STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montclair Care Center	111-115 Gates Avenue Montclair, NJ 07042

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 4 of 15 residents (Resident #1, 3, 4, and #55) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 11/24/25 at 9:04 AM, the surveyor provided the MDS Coordinator/Registered Nurse (MDSC/RN) with the list of 3 residents who had not completed an MDS in over 14 days. The surveyor also requested a copy of the resident's final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On the same date at 12:01 PM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who stated that he started in January this year. The MDSC is aware that the MDS assessment was late and is catching up. The surveyor reviewed with the MDSC/RN, who provided the surveyor with a final validation report from CMS, the 3 residents' MDS assessments that were not submitted within fourteen days of completion, as follows: 1. Resident #1 admission MDS (A/MDS) assessment has an assessment reference date (ARD, the last day of the observation period) of 10/7/25. It was signed as completed on 10/14/25, but not transmitted until 11/11/25. 2. Resident #3 discharged Return Not Anticipated MDS (DRNA/MDS) assessment has an ARD of 9/24/25. It was signed as completed on 10/8/25 and not transmitted until 11/21/25. 3. Resident #4 the admission MDS (A/MDS) assessment has an ARD of 8/19/25. It was signed as completed on 8/26/25, but not transmitted until 9/18/25. 4. Resident #55 the quarterly MDS (Q/MDS) assessment has an ARD of 8/21/25. It was signed as completed on 9/4/25 and not transmitted until 10/8/25. On 11/25/25 10:18 AM, the surveyor met with the Director of Nursing (DON) regarding the above concern; there is no information provided. NJAC 8:39-11.1

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montclair Care Center	111-115 Gates Avenue Montclair, NJ 07042

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure consistent maintenance of the system of record keeping of the Drug Enforcement Agency (DEA) order Form-222 (a federal narcotic requisition form), that enabled accurate reconciliation of controlled-dangerous substances (narcotic medications, that due to their high potential for abuse, are tracked with a degree of detail and attention) that was ordered and received. The deficient practice was identified for 1of 11 DEA Form-222s reviewed and was evidenced by the following: Reference:21 CFR 1305.16(b) Whenever any used or unused DEA Forms 222 are stolen or lost (other than in the course of transmission) by any purchaser or supplier, the purchaser or supplier must immediately upon discovery of the theft or loss, report the theft or loss to the Special Agent in Charge of the Drug Enforcement Administration in the Divisional Office responsible for the area in which the registrant is located, stating the serial number of each form stolen or lost . On 11/24/25 at 1:10 PM, the surveyor and the Director of Nursing (DON) reviewed the DEA Form-222 together and observed DEA order form number 221312108 was missing. At that time, the DON stated she would continue to search, investigate and contact the provider pharmacy. On 11/24/25 at 1:34 PM, in the presence of the survey team, the Regional Director of Operations (RDO), the Licensed Nursing Home Administrator (LNHA) and the DON, the surveyor discussed the concern regarding the inconsistent maintenance of the system of record keeping of the Drug Enforcement Agency (DEA) order Form-222 that was used to track the order and receipt of narcotics. On 11/25/25 at 1:04 PM, in the presence of the survey team, the LNHA, and the Licensed Practical Nurse/Infection Preventionist, the DON stated she was relatively new to the facility and since she had taken over, she kept the DEA Form-222 with her and double checked that all the forms were there. The DON also stated that the DEA order form number 221312108 could not be located, and the timeline of when it went missing could not be determined. No further information was provided. A review of the provided facility policy, Controlled Substance, dated/reviewed June 2025 included that the facility complied with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of Schedule II. NJAC 8:39-29.7(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation on 11/24/25, the surveyor observed two (2) nurses administer medications to five (5) residents. There were 25 opportunities for error, and two (2) errors were observed which resulted in a medication error rate of 8.0%. This deficient practice was identified for one (1) of five (5) residents (Resident #55), that was administered by one (1) of two (2) nurses and was evidenced by the following:On 11/24/25 at 9:54 AM, from the hallway, the surveyor observed Resident #55 awake, in bed, and well dressed. At 9:56 AM, the surveyor observed the Licensed Practical Nurse prepare medications for Resident #55. The medications prepared included the following physician's order (PO):-Colace (Docusate) oral capsules 100 milligrams (mg), to be given 2 capsules by mouth, one time a day for constipation (two (2) capsules = 200 mg). The PO was started on 11/10/25.-Vitamin B1 oral tablets 100 mg (Vit B1 100 mg) to be given 1 tablet by mouth, one time a day for supplement. The PO was started on 11/10/25. At that time, the LPN stated she could not find all the medications to be administered that morning to Resident #55 and had to check the supply room downstairs. At 10:02 AM, the surveyor and the LPN entered the supply room where surveyor observed the LPN pick up a bottle of Vitamin B12 500 microgram (mcg) and headed back to the unit upstairs. At 10:08 AM, while preparing medications for Resident #55, the LPN poured the following:-one (1) capsule of the Colace 100 mg, opposed to the PO of two (2) capsules.-two (2) tablets of the Vit B12 500 mcg, opposed to the PO of one (1) tablet Vitamin B1 100 mg. At 10:12 AM, the LPN informed the surveyor that she poured two (2) capsules of the B12 500 mcg to equal 100 mg of B1 100 mg. At 10:18 AM, the LPN poured water into a cup, confirmed she was ready to administer medications to Resident #55, turned and entered the resident's door threshold. At that time, the surveyor asked the LPN to step back outside the resident's room. The surveyor and the LPN reviewed the electronic Medication Administration Record (eMAR/MAR) together. At 10:24 AM, during the review of the eMAR, the LPN acknowledged and confirmed with the surveyor that she poured the wrong dose of the Colace and obtained the wrong drug B12 500 mcg which was not part of the PO. On 11/24/25 at 1:34 PM, in the presence of the survey team, the Regional Director of Operations (RDO), the Licensed Nursing Home Administrator (LNHA) and the DON, the surveyor discussed the concern regarding the medication pass errors that involved a wrong dose and a wrong drug. On 11/25/25 at 1:04 PM, in the presence of the survey team, the LNHA, and the Licensed Practical Nurse/Infection Preventionist, the DON stated she provided a 1:1 in-service to the nurse who made the errors and provided in-services to the staff that were on duty. A review of the provided facility policy, Administering Oral Medications, dated/reviewed June 2025 included under steps in the procedure, indicated to check the label of the medication and confirm the medication name and dose with the MAR and to prepare the correct dose of the medication. NJAC 8:39-29.2(d)