

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>(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>**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 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</p>		