via a phone call regarding the LPN administering the wrong medications to Resident #2. She stated that she had concerns about observing Resident #2 due to Resident #2's age and the type of medications that had been administered, as well as the potential side effects.On 5/13/25 at 11:49 AM, the surveyor interviewed the DON who stated there were pictures of the residents (referring to PCC) so she was unsure how or why the medication error occurred. She further stated that Resident #1 and Resident #2 are different ethnicities and skin tones and that the LPN did not follow the rights of medication by looking at the picture to identify the resident.On 5/13/25 at 12:55 PM, the surveyor interviewed the DON and LNHA with the LNHA in training present. The DON stated that the facility reviews medication pass during agency nurse orientation but that a direct med pass is not conducted. The LNHA stated that the medication error should not have occurred, whether an agency or a staff nurse, because all residents have pictures in PCC. He further stated that agency staff could also ask another staff (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	member to verify a resident's identity. On 5/14/25 at 12:30 PM in a phone interview with the UM the surveyor confirmed the UM had conducted and signed off on the LPN's Nursing Agency Orientation Checklist. The surveyor questioned the UM on what that orientation consisted of and how long it took. The UM stated that it takes about ten minutes and it's a review and reading of the facility policies that are listed on the checklist, including Medication Pass competency 5 rights.The facility addressed the situation by immediately removing the LPN, contacting the agencies who supply the facility with agency staff and requesting that all licensed nurses from agencies have completed abuse and neglect training and medication pass competency validation prior to their first shift at the facility, and completing in-services to all their licensed facility staff nurses regarding the Rights of Med Pass on 3/28/26.The IJ began 3/21/26, when the LPN failed to identify the correct resident to administer medications to, which led to a significant medication error. The IJ is Past Non-Compliance. The surveyor verified the implementation of the facility's Removal Plan (RP) while onsite on 5/13/26 and determined that there is sufficient evidence that the facility corrected the noncompliance on 3/28/256 and is in substantial compliance at the time of the current survey for the specific regulatory requirements for F760. N.J.A.C. 8:39-29.2(d)