

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 308119 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 05/03/2024 |
| NAME OF PROVIDER OR SUPPLIER SIGNATURE MEDICAL DAY CARE OF MONTCLAIR | | STREET ADDRESS, CITY, STATE, ZIP CODE 110 GREENWOOD AVENUE MONTCLAIR, NJ 07042 | | |
| (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) COMPLETE DATE |
| M 000 | <p>Initial Comments</p> <p>Type of Survey:</p> <p>Complaint #: NJ00173075</p> <p>Census: AM 134 and PM 93</p> <p>Sample Size: 3</p> <p>The facility was in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services.</p> | M 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE