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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint: # 2694001 STANDARD SURVEY: 1/16/26 CENSUS: 35 SAMPLE SIZE: 12+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F0000		01/23/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: 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	F0658	1.The Assisted Director of Nursing has since verified that Resident #25 EMAR has been signed off by Nurse for administering 6:00am [redacted] and verified no medications were left at bedside. 2. The facility acknowledges that all residents have the potential of being affected by the deficient practice. The Director of Nursing (DON) or designee has completed a 100% audit of all residents with 6:00am medications and found no other residents were affected. 3. The Director of Nursing or designee educated all nursing staff on Following the Standards of Practice for Medication Administration and reviewing the Medication Administration Observation Checklist which states Document medication administration after administration. Education will be completed by January 30th 2026. 4. The Director of Nursing or designee will complete an audit of 25% of current residents including new admissions to ensure medications were administered, not left at bedside weekly for one month and monthly for three months until 5/25/26. Audit findings will be reported to QAPI Monthly for review, additional audits and education will be determined based on Findings.	02/13/2026

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 reverse for further 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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 1 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 [redacted] to the surveyor's greeting and provided [redacted]. The surveyor observed on the resident's bedside table a clear medicine cup which contained [redacted] sprinkled with a [redacted]) medication. On 1/12/26 at 8:36 AM, the surveyor interviewed Resident #25's assigned [redacted] who stated she had not administered any medications to the resident yet on her shift. The surveyor with the [redacted] reviewed Resident #25's Medication Administration Record (MAR) which revealed the resident received [redacted] capsule (a medication used to [redacted], which inside contained [redacted] when opened). The [redacted] stated a nurse should ensure a medication was taken by a resident and medications should not be left at the resident's bedside. The [redacted] accompanied the surveyor to Resident #25's room and observed the medication at the resident's bedside. The [redacted] acknowledged that the medication should not be left at the bedside. The [redacted] 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 [redacted]) of the concern that a medication was found at Resident #25's bedside. The [redacted] 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	F0658		02/13/2026

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CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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F0658 SS = D	Continued from page 2 that included but were not limited to, NJ Exec Order 26.4b1 [redacted]), and NJ Exec Order 26.4b1 [redacted] A Comprehensive Minimum Data Set assessment, a tool used to facilitate management of care, dated NJ Exec Order 26 [redacted], indicated the facility assessed the resident's NJ Exec Order 26.4 [redacted] using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a NJ E [redacted] out of 15, which indicated the resident had NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted] A physician's order dated NJ Exec Order 26 [redacted] indicated to give NJ Exec Order 26.4b1 [redacted] one capsule by mouth two times a day. The medication was scheduled for 6 AM and 4 PM. A review of the NJ Exec Order 26.4b1 [redacted] Medication Administration Record (MAR) revealed the NJ Exec Order 26.4b1 [redacted] capsule entry was signed by the nurse as administered for the NJ Exec Order 2 [redacted], 6 AM dose. On 1/13/26 at 1:39 PM, the surveyor informed the U.S. FOIA (b)(6) [redacted]) and the U.S. FOIA (b)(6) [redacted] regarding the concern for the medication observed at Resident #25's bedside. The U.S. FOIA [redacted] 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)	F0658		02/13/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy	F0695	1. The Assisted Director of Nursing has since verified that Resident #25 orders were clarified, and EMAR corrected to reflect NJ Exec O [redacted] of NJ E [redacted]. 2. The facility acknowledges that all residents have	02/10/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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F0695 SS = D	Continued from page 3 care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to clarify NJ Exec Order 26.4b1 orders to ensure a resident received NJ Exec Order 26.4b1 as ordered by a physician in accordance with professional standards of practice for 1 of 1 resident (Resident #25) reviewed for NJ Exec Order 26.4b1 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 NJ Exec Order 26.4b1 to the surveyor's greeting and provided NJ Exec Order 26.4b1. Resident #25 was receiving NJ Exec Order 26.4b1 On 1/13/26 at 10:13 AM, the surveyor observed Resident #25 lying in their bed. The resident opened NJ Exec Order 26.4b1 to the surveyor's greeting and provided NJ Exec Order 26.4b1. Resident #25 was receiving NJ Exec Order 26.4b1 which was attached to a NJ Exec Order 26.4b1 set at NJ NJ Exec Order 26.4b1). 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, NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 A Comprehensive Minimum Data Set assessment, a tool used to facilitate management of care, dated NJ Exec Order 26, indicated the facility assessed the resident's NJ Exec Order 26.4 using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a NJ E out of 15, which indicated the resident had NJ Exec Order 26.4b1 NJ Exec Order 26.4b1	F0695	Continued from page 3 the potential of being affected by the deficient practice. The Director of Nursing (DON) or designee has completed a 100% audit of all residents with orders for oxygen, no other residents with oxygen orders were affected. 3.The Director of Nursing or designee will provide education to all nursing staff on following the Standards of Practice when administering oxygen, including the requirement that the prescribed liters per minute (LPM) be accurately entered into the EMAR. Education will be completed by January 30, 2026. 4. The Director of Nursing or designee will complete an audit on all current residents and new admissions with oxygen orders for orders in EMAR to include LPM. All oxygen orders are to be in TAR. Audits will be done Weekly for one only, monthly for three months until 5/25/26. Audit findings will be reported to QAPI Monthly for review, additional audits and education will be determined based on Findings.	02/10/2026

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CONTINUING CARE AT LANTERN HILL	537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974

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F0695 SS = D	Continued from page 4 A physician's order dated [redacted] indicated to administer [redacted] at [redacted] LPM for [redacted] less than [redacted] as needed (PRN) by shift. A physician's order dated [redacted] indicated [redacted] to keep [redacted] above [redacted]. There was no setting (or LPM) noted on the order. A review of the [redacted] Medication Administration Record (MAR) revealed the PRN [redacted] order entry was unsigned as administered and blank for the month of [redacted]. A review of the [redacted] Treatment Administration Record (TAR) revealed the order for [redacted], dated [redacted] was signed by the nurses. There was no rate of [redacted] (LPM) administered to the resident documented. On 1/13/26 at 12:37 PM, the surveyor interviewed Resident #25's assigned [redacted]) who stated the resident had [redacted] more [redacted] and was using [redacted] The [redacted] reviewed with the surveyor the resident's [redacted] orders. The [redacted] indicated the order for [redacted] dated [redacted] was the [redacted] order for the resident. The surveyor asked about the [redacted] of [redacted] for the order. The [redacted] acknowledged the order did not indicate a rate of [redacted] to administer and could not speak to why the order did not indicate the [redacted] The [redacted] continued to review the resident's physician orders and identified the PRN order of [redacted] for the resident. The surveyor asked if a PRN order should be signed when administered. The [redacted] replied the nurses documented in the notes if [redacted] was administered. On 1/13/26 at 1:39 PM, the surveyor, informed the [redacted] and the [redacted] of the above concern for Resident #25's [redacted] orders. The [redacted] stated she would review to provide a response to the surveyor. On 1/14/26 at 12:04 PM, the [redacted] and the [redacted] met with the survey team. The surveyor asked if it was expected for PRN [redacted] orders to be signed if administered. The [redacted] replied yes it was. The surveyor reviewed the concern that the PRN order for [redacted] was not signed by the nurse as administered and there was no additional [redacted] order. The [redacted] stated there was a	F0695		02/10/2026

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CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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F0695 SS = D	Continued from page 5 continuous [NJ Exec Order 26.4b1] and would provide the TAR to the surveyor. On 1/15/26 at 12:30 PM, the surveyor reviewed with the [U.S. FOIA] the resident's TAR and the [NJ Exec Order] order entry dated [NJ Exec Order 26] which no rate of [NJ Exec Order] was indicated. The [U.S. FOIA] acknowledged the concern that the [NJ Exec Order 2] order did not have a [NJ Exec Order 26.4b] for [NJ Exec Order] 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 documentation of oxygen administration. No additional policy for oxygen therapy was provided by the facility. NJAC 8:39-27.1(a)	F0695		02/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20016	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

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CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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S0000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S0000		01/23/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for 1 of 14 day shifts as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et	S0560	1. No residents were affected by the deficient practice. 2. The facility acknowledges that all residents have the potential of being affected by the deficient practice. The administrator has reviewed the staffing for 2 weeks to validate that the facility meets the minimum staffing requirement of certified nursing assistants. 3. The administrator or designee will provide education to clinical leadership and scheduler regarding the state required direct care staff to resident ratios. The facility has an active job postings and has advertising for all open certified nurse aide positions. The administrator or designee will pursue securing direct care staffing services from staffing agencies and will utilize floating staff from our Assisted Living with short notice vacancies. 4. The administrator or designee will review the certified nurse aide staffing and resident census to ensure compliance with the required direct care staff to resident ratios daily for one month and then weekly for two months. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly until 5/25/26. Additional audits and education may be determined based on audit findings.	02/10/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20016	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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S0560	Continued from page 1 seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 12/28/2025 to 01/10/2026 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements.	S0560		02/10/2026

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S0560	Continued from page 2 The facility was deficient in CNA staffing for residents on 1of 14 day shifts as follows: -01/10/26 had 4 CNAs for 37 residents on the day shifts, required at least 5 CNAs. On 1/15/26, at 12:00 PM, the surveyor informed the Licensed Nursing Home Administrator, and the Director of Nursing (DON), the above concerns for minimum staffing ratios not being met. There was no additional information provided by the facility.	S0560		02/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315523	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/10/2026 in relation to the 01/15/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	F0000		

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 reverse for further 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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20016	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/10/2026 in relation to the 01/15/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315523	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - CONTINUING...** B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

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CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/12/26 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Continuing Care at Lantern Hill is an eight-story building that was built in 2016. Skilled nursing is located on the fourth floor. It is composed of Type II (222) protected construction. The facility is divided into two - smoke zones. The 600 Kw generator powers 100 % of the building per the Facilities Manager. The number of occupied beds were 35 out of 40.	K0000		01/23/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observations, interview and record review, it was determined that the facility failed to ensure the fire alarm was tested semi-annually in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.3.1. This deficient practice had the potential to affect all 35 residents and was evidenced by the following: A review of the facility's "Inspection and Testing	K0345	No residents were harmed as a result of the semi-annual fire alarm inspection and testing not being completed at the original scheduled time. Upon identification, the facility immediately contacted its new fire safety vendor and completed the required inspection and and testing in accordance to NFPA 72 on 3/11/26. Documentation verifying completion of the inspection and testing was obtained and placed in the facility's Life Safety records. All residents were identified as having the potential to be affected by the deficient practice. Corrective action focused on ensuring the fire alarm system was inspected, tested, and fully compliant with applicable life safety requirements. No residents experienced harm. A semiannual fire alarm inspection and testing schedule has been established in accordance with NFPA 72. The General Services Director (GSD) or designee will schedule, track, and maintain documentation of all required fire alarm inspections and testing. A Life Safety Compliance Log has been	03/12/2026

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315523	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - CONTINUING...** B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINUING CARE AT LANTERN HILL	**537 MOUNTAIN AVENUE , NEW PROVIDENCE, New Jersey, 07974**

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K0345 SS = F Bldg. 01	Continued from page 1 Reports," provided by the U.S. FOIA (b)(6), revealed no documented evidence that the fire alarm had been inspected semi-annually in the past 12 months. Observations on 01/12/26 from 12:30 PM to 3:30 PM revealed the smoke detectors were in the corridors and in all sleeping rooms. During an interview at 01/12/25 at 3:45 PM, the U.S. FOIA (b)(6) confirmed the semi-annual testing had not been completed on the fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K0345	Continued from page 1 implemented to monitor all required inspections, testing, and preventive maintenance activities. General service staff were educated on the fire alarm inspection and testing schedule by the GSD. The (GSD) or designee will conduct quarterly audits of the Life Safety Compliance Log to verify that required semiannual fire alarm testing has been completed and documented. All documentation of completion will be provided to the administrator on a semi-annual basis until 3/11/2027. Findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) for review semi-annually or every 6 months until 3/11/2027. Any identified deficiencies will be addressed immediately through corrective action and staff re-education as necessary.	03/12/2026

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

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 01/12/26. The facility was found to be in compliance with 42 CFR 483.73	E0000		01/23/2026

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 reverse for further 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.

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/16/2026 in relation to the 01/15/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection	K0000		

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/16/2026 in relation to the 01/15/20026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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