STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056444	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Extended Care Hospital of Montclair	9620 Fremont Ave Montclair, CA 91763

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents received medications as clinically indicated and free from unnecessary medications for two out of four sampled residents (Residents 1 and 2) when:1. Resident 1 did not receive prescribed medication that was intended to treat his medical condition.2. Resident 2 received a medication that was not intended for her and for which she had no clinical indication.These failures had the potential to cause harm when Resident 1 did not receive a prescribed medication, placing him at risk for an untreated medical condition and Resident 2 was exposed to unnecessary medication and possible adverse effects.1. During a review of Resident 1's admission Record (clinical record with demographic information), it indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of seizure (neurological disorder that results from abnormal activities in the brain) and acute kidney failure (A condition when the kidneys suddenly lose the ability to remove waste and balance your body's fluids and electrolytes).During a concurrent record review, and interview, on December 29, 2025, at 2:45 PM, with the Director of Nurses (DON), the DON reviewed and confirmed Resident 1's admission physician order list dated December 16, 2025, did not include Valproic Acid (a prescription medication used to prevent and control seizures). 2. During a review of Resident 2's admission Record, it indicated Resident 2 was admitted to the facility on [DATE], with diagnoses of rhabdomyolysis (a condition when muscle tissue gets severely damaged causing pain, kidney damage, and dark urine output) and muscle weakness.During a concurrent record review, and interview, on December 29, 2025, at 3:00 PM, with DON, the DON reviewed and confirmed that Resident 2's admission physician order list dated December 16, 2025, indicated, Valproic Acid Oral Capsule 250 MG [milligram is unit of measure] Give 1 capsule by mouth three times a day for Seizures. The DON stated Registered Nurse 1 (RN 1) who handled the admission on [DATE], had mistakenly added the Valproic Acid order to Resident 2's records instead of Resident 1's.A review of the Facility's Incident Description dated December 22, 2025, indicated . Date of Incident Discovery: December 19, 2025. Type of Event: Medication Error - Misadministration of Anti-Seizure Medication. Findings Summary: Physician order for Valproic Acid [for Resident 1] was mistakenly entered for the wrong patient [Resident 2]. Patient [Resident 2] received 6 doses of Valproic Acid administered . between 12/16/25 and 12/19/25 [December 16, 2025, and December 19, 2025].A review of Resident 2's MAR (Medication Administration Record) for the period of December 16, 2025, to December 31, 2025, indicated .Valproic Acid . 250 MG. Give 1 capsule by mouth three times a day. was administered on December 17, 18, and 19, 2025. The initials provided confirmation the Valproic Acid was administered to Resident 2 as scheduled, for a total of nine doses unnecessarily and without clinical indication.During an interview on December 29, 2025, at 3:30 PM, with DON, the DON stated the facility does not have a written policy and procedure (P&P) for the admission process, including medication orders. The DON further stated, in practice, the facility reviews newly admitted residents' records on the following day to ensure completeness and accuracy of continuation of care, including medication orders and any other necessary care.During an interview on December 30, 2025, at 3:30 PM, with Registered Nurse 1 (RN 1), the RN 1 stated she is aware of her responsibility as the admission nurse to review hospital records and verify medication indications upon admission. RN 1 further stated, I am not sure how the mistake happened; I ended up putting the medication order to the wrong resident.During a follow up interview on December 30, 2025, at 3:30 PM, with RN 1, the RN 1 stated, It was my mistake that caused Resident [1] did not receive his Valproic Acid to manage his clinical condition that make Resident [2] received Valproic Acid that was unnecessary for her, unfortunately. RN 1 further stated she should have double checked the medication order against hospital discharged records and confirmed with the physician prior to entering the order, but she did not.During an interview on December 31, 2025, at 1:00 PM, the Administrator acknowledged the medication reconciliation practice error, stating Resident 1 did not receive his prescribed medication to manage his medical condition, and it was instead entered under Resident 2, who received six doses unnecessarily. The Administrator stated the facility expects the admission nurse to review hospital records and verify medication indications at admission and DON will review the admission chart the next business day after admission for accuracy and completeness. The Administrator also acknowledged that the facility does not have a written P&P governing the admission process, including medication orders upon admission. A review of Resident 1's MAR for the period of December 16, 2025, through December 31, 2025, indicated that Valproic Acid 250 mg, 1 capsule by mouth