STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315523	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Lantern Hill	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review it was determined the facility failed to follow standards of clinical practice with regards to ensuring a medication was administered to a resident and not left at the bedside for 1 of 12 residents (Resident #25).This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 1/12/26 at 8:30 AM, the surveyor observed Resident #25 lying in their bed. The resident opened their eyes to the surveyor's greeting and provided no verbal response. The surveyor observed on the resident's bedside table a clear medicine cup which contained apple sauce sprinkled with a white colored pellet (sprinkle) medication.On 1/12/26 at 8:36 AM, the surveyor interviewed Resident #25's assigned Licensed Practical Nurse (LPN) who stated she had not administered any medications to the resident yet on her shift. The surveyor with the LPN reviewed Resident #25's Medication Administration Record (MAR) which revealed the resident received omeprazole capsule (a medication used to reduce stomach acid, which inside contained enteric-coated pellets when opened). The LPN stated a nurse should ensure a medication was taken by a resident and medications should not be left at the resident's bedside.The LPN accompanied the surveyor to Resident #25's room and observed the medication at the resident's bedside. The LPN acknowledged that the medication should not be left at the bedside. The LPN took the medication to be disposed of and stated she would call to inform the physician.On 1/12/26 at 8:39 AM, the surveyor informed the Clinical Manager (CM) of the concern that a medication was found at Resident #25's bedside. The CM acknowledged the concern and stated that all nurses knew they were not to leave medications at the resident's bedside as it was against protocol.On 1/12/26 at 10:40 AM, the surveyor reviewed the Electronic Medical Record (EMR) of Resident #25.The Face Sheet (a summary of important resident information) revealed Resident #25 had diagnoses that included but were not limited to, hemiplegia (a paralysis or severe weakness affecting one side of the body), aphasia (a disorder that affects how you communicate), and heart failure.A Comprehensive Minimum Data Set assessment, a tool used to facilitate management of care, dated 12/12/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a 3 out of 15, which indicated the resident had severe cognitive impairment.A physician's order dated 2/22/25 indicated to give omeprazole 40 mg, one capsule by mouth two times a day. The medication was scheduled for 6 AM and 4 PM.A review of the January 2026 Medication Administration (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record (MAR) revealed the omeprazole capsule entry was signed by the nurse as administered for the 1/12/26, 6 AM dose.On 1/13/26 at 1:39 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the concern for the medication observed at Resident #25's bedside. The DON acknowledged the concern, stated that an investigation was initiated immediately, and education would be provided to all staff. There was no additional information provided by the facility.The surveyor reviewed the facility provided policy titled, Medication Administration, Receipt, Storage & Disposal with a version date of October 2023. The policy did not address administering medication to a resident or leaving medications at the bedside. No additional medication administration policy was provided by the facility. The surveyor reviewed the facility provided Medication Administration Observation Checklist, used to evaluate a nurse's competency, which listed the steps of medication administration. Under Standard revealed the steps which included observation of a resident swallowing medications and documentation of a medication administered after its administration. NJAC 8:39-11.2 (b); 29.2(d)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, it was determined that the facility failed to clarify oxygen therapy orders to ensure a resident received respiratory care as ordered by a physician in accordance with professional standards of practice for 1 of 1 resident (Resident #25) reviewed for respiratory care. The deficient practice was evidenced by the following:On 1/12/26 at 8:30 AM, the surveyor observed Resident #25 lying in their bed. The resident opened their eyes to the surveyor's greeting and provided no verbal response. Resident #25 was receiving oxygen via a nasal cannula (NC; plastic prongs attached to a tube inserted into the nostrils that oxygen flows through) which was attached to a concentrator (an oxygen delivery system).On 1/13/26 at 10:13 AM, the surveyor observed Resident #25 lying in their bed. The resident opened their eyes to the surveyor's greeting and provided no verbal response. Resident #25 was receiving oxygen via NC which was attached to a concentrator set at 2 liters per minute (LPM).The surveyor reviewed the Electronic Medical Record (EMR) of Resident #25.The Face Sheet (a summary of important resident information) revealed Resident #25 had diagnoses that included but were not limited to, hemiplegia (a paralysis or severe weakness affecting one side of the body), aphasia (a disorder that affects how you communicate), and heart failure.A Comprehensive Minimum Data Set assessment, a tool used to facilitate management of care, dated 12/12/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a 3 out of 15, which indicated the resident had severe cognitive impairment.A physician's order dated 1/6/24 indicated to administer oxygen at 2 LPM for oxygen saturation less than 90% as needed (PRN) by shift.A physician's order dated 12/31/25 indicated oxygen via nasal cannula to keep oxygen saturation above 92%. There was no setting (or LPM) noted on the order. A review of the January 2026 Medication Administration Record (MAR) revealed the PRN oxygen order entry was unsigned as administered and blank for the month of January 2026. A review of the January 2026 Treatment Administration Record (TAR) revealed the order for oxygen via NC, dated 12/31/25 was signed by the nurses. There was no rate of oxygen (LPM) administered to the resident documented.On 1/13/26 at 12:37 PM, the surveyor interviewed Resident #25's assigned Licensed Practical Nurse (LPN) who stated the resident had needed oxygen therapy more recently and was using continuously. The LPN reviewed with the surveyor the resident's oxygen therapy orders. The LPN indicated the order for oxygen via NC dated 12/31/25 was the continuous oxygen order for the resident. The surveyor asked about the LPM of oxygen for the order. The LPN acknowledged the order did not indicate a rate of oxygen to administer and could not speak to why the order did not indicate the LPM.The LPN continued to review the resident's physician orders and identified the PRN order of oxygen for the resident. The surveyor asked if a PRN order should be signed when administered. The LPN replied the nurses documented in the notes if oxygen was administered.On 1/13/26 at 1:39 PM, the surveyor, informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the above concern for Resident #25's oxygen orders. The DON stated she would review to provide a response to the surveyor.On 1/14/26 at 12:04 PM, the LNHA and the DON met with the survey team. The surveyor asked if it was expected for PRN oxygen orders to be signed if administered. The DON replied yes it was. The surveyor reviewed the concern that the PRN order for oxygen was not signed by the nurse as administered and there was no additional oxygen therapy order. The DON stated there was a continuous oxygen order and would provide the TAR to the surveyor.On 1/15/26 at 12:30 PM, the surveyor reviewed with the DON the resident's TAR and the oxygen order entry dated 12/31/25 which no rate of oxygen was indicated. The DON acknowledged the concern that the oxygen order did not have a rate (LPM) for oxygen delivery and the order should have been clarified. There was no additional information provided by the facility. A review of the facility provided policy with the subject of Respiratory Equipment revealed under Procedure, a physician's order was required for respiratory equipment. The policy did not further address physician's orders for oxygen therapy and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of oxygen administration. No additional policy for oxygen therapy was provided by the facility. NJAC 8:39-27.1(a)