STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	**1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052**

(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 #s NJ 392824 STANDARD SURVEY: 3/6-3/12/26 CENSUS: 107 SAMPLE SIZE: 22+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		04/17/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	Criteria 1: The spices found with lids open were closed at time of inspection. The steam table pans that were found wet nested were re-washed, air dried and stored properly. Criteria 2: All residents have the potential to be affected by this practice. Criteria 3: All dietary staff have been educated on proper storage of food products and pans being washed in three compartment sink to be air dried prior to storage. Spice containers were closed at time of inspection. Pans noted during inspection were re-washed and air dried prior to storage. Criteria 4: Kitchen sanitation audits will completed five times per week by the kitchen general manager/designee	04/17/2026

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: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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F0812 SS = F	Continued from page 1 Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to sanitize and air dry steam table pans in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 3/9/26 at 11:07 AM, in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), the surveyor observed the following:On the dairy side of the kitchen, on a shelf in the food preparation area, the surveyor also observed 6 spice containers with their tops opened. The U.S. FO stated these lids should be closed. On the dairy side of the dish washing area, the surveyor observed 2 large shallow steam table pans, stacked and wet nested with water between them, the surveyor also observed 3- 2/3rd sized steam table pans, stacked and wet nested with water between them. The U.S. FO stated that the steam table pans should not be stacked when wet and should have been air dried first. A review of the Labeling and Dating policy, dated 5/2023, revealed all foods are labeled, dated, and securely covered. A review of 3 Compartment sink policy, dated 5/2023 revealed dishes should be air dried and do not stack wet dishes. NJAC 8:39-17.2(g)	F0812	Continued from page 1 for one month, then three times month for the next month, then monthly. Results of these audits will be reported to the facility's QAPI committee monthly for the first three months then quarterly thereafter for one year.	04/17/2026
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy 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, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) that the physician's orders were followed according to	F0695	Criteria 1: The facility failed to ensure that a) that the physicians orders were followed according to the standard of clinical practice for resident #8, #72, #108 and # 114, and b) failed to provide NJ Ex Order 26.4(b)(1) according to facility policy for resident #108. Resident #8 had the NJ Ex Order 26.4(b)(1) adjusted on their NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b) as stated in the physician orders. Resident #72 had the NJ Ex Order 26.4(b)(1) adjusted on their NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b) as stated in the resident's physician orders. Resident #108 had the NJ Ex Order 26.4(b)(1) on their NJ Ex Order 26.4(b)(1) adjusted to NJ Ex Order 26.4(b)(1) as stated in the resident's physician orders and a NJ Ex Order 26.4(b) placed.	04/17/2026

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F0695 SS = E	Continued from page 2 the standard of clinical practice for 4 of 4 residents, (Resident #8, 72, 108 and 114), reviewed for NJ Ex Order 26.4(b)(1), and b.) failed to provide a NJ Ex Order 26.4(b) according to the facility's policy and procedure for one (1) of 4 residents, (Resident #108) reviewed for NJ Ex Order 26.4(b)(1). This deficient practice was evidenced by the following: 1.On 3/6/26 at 10:35 AM, the surveyor observed Resident #8 in bed in their room, receiving oxygen via a n NJ Ex Order 26.4(b)(1)) from NJ Ex Order 26.4(b)(1) and the surveyor observed the NJ Ex Order 26.4(b)(1) was set at NJ Ex Order 26.4 A review of Resident #8's electronic health record (EHR) reflected that the resident was admitted to the facility on NJ Ex Order 2 with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)) and NJ Ex A review of Resident #8's Annual Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4 revealed Resident #8 has NJ Ex Order 26.4(b)(1) and is NJ Ex Order 26.4(b)(1) with all activities of daily living and NJ Ex Order 26.4(b) A review of Resident # 8's physician orders revealed an order with a start date of NJ Ex Order 26 and the details of the order prescribed resident to receive NJ Ex Order 26 at a NJ Ex Order 26.4(b)(1). On 3/6/225 at 12:50 PM, the surveyor made a second observation of Resident #8 in bed in their room, receiving NJ Ex Order 26.4(b)(1) from a NJ Ex Order 26.4(b)(1) and the surveyor confirmed the NJ Ex Order 26 was set at NJ Ex Order 26.4 On 3/6/26 at 12:55 PM, the surveyor interviewed the (Licensed Practical Nurse (LPN #1) assigned to Resident #8's care. The LPN #1 confirmed that Resident #8's NJ Ex Order 26 orders in the resident's electronic health record (EHR) indicated that NJ Ex Order 26 was ordered for a NJ Ex Order 26.4(b)(1) On 3/6/26 12:58 at PM, the LPN accompanied the surveyor to Resident #8's room, and the LPN #1 confirmed the resident's NJ Ex Order 26 was NJ Ex Order 26.4(b)(1) according to NJ Ex O meter on the NJ Ex Order 26.4(b)(1) She readjusted the flow to the prescribed rate of NJ Ex Orde. The surveyor asked the	F0695	Continued from page 2 Resident #114 has the NJ Ex Order 26.4(b)(1) on their NJ Ex Order 26.4(b)(1) adjusted to NJ Ex Order 26.4(b) as stated in the resident's physcian orders Criteria 2: All residents with orders for oxygen are at risk for this deficient practice. Criteria 3: Polices and procedures related to oxygen were reviewed and revised as necessary. Nursing staff were educated on how to follow respiratory care management orders and reviewed when the use of a humidifier is necessary when administering oxygen. Criteria 4: Weekly audits of respiratory care orders being followed, with infection control guidelines are being met will be conducted by the DON/designee. Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly for one year.	04/17/2026

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F0695 SS = E	Continued from page 3 LPN #1 about [NJ Ex Order 26] administration for Resident #8 and the LPN #1 stated that only nurses set or adjust [NJ Ex Order 26.4(b)(1)] and that [NJ Ex Order 26] should always be administered as ordered by physician. 2. On 3/6/26 at 10:25 AM, the surveyor observed Resident #72 awake, lying in bed with a [NJ Exec Order 26.4b1] On 3/9/26 at 10:37 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #72, which revealed the following: A review of the Admission [NJ Ex Order 26.] (AR, an admission summary) reflected that Resident #72 was admitted with diagnoses that included but were not limited to [NJ Ex Order 26.4(b)(1)] . A review of the admission MDS, (an assessment tool used to facilitate the management of care) dated [NJ Ex Order 26.4] indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of [] out of 15, which indicated that the residents had [NJ Ex Order 26.4(b)(1)] . Further review of the A/MDS, as reflected in section [NJ Ex Order 26.4(b)(1)] , revealed that Resident #72 was [NJ Ex Order 26.4(b)] while a resident in the facility. A review of the Physician Order (PO) with the start date of [NJ Ex Order] , [NJ Ex Order 26.4(b)(1)] . A review of the care plan (CP) activity report initiated on [NJ Ex Order 26.4] focused on the residents at risk for respiratory distress due to [NJ Ex Order 26.4(b)(1)] but was not limited to, O2 therapy as per the physician's order. 3. On 3/6/26 at 10:52 AM and on 3/9/26 at 10:12 AM, the surveyor observed Resident #108 awake, lying on the bed, receiving [NJ Ex Order 26.4(b)(1)] attached to [NJ Ex Order 26.4(b)(1)] rator. On 3/11/26 at 10:32 AM, the surveyor observed Resident #108 [NJ Ex] is at [NJ Ex Order 26.4(b)(1)] attached to the [NJ Ex Order 26.4(b)(1)] . The surveyor interviewed the Licensed Practical Nurse (LPN#1), who is in the room with the surveyor. LPN#1 checked the [NJ Ex] parameter of the resident and confirmed that it was at [NJ Ex Order 26.4] LPN #1 stated that during his rounds at 7:00 AM, the [NJ Ex] was [NJ Ex Order 26.] ,	F0695		04/17/2026

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F0695 SS = E	Continued from page 4 and he did not know what happened next. On 3/6/26 at 1:21 PM, the surveyor reviewed the hybrid medical record of Resident #108, which revealed the following: A review of the AR reflected that Resident #108 was admitted with diagnoses that included but were not limited to [redacted]. A review of the A/MDS dated [redacted] indicated that the facility assessed the residents' cognitive status using a BIMS score of [redacted] out of 15, which indicated that the residents had [redacted]. Further review of the A/MDS, as reflected in section [redacted], revealed that Resident #108 was using [redacted] while a resident in the facility. A [redacted] at [redacted] every shift for [redacted]. A review of the CP activity report initiated on [redacted] focused on the residents at risk of having complaints of [redacted], but was not limited to, [redacted] as per the physician's order. On 3/9/26 at 12:53 PM, the surveyor interviewed LPN #2, who stated that he does not put [redacted] in Resident #108's room because there is no order. 4. On 3/6/26 at 10:41 AM, the surveyor observed Resident #114 was awake and was using [redacted] attached to [redacted]. On 3/9/26 at 10:26 AM, the surveyor observed Resident #114 in bed awake on [redacted]. The LPN#2 confirmed that the resident was receiving [redacted] and did not provide further information. A review of the AR reflected that Resident #114 was admitted with diagnoses that included but were not limited to [redacted]. There was no recent MDS assessment available for Resident #114 in the hybrid medical record. A review of the CP activity report initiated on [redacted] focused on the residents at risk of having	F0695		04/17/2026

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F0695 SS = E	Continued from page 5 NJ Ex Order 26.4(b)(1). Intervention included, but was not limited to, NJ Ex Order 26.4(b)(1) as per the physician's order. A review of the PO with the start date of NJ Ex Order 2, NJ Ex Order 26.4(b)(1) as needed for NJ Ex Order 26.4(b)(1), or NJ Ex Order 26.4(b)(1). A review of the Resident Treatment Administration Record for Resident #114 revealed that there is no record for NJ Ex Order 2 and NJ Ex Order that the resident received NJ Ex Order 26.4(b)(1). On 3/11/26 1:54 PM, the team of surveyors met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6), and the U.S. FOIA (b) (6) regarding the above concern, but did not provide further information. A review of the facility policy title "Oxygen Therapy," revised date of June 2025, revealed under "Procedures: 1. Check the order in the resident's chart for the amount of oxygen and frequency of administration, or follow standard of practice to maintain saturation level." and 2. If oxygen is more than 3L (liters), use a humidifier bottle with sterile water to the indicated level. Date the humidifier and change it daily." NJAC 8:39-25.2(c)3	F0695		04/17/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing	F0880	Criteria 1: The facility failed to follow appropriate infection control practices to prevent and control the spread of infection, specifically the faicility failed to; a) post required signage at the rooms for 9 of 9 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #'s 1, 2, 4, 8, 12, 67, 108, 113, 114), Residents #'s 1,2,4,8,12,67,108,113,114 had proper signage posted to inform staff and visitors of NJ Ex Order 26.4(b)(1). b) The facility failed to handle medications in a sanitary manner during observed medication administration as evidenced by nurse #4 placing an NJ Ex Order 26.4(b)(1 in her pocket, dropping NJ Ex O on floor and placed in plastic bag without cleansing it. NJ Ex Order 26.4(b)(1 was discarded and new one ordered. LPN#5 was observed to have a bottle of NJ Ex Order 26.4(b)	04/17/2026

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F0880 SS = E	Continued from page 6 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP	F0880	Continued from page 6 in their pocket. The [NJ Ex Order 26.4(b)] were discarded and reordered. Both LPN #4 and 5 received one to one education by the IP. c) Failure to clean [NJ Ex Order 26.4(b)(1)] by one of three nurses observed during med pass. LPN #4 was given one to one education regarding proper storage and handling of medications and patient equipment and [NJ Ex Order 26.4(b)(1)] competency was completed by the IP. Criteria 2: All residents have the potential to be affected by this practice. Criteria 3: Policies and procedures related to appropriate signage for enhanced based precautions, infection control, patient care equipment cleaning and protocols, and to handling medications in a sanitary manner were reviewed and revised as necessary. Nursing staff was educated on glucometer use and cleaning protocols, enhanced based precautions and sanitary handling of medications and equipment. Criteria 4: Weekly audits of proper signage, proper handling and cleaning of medication and equipment will be conducted by the DON/desiginee. Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

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F0880 SS = E	Continued from page 7 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices to prevent and control the spread of infection. Specifically the facility failed to: a) post required signage at the rooms for 9 of 9 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #'s 1, 2, 4, 8, 12, 67, 108, 113, 114), b) failed to handle medications in a sanitary manner during medication administration observation and medication storage review by 1 of 3 nurses observed during medication administration and 1 of three nurses observed during medication storage review, and c) a failure to cleanse NJ Ex Order 26.4(b)(1) between uses by 1 of 3 nurses observed during medication administration. This deficient practice was evidenced by the following: 1.On 3/6/25 at 10:35, the surveyor conducted initial tour of the HP nursing care unit and observed no NJ Ex Order 26.4(b)(1)) signage on door, doorway or entrance to room # NJ Ex Order 26, a private room of Resident #8. A review of Resident #8's electronic health record (EHR) reflected the resident was admitted to the facility on NJ Ex Order 26.4(with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1))NJ Ex Order 26.4(b)(1)) and NJ Ex . A review of Resident #8's Annual Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26 revealed Resident #8 has NJ Ex Order 26.4(b)(1) and is NJ Ex Order 26.4(b)(1 for all activities of daily living and NJ Ex Order 26.4(b). A review of Resident # 8's physician orders reflected that the resident is ordered to receive no NJ Ex Order 26.4(b)(1) but received NJ Ex Order 26. through a NJ Ex Order 26.4(b)(1) through the NJ Ex Order 26.4(b)(1) into the NJ Ex Order 26.4(b On 3/6/26 at 1:00PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) assigned to care for Resident #8. The LPN # 1 accompanied the surveyor to room NJ Ex Order 26 and the surveyor asked	F0880		04/17/2026

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F0880 SS = E	Continued from page 8 the LPN #1 how a staff member would know a resident was on [NJ Ex Or] and what activities and personal protective equipment (PPE) would be required to care for the resident, the LPN # 1 stated there is a bin of PPE in the doorway. The surveyor asked the LPN #1 about appropriate signage to indicate NJ Ex Order 26.4(b)(1). The LPN # 1 stated there was no signage in use on this resident's door or doorway and she acknowledged Resident #8 was placed on [NJ Ex Or] due to [NJ Ex] NJ Ex Order 26.4(b)(1). 2. On 3/6/26 at 10:38 AM, during a tour on a unit, the surveyor observed a clear storage bin outside of Resident #4's room. There was an [NJ Ex Order 26.4(b)(1)] magnetic dot on the door frame. The bin stored personal protective equipment (PPE) gowns and other supplies. There was no signage at the door or on the bin to indicate usage of PPE. The surveyor reviewed the electronic medical record of Resident #4. A physician order dated [NJ Ex Order 26] indicated [NJ Ex Or] every shift. A review of a care plan for Resident #4 with a focus of [NJ Ex Or] related to the presence of [NJ Ex Order 26.4] revealed an intervention which indicated clear signage must be posted on the door or wall outside of the resident room indicating the type of precautions and required PPE. The intervention and care plan was dated [NJ Ex Order 2] 3. On 3/9/26 at 10:20 AM, during a tour on a unit, the surveyor observed a clear storage bin outside of Resident #113's room. The bin stored PPE gowns and other supplies. There was an [NJ Ex Order 26.4(b)(1)] magnetic dot on the door frame. There was no signage at the door or on the bin to indicate the use of PPE. The surveyor reviewed the electronic medical record of Resident #113. A physician order dated [NJ Ex Order 26.4] indicated [NJ Ex Or] [NJ Ex Order 26.4] A review of a care plan for Resident #113 with a focus of [NJ Ex Or] related to the presence of [NJ Ex Order 26.4] and NJ Ex Order 26.4(b)(1) revealed an intervention which indicated clear signage must be posted on the door or wall outside of the resident room indicating the type of precautions and required PPE. The intervention and care plan was dated [NJ Ex Order 26.4]	F0880		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	**1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052**

(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
F0880 SS = E	Continued from page 9 On 3/9/26 at 10:23 AM, the surveyor interviewed LPN # 2 assigned to the residents about the bins at the resident's door. The LPN # 2 stated the bins stored PPE supplies used by staff when providing care to residents with NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). The LPN # 2 was not sure of the name for the type of NJ Ex Order 26.4(b)(1). The surveyor asked the LPN # 2 how staff and visitors would know what protocols to follow for the NJ Ex Order 26.4(b)(1). The LPN # 2 replied that the PPE in bin were for staff and not visitors as they provided high contact care to residents. LPN #2 further explained that a resident with an active infection that required another type of NJ Ex Order 26.4 there would be a sign on the door to see the nurse prior to entering the room. The surveyor asked the LPN # 2 about the NJ Ex Order 2 magnetic dot on the door. The LPN # 2 replied to the surveyor they were not sure what it was for. 4. On 3/6/26 at 10:52 AM and on 3/9/26 at 10:12 AM, the surveyor observed Resident #108 awake, lying on the bed, with NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) attached to the lower side of the bed. On 3/6/26 at 1:21 PM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #108, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #108 was admitted with diagnoses that included, but were not limited to, NJ Ex Order 26.4(b)(1). A review of the admission MDS, (an assessment tool used to facilitate the management of care) dated NJ Ex Order 26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that the residents had NJ Ex Order 26.4(b)(1) A review of the physician order with the start date of NJ Ex Order, check for NJ Ex Order 26.4(b)(1) placement every shift. A review of the care plan (CP) activity report initiated on NJ Ex Order focused on the residents who had an NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1). 5. On 3/6/26 at 10:41 AM, the surveyor observed that Resident 114 was lying in bed awake. A review of the AR reflected that Resident #114 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1)),	F0880		04/17/2026

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F0880 SS = E	Continued from page 10 NJ Ex Order 26.4(b)(1) . There is no recent MDS assessment available for Resident #114 in the hybrid medical record. A review of the physician order to clean the NJ Ex Order with NJ Ex Order 26.4(b)(1), apply NJ Ex Order 26.4(b)(1) daily with a start order of NJ Ex Order 2 and an NJ Ex Ord with an order date on NJ Ex Order 2 A review of the CP activity report initiated on NJ Ex Order focused on the residents, NJ Ex Order 26.4(b)(1) located in NJ Ex Order 26.4(b)(1) intervention included, but was not limited to, monitoring for signs and symptoms of infection. There is no intervention for the NJ Ex Or order. On 3/9/26 at 10:14 AM, the surveyor interviewed the LPN # 3 assigned to the HP unit regarding the NJ Ex Orc She stated that the NJ Ex Order 2 dot is the NJ Ex Order 26.4(b)(1), but did not provide further information regarding the orange dot. On 3/9/26 at 12:50 PM, the surveyor interviewed CNA #1 and CNA#2 from the HP unit, who stated that they do not know what the NJ Ex Order 2 dot in the outside room of the resident is. 6. On 3/9/26 at 8:32 AM, the surveyor observed medication administration. The surveyor observed that the LPN # 4 did not clean or disinfect the NJ Ex Order 26.4(b)(1) after using it on Resident #58. On 3/9/26 at 9:15 AM, the surveyor interviewed LPN #4 who stated that they did not clean the NJ Ex Order 26.4(b)(1) after use because the wipes were not at their cart. However, LPN #4 stated that they cleaned the NJ Ex Order 26.4(b)(1) before use when they wiped down all the items on their medication cart before beginning medication administration earlier that day. The surveyor asked LPN #4 if the NJ Ex Order 26.4(b)(1) are shared among residents, and LPN#4 stated that each resident has their own NJ Ex Order 26.4(b)(1) The surveyor observed that there was no resident label on the NJ Ex Order 26.4(b)(1) There was a capital letter 'NJ E written in permanent marker on the NJ Ex Order 26.4(b)(1) When the surveyor asked LPN #4 how they knew this NJ Ex Order 26.4(b)(1) belonged to Resident #58, LPN #4 stated that this was what their supervisor told them. They did not know what the letter 'NJ E meant and stated that they thought it was the resident's initial. LPN #4 acknowledged that the nurses are supposed to wipe down the NJ Ex Order 26.4(b)(1) before and after using them. On 3/9/26 at 1:01 PM, the survey team met with the U.S. FOIA (b) (6)) and	F0880		04/17/2026

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F0880 SS = E	Continued from page 11 the U.S. FOIA (b) (6) The U.S. FOIA (b) stated that the glucometers are shared among residents. They clarified that the letter 'NJ E written on the NJ Ex Order 26.4(b)(1) referred to Cart A and did not refer to a resident. A review of the facility's procedure for "Blood Glucose Monitoring," revised 7/2025, revealed next to number 18, "Disinfect glucometer prior to storing in cart.-Dispatch wipes." On 3/9/26 at 8:40 AM, the surveyor observed that LPN #4 placed the NJ Ex Order 26.4(b)(1) in their pocket after they administered the NJ Ex Order 2 to Resident #58. LPN #4 also dropped the NJ Ex Order 26.4(b)(1 on the floor as they exited the resident's room. Then, LPN #4 placed the NJ Ex Order 26.4(b)(1) back inside the plastic bag in the medication cart without cleaning or sanitizing the NJ Ex Order 26.4(b)(1) On 3/10/26 at 12:34 PM, in the presence of the survey team, the surveyor interviewed the U.S. FOIA (b) (6) , who acknowledged that it is not the correct practice to store medication in a pocket of clothing. The U.S. FOIA (b) (6) stated that LPN #4 should have cleaned and disinfected the NJ Ex Order 26.4(b)(1) after they dropped it on the floor. 7. On 3/11/26 at 11:38 AM, the surveyor inspected Medication Cart B on Unit NJ E in the presence of the LPN #5. The surveyor observed that the NJ Ex Order 26.4(b)(1) box labeled for Resident #32 was open, and the bottle was missing. The surveyor asked LPN #5 where the bottle was located, and LPN #5 removed the bottle from their shirt pocket. On 3/11/26 at 1:21 PM, the surveyor interviewed LPN #5 who acknowledged that it is not the correct practice to store medication in a pocket of clothing. LPN #5 stated that medications should be stored in the medication cart. On 3/11/26 at 1:33 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that it is not the correct practice to store medication in a pocket of clothing. A review of the facility's "Administration of Medications Procedure," revised 5/2025, revealed, "Return all medications to the cart." A review of the facility's Policy, "Medication Storage," revised 11/2025, revealed, "Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier."	F0880		04/17/2026

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F0880 SS = E	Continued from page 12 A review of the facility's "Comprehensive Infection Control Policy" revealed, "It is the policy that this facility's Infection Prevention and Control Program (ICPC) is based upon information from the Facility assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible." Section 1c of the policy revealed, "Standard and transmission-based precautions to be followed to prevent the spread of infections." 8. On 3/6/26 at 10:13 AM, the surveyor observed that [redacted] signage was lacking on the door of the room for Resident #67. The surveyor observed that the resident had [redacted]. A review of the electronic health record of Resident #67 revealed an order for "[redacted]" originally ordered on [redacted], with a schedule of "Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00 pm-7:00 am." Moreover, the care plan of Resident #67, effective [redacted] revealed, "Resident #67 requires [redacted] related to (r/t) presence of [redacted] and [redacted] Interventions included, but were not limited to, "Clear signage must be posted on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g. gown and gloves)." 9. On 3/6/26 at 10:53 AM, the surveyor observed that [redacted] signage was lacking on the door of the room for Resident #12. A review of the electronic health record of Resident #67 revealed an order for "[redacted]," originally ordered on [redacted] On 3/6/26 at 11:11 AM, the surveyor interviewed the Registered Nurse #1 (RN #1). RN #1 stated that the way staff would know a resident is on [redacted] is by the box with the blue gowns outside the door. RN #1 was not aware of signage for [redacted] On 3/10/26 at 12:34 PM, in the presence of the survey team, the surveyor interviewed the [redacted]) who stated that the facility puts a bin outside the door and an [redacted] tag on the doorpost to indicate [redacted] The [redacted] stated they were aware of the need for [redacted] signage. The facility's policy, "Enhanced Barrier Precautions," revised 1/2026, did not address signage for EBP.	F0880		04/17/2026

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F0880 SS = E	Continued from page 13 10.On 3/6/26 at 11:22 AM, the surveyor observed Resident #1 seated in a wheelchair in the unit day room watching television. At the same time, the surveyor observed the resident's room. There was a plastic 3 drawer bin at the entrance to the room containing disposable gowns, masks and gloves. No signage for [redacted] instructions was visible at the entrance to the room. A review of the resident's electronic medical record revealed the following information. The [redacted] Admission MDS assessment tool indicated the resident was [redacted] as evidenced by a BIMS score of [redacted] out of a possible 15 (Section C). The resident was admitted with [redacted] (Section [redacted] The [redacted] consultant documented that the resident had [redacted] to the [redacted] and the [redacted] and [redacted] to the [redacted] and [redacted]. The Physician's Orders report contained a [redacted] treatment order for a [redacted] to the [redacted] with a [redacted] and [redacted] with [redacted]. The Physician's Orders report did not include an order for [redacted] a type of [redacted] used for close contact with residents who have [redacted] and [redacted] The Centers for Disease Control updated its [redacted] recommendations in July 2022, which included requirements for signage at the entrance to resident rooms with instructions for caregivers as to what tasks are considered close contact. Close contact tasks would require the caregiver to wear a gown and gloves. 11.On 3/6/26 at 11:34 AM, the surveyor observed Resident #2 in bed with eyes closed. The surveyor observed an [redacted] in place in a [redacted] Signage for [redacted] instructions was not visible at the entrance to the resident room. A 3 drawer plastic bin containing personal protective equipment was located at the entrance to the room. A review of the electronic medical record included the following information. The [redacted] Admission MDS assessment tool indicated the resident was [redacted] as evidenced by a BIMS score of [redacted] out of a possible 15 (Section C) and utilized [redacted]	F0880		04/17/2026

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F0880 SS = E	Continued from page 14 NJ Ex Order 26.4 (Section H). The Physician's Orders report included a NJ Ex Order order for NJ Ex Order 26.4(b)(1). On 3/6/26 at 10:40 am, the surveyor interviewed the RN #2. RN#2 stated residents with NJ Ex Order 26.4(b)(1) and those with NJ Ex Order 26.4(b)(1) should be on NJ Ex Ord RN#1 was unaware of the requirement for signage for NJ Ex Ord On 3/9/26 at 8:31am, the surveyor interviewed CNA#3 who was unaware of the use of NJ Ex Or for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). On 3/10/26 at 12:46pm, the surveyor interviewed the U.S. FOIA (b) (6) The U.S. FOIA is responsible for oversight of the facility's Infection Control Program. The NJ Ex Orde confirmed residents with NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) required NJ Ex Ord She was unaware of the CDC requirement for signage alerting caregivers of the type of NJ Ex Order 26.4 and instructions for close contact with those residents. On 3/10/26 at 1:30 pm, the surveyor discussed the infection control concerns with the U.S. FOIA (b) The surveyor reviewed the facility policy titled Enhanced Barrier Precautions, initiated 3/2024 and last reviewed 3/2025. The policy failed to include the necessity for signage outside of resident rooms with U.S. FOIA The surveyor reviewed the facility document titled Infection Control and Prevention, updated 10/2025. It included instructions to "place appropriate isolation signage outside of the resident's room and designated units" (Step 9). NJAC 8:39-19.4(a); 27.1(a)	F0880		04/17/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure	F0558	Criteria 1: The facility failed to ensure that residents' call device was readily accessible for residents #19, 61, 108 and #114 for reasonable accommodations of needs/ preferences. Residents #19, 61, 108 and 114 had their call bells immediately placed within their reach. Criteria 2:	04/17/2026

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F0558 SS = D	Continued from page 15 the resident's call device was readily accessible. The deficient practice was identified for 4 of the 22 residents (Resident #19, 61, 108, and #114) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: 1. On 3/6/26 at 10:33 AM, the surveyor observed Resident #19 in bed awake, alert, and able to make needs known. The surveyor observed that the resident's call device was hanging on the bed, and the resident was leaning to the opposite side of the bed, where the call bell was out of reach. Resident #19 was asking where the call device was, and they stated they cannot reach it. On the same day at 12:09 PM, the surveyor observed that the resident's call device was out of the resident's reach. On 3/6/26 at 12:54 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #19, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #19 was admitted with diagnoses that included but were not limited to an [redacted] and [redacted]). A review of the significant change Minimum Data Set (SC/MDS), (an assessment tool used to facilitate the management of care) dated [redacted] indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident had [redacted]. Further review of the SC/MDS, as reflected in section GG, revealed that Resident #19 was [redacted] staff for activities of daily living (ADL). A review of the Care Plan (CP) activity report initiated on [redacted] focused on the residents' resistance to care, refusal of [redacted] refusal of [redacted] and [redacted].... Interventions included, but were not limited to, keeping the call bell within easy reach when the resident is in bed.	F0558	Continued from page 15 All residents have the potential for this deficient practice. Criteria 3: Policies and procedures related to call bells were reviewed and revised as necessary. Nursing staff was educated to ensure that all call bells are within resident's reach and accessible when residents are in their room. Criteria 4: Weekly call bell audits will be conducted by the DON/designee to ensure that call bells are within resident's reach. Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

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F0558 SS = D	Continued from page 16 2. On 3/6/26 at 10:35 AM, the surveyor observed Resident#61 asleep in bed. The call device is located hanging on top of the resident's headboard. It was clipped to the wall itself, four inches from the outlet. On the same day at 12:11 PM, the surveyor observed that the resident's call device was still hanging on top of the resident's headboard, out of the resident's reach. On 3/6/26 at 1:04 PM, the surveyor reviewed the hybrid medical record of Resident #61, which revealed the following: A review of the AR reflected that Resident #61 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted]). A review of the quarterly MDS (Q/MDS) dated [redacted] indicated that the facility assessed the residents' cognitive status using a BIMS score of [redacted] out of 15, which indicated that the resident had [redacted] Further review of the Q/MDS, as reflected in section [redacted] revealed that Resident #61 was [redacted] staff for ADL. A review of the CP activity report indicates that there are no interventions that include the call light, which should be within easy reach of the resident for assistance. 3. On 3/6/26 at 10:52 AM, the surveyor observed that Resident #108's call device was located on the floor under the bed. Resident #108 stated that they cannot find the call device because they wanted the television to be turned on. On the same day at 12:13 PM, the surveyor checked the call device of Resident #108. It was observed that the call device was still located on the floor under the resident's bed. On 3/6/26 at 1:21 PM, the surveyor reviewed the hybrid medical record of Resident #108, which revealed the following:	F0558		04/17/2026

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F0558 SS = D	Continued from page 17 A review of the AR reflected that Resident # 108 was admitted with diagnoses that included but were not limited t [redacted]. A review of the admission MDS (A/MDS) dated [redacted] indicated that the facility assessed the residents' cognitive status using a BIMS score of [redacted] out of 15, which indicated that the residents had [redacted]. Further review of the A/MDS, as reflected in section [redacted] revealed that Resident #108 requires staff [redacted] for ADLs. A review of the CP activity report initiated on [redacted] focused on the residents, showing [redacted] in ADL activities secondary to [redacted]. Intervention included, but was not limited to, keeping the call bell within reach when in the room. 4. On 3/6/26 at 10:41 AM, the surveyor observed that the Resident #114 call device was tied to the [redacted] and was hanging off the bed out of the resident's reach. It was observed that the resident was [redacted] reach out for the call device due to the [redacted] in the [redacted]. On 3/6/26 at 1:51 PM, the surveyor reviewed the hybrid medical record of Resident #114, which revealed the following: A review of the AR reflected that Resident #114 was admitted with diagnoses that included but were not limited to [redacted]. There is no recent MDS assessment available for Resident #114 in the hybrid medical record. A review of the CP activity report initiated on [redacted] focused on the residents, showing [redacted] in ADL activities secondary to [redacted] and [redacted]. Intervention included, but was not limited to, keeping the call bell within reach when in the room.	F0558		04/17/2026

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F0558 SS = D	Continued from page 18 On 3/9/26 at 10:23 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the call device should be placed on the right side of the resident, since the NJ Ex Order 26.4(b)(1) and the right hand is to reach the call bell. The added that the call device should be within the resident's reach. On 3/9/26 at 10:32 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that the resident should have a call device and should be placed within their easy reach, even if the BIMS is because the first cry for help is to use the call bell. On 3/11/26 at 1:54 PM, the team met with the U.S. FOIA (b) (6) . and the U.S. FOIA (b) (6) regarding the concern above, but did not provide further information. A review of the facility policy title "Call Bell Monitoring & Responsibility," revised date of August 2025, revealed under "Policy: 6. Call bells are to be left within reach at all times." NJAC 8:39-31.8(c)9	F0558		04/17/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the	F0584	Criteria 1: The facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for one resident's room (Resident # 3's room and in the hallway of the unit. Resident #103, room had the wallpaper repaired and the corner guard replaced. The wallpaper was repaired in the area of room on the unit. The 3 stained ceiling tiles in the same area were replaced. The wallpaper was repaired in the common area living room on the unit. The baseboard heater cover in the common area living room was cleaned and repaired. Criteria 2:	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	**1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052**

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F0584 SS = D	Continued from page 19 protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for one resident's room (Resident # 3's room [NJ Ex On] and in the hallway of the [NJ Ex] unit. This deficient practice was evidenced by the following: 1. On 3/6/26 at 12:32 PM, in Resident # 3's room (room [NJ Ex On] the surveyor observed that approximately 10 inches of the wall paper was peeling off the wall near the bottom of the window sill. The surveyor also observed an approximately 2 inch break in the plastic corner protector on the wall in the resident's room. 2. On 03/6/26 at 11:00 AM, during the initial tour of the facility the surveyor observed the following in the hallway and common area of the [NJ Ex] nursing care unit:	F0584	Continued from page 19 All areas of the facility are at risk for this practice. Criteria 3: The Building Services staff were in-serviced regarding maintaining the residents' living environment in a clean, sanitary, and homelike manner. The Director of Building Services/designee will conduct monthly building rounds of resident rooms, hallways and common areas to ensure a safe/clean/comfortable/ homelike environment. Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

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F0584 SS = D	Continued from page 20 In the hallway, near the smoke doors in the area of room [NJ Ex Or] there was an approximately 24 inch wide by 4-foot-tall area of missing wallpaper with hanging ragged edges. In the same area of the hall as the first observation, the surveyor observed a second an approximately 8 inch wide 4 foot tall area of torn missing wallpaper. On the ceiling, in the same area of the hallway, the surveyor observed several large brown colored stains on 3 ceiling tiles. In the common room marked living room for the [NJ Ex] nursing care unit, the surveyor observed an approximately 6 foot wide area of torn missing wallpaper above the heating baseboard unit, under the window. The exposed area of wall above the heating baseboard unit, had dried brown stains, and the baseboard heater had a crusty brown substance and dents on it. On 3/11/26 at 1:15 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding findings on the [NJ Ex] nursing care unit. The [U.S. FOIA] reviewed photos of the surveyor's findings and discussed responsibility for repairs. The [U.S. FOIA] acknowledged the areas of disrepair and stated his department was responsible for repairs of the facility. He stated the areas should be repaired and acknowledged the appearance of these areas in their current state detracted from the facility's homelike environment On 03/11/26 at 1:55 PM, the surveyor discussed the above concerns with [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)], and the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] acknowledged the missing wall paper and stained ceiling tiles in [NJ Ex] hallways detracted from the facility's homelike environment. All agreed these issues should be repaired. On 3/12/26 at 11:36 AM, the surveyor discussed the above concerns for room 101 with the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)], who also agreed these issues should be repaired. NJAC 8:39-4.1(a)11. 31.4 (a), (b), (c), (f)	F0584		04/17/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F0641	Criteria 1: The facility failed to accurately code the MDS in accordance with federal guidelines for resident #108. The MDS assessment for resident #108 immediately had their MDS corrected and submitted modification to iQIES to reflect the [NJ Ex Order 26.4(b)(1)].	04/17/2026

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F0641 SS = D	Continued from page 21 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool used to facilitate the management of care), in accordance with federal guidelines, for 1 (one) of 22 residents (Resident #108), who were reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: On 3/6/26 at 10:52 AM and on 3/9/26 at 10:12 AM, the surveyor observed Resident #108 awake, lying on the bed, with NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) attached to the lower side of the bed. On 3/6/26 at 1:21 PM, the surveyor reviewed the	F0641	Continued from page 21 Criteria 2: All residents are at risk for this practice. Criteria 3: Policies and procedures related to resident assessments were reviewed and revised as necessary. MDS Coordinator will review all MDS for accuracy prior to submission. Criteria 4 The MDS coordinator will conduct weekly audits of the resident assessments and MDS to ensure that MDS coding is accurate and reflects the resident. Results of these audits will reported to the facility's QAPI committee monthly for three months and then quarterly for one year.	04/17/2026

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F0641 SS = D	Continued from page 22 hybrid (paper and electronic) medical record of Resident #108, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #108 was admitted with diagnoses that included, but were not limited to, NJ Ex Order 26.4(b)(1) . A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated NJ Ex Order 26.4, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of N out of 15, which indicated that the residents had NJ Ex Order 26.4(b)(1). Further review of the A/MDS, as reflected in section NJ Ex Order 26.4(b)(1) revealed that the NJ Ex Order 26.4(b) was not coded for appliances. A review of the Physician Order (PO) with the start date of NJ Ex Order 26 check for NJ Ex Order 26.4(b)(1) placement every shift. A review of the care plan (CP) activity report initiated on NJ Ex Order focused on the residents who had an NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1). On 3/10/26 at 11:00 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that she should code the Resident #108's NJ Ex Order 26.4(b)(1). On 3/11/26 1:54 PM, the team of surveyors met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) regarding the above concern, but did not provide further information. NJAC 8:39-33.2 (c)5	F0641		04/17/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment	F0684	Criteria 1: The facility failed to ensure that care and services were provided in accordance with standards of practice, the facility failed to clarify a physicians order resulting in duplicative treatment orders for Resident #1 and failed to provide comprehensive NJ Ex Order 2 management for resident #11.	04/17/2026

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F0684 SS = D	Continued from page 23 of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure care and services were provided in accordance with professional standards of practice for 2 of 22 residents reviewed (Residents #1 and #11). Specifically, the facility failed to clarify a physician order resulting in duplicative treatment orders, accurately document completion of a treatment order for Resident # 1, and provide comprehensive [NJ Ex Order] management for Resident # 11. The findings are as follows: 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." 1.On 3/6/26 at 11:22 AM, the surveyor observed Resident #1 seated in a wheelchair in the unit day room watching television. A review of the electronic medical record revealed the following information. The [NJ Ex Order 26.4] Admission Minimum Data Set (MDS) assessment tool indicated the resident had no cognitive deficits as evidenced by a Brief Interview	F0684	Continued from page 23 Resident #1 with duplicate treatment orders were corrected. The order for the [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] was discontinued. RN#1 was educated one to one by the DON on proper documentation after completion of treatments. Resident #11 had comprehensive [NJ Ex Order] management care plan put into place Resident #11 had [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order] reviewed by the physician Criteria 2: All residents have the potential to be affected by this practice Criteria 3: All nursing staff were educated on following and maintaining physician orders by the Director of Nursing. Policies and procedures related to insulin management, physician orders were reviewed and revised as necessary. Criteria 4: Weekly audits of physician orders being followed will be conducted weekly byt the DON/designee. Results of these audits will be reported to the facility's QAPI committee monthly for three months, then quarterly for one year.	04/17/2026

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F0684 SS = D	Continued from page 24 for Mental Status score of [NJ E] of a possible 15 (Section [NJ E] and was admitted with [NJ Ex Order 26.4(b)(1)] (Section [NJ Ex O] The [NJ Ex Order 2] Physician's Orders (PO) report included a [NJ Ex Order 2] treatment order for the [NJ Ex Order 26.4(b)(1)] for NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1)] Also included in the [NJ Ex Order 2] PO was a [NJ Ex Order 2] treatment order for the NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and [NJ Ex Order 2] was to be [NJ Ex Order 26.4(b)(1)] The [NJ Ex Order 2] electronic Treatment Administration Record (eTAR) contained nursing documentation that both treatments were done to the same [NJ Ex O] on [NJ Ex O] On 3/10/26 at 10 AM, the surveyor reviewed wound consultation reports. The most recent report in the electronic medical record was dated [NJ Ex Order 26]. The U.S. FOIA (b) (6) wrote a treatment recommendation to continue NJ Ex Order 26.4(b)(1), [NJ Ex Order 26.4(b)(1)] and NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) documented "this treatment will be done daily until discontinued…" On 3/10/26 at 11:30 AM, the surveyor observed the facility Registered Nurse (RN #1) perform a [NJ Ex Order 2] treatment to the resident's NJ Ex Order 26.4(b)(1). RN #1 applied [NJ Ex Order 26.4] and [NJ Ex Order 26.4(b)(1)] to the NJ Ex Order 26.4(b)(1) and left the NJ Ex Order 26.4(b)(1). Resident #1 questioned RN #1 why he was not NJ Ex Order 26.4(b)(1). RN #1 stated the resident was confusing the order with an older previous order. RN #1 completed the order and logged into the eTAR to document completion of the [NJ Ex Order 2] treatment. The surveyor observed in the eTAR that the treatment had been documented as having been done hours earlier. RN #1 stated "I documented it as done when it was not done. I should have waited until I completed the treatment to document its' completion." On 3/10/26 at 1:44 PM, the surveyor discussed the duplicate treatment order and the nurse signed as done when the treatment was not completed with the U.S. FOIA (b) (6)).	F0684		04/17/2026

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F0684 SS = D	Continued from page 25 On 3/11/26 at 10:07 AM, the U.S. FOIA (b responded there was a NJ Ex Order 26.4(b)(1) care consultation that was not uploaded into the electronic medical record until NJ Ex Order 2 The U.S. FOIA (b provided a PO indicating on NJ Ex Order 2 at 4:20 PM the order for a NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) was discontinued. 2. A review of resident #11's Electronic Health Record reflects the resident was admitted to the facility on NJ Ex Order with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26. and NJ Ex Order 26.4(b)(1) A review of Resident #11's Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4 reflected that the resident had a brief interview for mental status (BIMS) score "NJ E out of 15," which indicated NJ Ex Order 26. A review of the resident Plan of Care effective date of NJ Ex Order 26 reflects no focuses, interventions or goals are included to outline care for resident's NJ Ex O A review of resident 11's physician orders reflects the resident had an order dated NJ Ex Order 26.4(prescribing NJ Ex Order 26.4(b)(1) before meals and at bedtime per NJ Ex Order 26.4(b)(1) coverage after testing NJ Ex Order 26.4(b)(1). Scheule every day at 8:15 am, 12:30pm, 5:15 pm and 9:00 pm. Protocol: NJ Ex Order 26.4(b)(1) if NJ Ex Order 26.4(b)(1) and notify Physician or U.S. FOIA (b) (6) A review of Resident #11's record of NJ Ex Order 26.4(b)(1) readings reveals the resident's NJ Ex Order 26.4(b)(1) result documented on NJ Ex Order 26.4 at 9:43 pm was NJ Ex Or The resident's medication administration record (MAR) reflected documentation that NJ Ex Order 26.4(b)(1) were administered as ordered but no documentation was evident in the MAR or the remainder of EHR indicates the physician or U.S. FOIA (b) (6) were notified of these results as required by the physician's order. On 3/12/26 at 10:40 AM the surveyor interviewed U.S. FO assigned to the care of Resident #11. The surveyor asked the U.S. FO about care plans for residents with NJ Ex Order 26.4(b)(1), The U.S. FO agreed residents with NJ Ex Order 26.4(b)(1) should have	F0684		04/17/2026

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F0684 SS = D	Continued from page 26 care plans with focuses and interventions to manage [redacted]. The [redacted] acknowledged after consulting the EHR that Resident#11 did not have a care plan with focuses or interventions for [redacted]. The [redacted] confirmed that Resident#11 has order since [redacted] including directions that if the resident had [redacted] test result over [redacted] the resident was to be administered [redacted] and that physician or [redacted] were to be notified of the result and the notification would be charted in the resident's EHR. On 3/12/26 at 11:03 AM, the survey met with the [redacted] and discussed that residents EHR does not reflect a care plan for [redacted] and does not include documentation of Physician notification of a [redacted] result or [redacted]. The [redacted] stated she would review Resident #11's EHR and respond. On 3/12/26 at 11:45 AM, the surveyor and team met with the [redacted] and discussed the concerns with Resident #11. The [redacted] confirmed that the resident's EHR does not reflect documentation that physician notification occurred for the [redacted] results on [redacted] as ordered. The [redacted] confirmed that no focuses or intervention were documented or included in the plan of care for Resident # 11 and that the care plan should include measures for [redacted] NJAC 8:39-27.1	F0684		04/17/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F0756	Criteria 1: The facility failed to address the recommendations made by the Consultant Pharmacist for resident #113 for unnecessary medications. Resident #113 had the recommendations for their [redacted] order reviewed by their attending physician as recommended in the consultant pharmacist's report. Resident #113 had their order for [redacted] clarified to reflect on for twelve hours, on at 9am and off 9pm to [redacted]. Criteria 2: All residents have the potential to be affected by this practice.	04/17/2026

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F0756 SS = D	Continued from page 27 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to address the recommendations made by the U.S. FOIA (b) (6) which was identified for 1 of 5 residents (Resident #113) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 3/9/2026 at 10:20 AM, the surveyor observed Resident #113 lying in their bed, alert, NJ Exec Order 26.4b1 . Resident #113 was receiving via a NJ Ex Order 26.4(b)(1). The resident had NJ Ex Order 26.4(b)(1) covered with a NJ Ex Order 26.4(b)(1), hanging from the bottom of the bed frame. On 3/9/2026 at 10:45 AM, the surveyor reviewed the facility provided Admission Medication Review (aMRR) for Resident #113 dated NJ Ex Order 26.4 completed by the U.S. FOIA (b) (6)). The aMRR included a recommendation to clarify the resident's NJ Ex Order 26 capsule order with the physician as the medication should be NJ Ex Order 26.4(b)(1) and the resident received	F0756	Continued from page 27 Criteria 3: Nursing supervisors were educated by the DON on processes and protocols for reviewing consultant pharmacist recommendation for new admissions. Polices and procedures for consultant pharmacist review and recommendations were reviewed and revised as necessary. Criteria 4: Weekly audits of all new admissions consultant pharmacist recommendations are reviewed and carried out in a timely manner will be conducted by the DON/designee. Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052

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F0756 SS = D	Continued from page 28 medication via [NJ Ex Order 26.4(b)(1)]. The recommendations were unsigned to indicate the recommendations were followed up. The surveyor reviewed the electronic medical record (EMR) of Resident #113. The Resident Face Sheet (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to [NJ Ex Order 26.4(b)(1)]. A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated [NJ Ex Order 26.4] indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #113 scored a [NJ E] which indicated the resident had [NJ Ex Order 26.4(b)(1)]. In Section [NJ Ex Order 26.4(b)(1)], Resident #56 was coded as [NJ Ex Order 26.4(b] through [NJ Ex Order 26.4(b)(1)] while a resident. A physician's order dated [NJ Ex Order 26.4] documented [NJ Ex Order 26.4(b)(1)] capsule, give one capsule by [NJ Ex Order 26.4(b)(1)]) once daily. On 3/9/26 at 11:29 AM, the surveyor interviewed the [U.S. FOIA (b) (6)], about [U.S. F] recommendations who stated the [U.S. FOIA (b) (6)] was responsible for reviewing and following up on [U.S. F] recommendations. The [U.S. FOIA (b) (6)] further explained that when the [U.S. FOIA] was absent the [U.S. FOIA (b) (6)] would be responsible. The surveyor asked the [U.S. FOIA (b) (6)] after receiving [U.S. F] recommendation reports how soon it would be expected for the recommendations to be followed up. The [U.S. FOIA (b) (6)] replied that they would be completed within the same week and for high priority recommendations would be followed up with physician right away. The [U.S. FOIA (b) (6)] further explained the report would have written notations and be signed to indicate completion. The surveyor discussed Resident #113's [U.S. F] recommendations and review of the EMR revealed no documentation of follow up. Additionally, the report was unsigned. The [U.S. FOIA (b) (6)] stated that it would have been reviewed by the [U.S. FOIA] and would follow up to provide any additional information. On 3/10/2026 at 11:03 AM, the [U.S. FOIA (b) (6)] informed the surveyor that they followed up with the physician regarding the [U.S. FOIA] recommendation for	F0756		04/17/2026

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F0756 SS = D	Continued from page 29 NJ Ex Order 26 yesterday and clarified the order. The U.S. F acknowledged the recommendation was not followed up prior to surveyor inquiry. On 3/10/26 at 12:30 PM, Additional review of the aMRR revealed NJ Ex Order 26.4(b)(1) recommendations to NJ Ex Order 26.4(b)(1 administration at 9am and removal at 9pm as the medication was effective for 12 hours. A review of the physician's orders and NJ Ex Order 26.4(b)(1) Medication Administration Record (MAR) revealed an order dated NJ Ex Order 26 for NJ Ex Order 26.4(b)(1) once daily to NJ Ex Order 26.4(b)(1 ; NJ Ex Order 26 at bedtime. The NJ Ex Order 26.4(b) patch was timed for 7 AM to 3 PM and 3 PM to 11PM. On 3/10/26 at 1:56 PM, the surveyor informed the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) of the above concerns that not all U.S. FO recommendations from NJ Ex Order 26.4 were followed up by the facility and the report was unsigned to indicate review by the nursing staff and physician. The U.S. FOIA (b stated she would discuss with the U.S. F to provide additional information. On 3/11/26 at 10:03 AM, the U.S. FOIA (b) U.S. FOIA (b) (6), and the U.S. FOIA met with the survey team. The U.S. FOIA stated as of that morning all recommendations were followed up. The U.S. FOIA stated she could not speak to why the U.S. F recommendations were not addressed prior to surveyor inquiry. The surveyor received the facility policy for aMRR. The surveyor requested any other facility policies related to U.S. F recommendations. On 3/12/26 at 12:00 PM, the U.S. FOIA stated there was no additional policy related to U.S. FO recommendations. No additional information was provided by the facility. A review of the undated facility policy titled "ADMISSION MEDICATION RECONCILIATION PROTOCOL AND CONTACTING OUTSIDE PCP [Primary Care Provider]" which revealed under Policy: "All admitted residents will have their transfer orders reviewed and reconciled The R.N. Supervisor or designate and Medical Director or designee will coordinate clarification orders." Under the policy's Procedure revealed: "… 2. All new admission physician orders will be faxed to pharmacy consultant for review and reconciliation.	F0756		04/17/2026

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F0756 SS = D	Continued from page 30 3. The R.N. Supervisor or designee will review and reconcile the discharge orders of all newly admitted admissions to [facility] within 24 hours of admission. Medication requiring clarification will be discussed with the attending physician…" The policy did not further address the procedure for follow up of CP recommendation reports. NJAC 8:39-27.1 (a); 29.3	F0756		04/17/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to: (a) properly store, and date medications in 1 of 4 medication carts and 1 of 2 medication storage rooms inspected; and (b) ensure controlled medications were stored in a separately locked, permanently affixed compartment in 1 of 3 medication carts inspected for medication storage. This deficient practice was evidenced by the	F0761	Criteria 1: The facility failed to a) properly store and date medication and b) ensure controlled medications were stored in a separately locked , permanently affixed compartment of the med cart. Expired and undated medication were destroyed, and [redacted] box was permanently affixed with bolts upon findings. The expired IV bags found in the medication room were removed and destroyed. The [redacted] was removed and destroyed. The [redacted] were removed and destroyed. The [redacted] found in the med cart was removed and disposed of. Resident #104 [redacted] was removed and disposed of. Resident #3 [redacted] was removed and disposed of The compartment for storage of controlled medications on the medication cart B on LP was securley affixed to the medication cart. Criteria 2: All residents are at risk for this deficient practice. Criteria 3: LPN1, LPN2 and LPN3 were given one to one education regarding proper labeling, storage and securing of medication by the director of nursing. Policies and procedures related to proper labeling, storage and securing of medication were reviewed and revised as necessary.	04/17/2026

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F0761 SS = D	Continued from page 31 following: 1. On 3/11/26 at 11:08 AM, the surveyor inspected the medication storage room on the HP unit in the presence of Licensed Practical Nurse (LPN) # 1 assigned to the unit. There were 2- 0.45% Normal Saline, one Liter intravenous bags which both had a manufacturer's expiration date of January 2026 stored in a cabinet. LPN #1 confirmed the IV bags were expired and removed them to be disposed. The U.S. FOI stated she was unsure of when the eye drops were opened or if it was used. The pharmacy label read "refrigerate before opening". There was a NJ Ex Order 26.4(b)(1) for a resident observed with a written open date of NJ Exec on the plastic bag it was stored in and written on the NJ Ex Order 26 itself. The pharmacy label on the NJ Ex Order 26 appeared to have a written date of NJ Exec Or. The LPN #1 stated the date opened was NJ Exec O and not NJ Exec 2. On 3/11/2026 at 11:21 AM, the surveyor inspected medication cart A on the NJ Ex unit in the presence of LPN #2. Upon opening a drawer of the cart, the surveyor observed an opened NJ Ex Order 26.4(b)(1) foil packet containing NJ Ex Order 26.4(b)(1). The foil packet had a written date of NJ Exec Order and had no resident name written on it. LPN #2 stated the date indicated when the packet was opened. The LPN #2 could not say which resident it belonged to and acknowledged it should have been stored in the resident's NJ Ex Order 26 manufacturer box which had a label with the resident's name on it. The LPN #2 believed the NJ Ex Order 26 medication's expiration after opening the foil packet was two weeks but was not sure. LPN #2 stated he would ask their U.S. FOIA (b) (6). In the same drawer the surveyor observed Resident #104's NJ Ex Order 26 manufacturer box which had a pharmacy label with an order date of NJ Exec Order 26 and indicated the NJ Ex Order 26 order was for a ten day duration. Inside the box there was an opened foil packaging containing NJ Ex Order 26.4(b)(1) with no date on it; and underneath the packaging were four attached NJ Ex Order 26.4(b)(1) not stored in a foil packaging with no date on them. In the same drawer, the surveyor observed Resident #33's NJ Ex Order 26 manufacturer box which contained inside a single foil packet which had a written date of NJ Exec Order 2. The LPN #2 removed identified items from the medication cart and stated he would follow up with the U.S. FOIA (b) (6).	F0761	Continued from page 31 Criteria 4: Weekly audits of the medication rooms and carts for expired/discontinued medications, proper labeling and dating and to ensure the compartment for storage for controlled medication is securely affixed will be conducted by the DON/designee. Results of these audits will be reported to the facility's QAPI committee monthly for three months then quarterly thereafter for one year	04/17/2026

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F0761 SS = D	Continued from page 32 On 3/11/26 at 1:28 PM, the surveyor informed the U.S. FOIA (b) (6) of the above medication storage concerns. The U.S. FOIA (b) (6) acknowledged the IV bags in the medication should have been disposed as it expired in January 2026. The U.S. FOIA (b) (6) was not sure of the medication's expiration after opening the foil packaging. The RN supervisor acknowledged items should be stored in a resident specific medication box and not kept loose in the drawer. The U.S. FOIA (b) (6) stated she would follow up with the U.S. FOIA (b) (6)) and the pharmacy. 3. On 3/11/26 at 11:38 AM, the surveyor inspected Medication Cart B on Unit LP in the presence of the LPN #3. The surveyor observed that the compartment for storage of NJ Ex Order 26.4(b)(1) was not permanently affixed to the medication cart. The surveyor was able to lift and fully remove the compartment from the medication cart. When the surveyor lifted the compartment, they observed that the compartment had no bottom, and the NJ Ex Order 26.4(b) were visible and accessible. On 3/11/26 at 11:49 AM, the surveyor interviewed LPN #3 who acknowledged that the compartment for storage of NJ Ex Order 26.4(b)(1) should be affixed and will notify their supervisor. On 3/11/26 at 1:33 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that they will follow up to provide a response regarding the above concern. On 3/11/26 at 1:52 PM, the surveyor informed the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6), and the U.S. FOIA of the above medication storage concerns. On 3/12/26 at 9:15 AM, the U.S. FOIA provided the surveyor a document, dated 7/22/25 titled "Medications which need to be dated upon opening" from their pharmacy consultant which listed medications and expiration after opening. The list included NJ Ex Order 26.4 6 pack foil packet which indicated expiration 7 days after opening; and NJ Ex Order 26.4 30 pack foil packet which indicated expiration 14 days after opening. On 3/12/26 at 11:45 AM, the U.S. FOIA stated to the surveyor all identified IV and NJ Ex Order 26.4(b) medications were disposed. There was no additional information provided by the facility. A review of the facility's policy and procedure titled, "Medication Storage", with a revised date of November 2025 under Policy revealed: "Medications	F0761		04/17/2026

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F0761 SS = D	Continued from page 33 and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier". The facility's "Administration of Medications Procedure," "Medication Administration Policy," and "Medication Storage Policy and Procedure" did not address the requirement of the facility to provide permanently affixed compartments for storage of controlled drugs. NJAC 8:39-29.4	F0761		04/17/2026

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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 the interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Be 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 seq.) shall maintain the following minimum direct care staff-to-resident ratios: (1) one certified nurse aid 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	S0560	Criteria 1: The facility failed to maintain minimum direct care staff ratios. No residents were directly affected by this practice. Staffing schedules were reviewed byt DON for compliance. Appropriate number of staff will be scheduled according to census and matrix acuity. Criteria 2: All residents have the potential to be affected by this practice. Criteria 3: All nursing administration staff were educated regarding maintaining staffing levels to ensure that staffing mandate requirements are being met. Criteria 4: Staffing ratios will be reviewed daily by the DON and Assistant Administrator. Results will be presented at the facility's QAPI committee meetings monthy for three months and then quarterly thereafter for one year.	04/17/2026

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

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S0560	Continued from page 1 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 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 the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing period before the survey, beginning 2/15/26 and ending 2/28/26, for the 03/12/2026 Standard survey at the facility, revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 2 of 14- day shifts as follows: On 2/21/26, had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. On 2/22/26, had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. On 3/12/26 at 10:35 AM, the surveyor interviewed the Assistant License Nursing Home Administrator and the Director of Nursing (DON) regarding the concern above. The DON stated that during the specific days of 2/21/26 and 2/22/26, there is a snow blizzard and there is a shutdown of transportation. The DON added that they have a van	S0560		04/17/2026

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S0560	Continued from page 2 driver to pick up the staff who got stuck in their home. They outsourced from the [Name Redacted] agency at that time and got 2 CNA's who worked those days. A review of the facility policy title "Issue: S560-Staffing with a revised date of November 2025 under "Purpose: 1. DON/designee will oversee staffing levels based on census and state recommendations."	S0560		04/17/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and a review of other facility documentation, it was determined that the facility failed to ensure that employees received a physical examination performed by a physician, an advanced practice nurse, or a licensed physician assistant within two weeks prior to the first day of employment or upon employment. This deficient practice was identified in 18 of 28 new employees (Staff#1, 4, 5, 6, 7, 9, 11, 14, 15,16, 17, 18, 20, 23, 24, 25, 26, and #27). This deficient practice was evidenced by the following: The surveyor reviewed 28 newly hired employee files. A review of health examinations upon hire for 18 of the 28 new employees revealed the following:	S1405	Criteria 1: The facility failed to ensure that employees received a physical examination performed by a physician, advanced practical nurse or licensed physician assistant within two weeks prior to the first day of employment. Active staff identified during survey, #4, #5, #7, #9, #11, #14, #15, #17, #18, #20, #23, #27) that did not receive a physical exam by a licensed physician, advanced practice nurse, or physician assistant have had their physical completed. Employees #1, #6, #16, #24, #25, #26 are terminated and no longer active at the facility. Criteria 2: Policies and procedures related to onboarding new employees have been reviewed and revised as necessary. All Hiring Managers were in-serviced regarding the policies and procedures for new hire physical examinations by the Assistant Administrator. Assistant Administrator will monitor all new hires to ensure that they receive proper physical exams. Criteria 3: All new employees are at risk. Criteria 4: Audits of new hires will be conducted by the Assistant Administrator/designee weekly for four weeks, then monthly. Reports of these audits will be	04/17/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052

(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
S1405	Continued from page 3 Staff #1, a Certified Nurse Assistant (CNA), was hired on [NJ Ex Order 26] and has not completed a physical examination at least within two weeks before the first day of employment or upon employment. Staff #4, a CNA, was hired on [NJ Ex Order 2] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #5, a housekeeper, was hired on [NJ Ex Order 26.4] and has not completed a physical examination at least within two weeks before the first day of employment or upon employment. Staff #6, a CNA, was hired on [NJ Ex Order 26.4] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #7, an accountant, was hired on [NJ Ex Order 26] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #9, a Dietary Aide (DA), was hired on [NJ Ex Order 26] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #11, an Activity Assistant (AA), was hired on [NJ Ex Order 26] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #14, a Dietary Aide (DA), was hired on [NJ Ex Order 26] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #15, a nursing supervisor, was hired on [NJ Ex Order 26.4] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #16, a CNA, was hired on [NJ Ex Order 26.4] and has not completed a physical examination at least two weeks	S1405	Continued from page 3 reported to the facility's QAPI committee monthly for three months and then quarterly for one year.	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030703	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052

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S1405	Continued from page 4 before the first day of employment or upon employment. Staff #17, a Licensed Practical Nurse (LPN), was hired on [NJ Ex Order 2] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #18, a CNA, was hired on [NJ Ex Order 26] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #20, a non-certified aide, was hired on [NJ Ex Order] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #23, an LPN, was hired on [NJ Ex Order 26.4] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #24, a CNA, was hired on [NJ Ex Order 26.] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #25, an LPN, was hired on [NJ Ex Order 26.] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #26, a CNA, was hired on [NJ Ex Order 26.] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. Staff #27, a social worker, was hired on [NJ Ex Order 26.4(b] and has not completed a physical examination at least two weeks before the first day of employment or upon employment. On 3/10/26 at 1:59 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Assistant LNHA. The Asst. LNHA stated that her responsibility is the new hire, HR	S1405		04/17/2026

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S1405	Continued from page 5 portion, licenses, and background checks. Their process for the new hire is that if they have had a physical test done within the last 6 months, the new hire can bring the results, and they will accept them. No further information was provided. A review of the facility policy title "Policy and Procedure Employee Health Services" with a revised date of December 2025 under "Procedure 1. Pre-employment physicals are scheduled by the Personnel Department with the Medical Director (MD) or designee. (Employee candidates, at their own expense, have the option of having their pre-employment physicals done by their private physician. A form utilized by Daughters of Israel for pre-employment physicals will be provided to the employee candidate.)	S1405		04/17/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and record reviews of pertinent facility documentation, it was determined that the facility failed to ensure newly hired employees completed the required NJ Ex Order 26.4(b)(1) screening (i.e., NJ Ex Order 26.4(b)(1)) or NJ Ex Order 26.4(b)(1)	S1410	Criteria 1: The facility failed to ensure that employees completed the required NJ Ex Order 26.4(b)(1) test, NJ Ex Orde or NJ Ex Order 26.4(b)(1) test before the date of hire to evaluate the individual's NJ Ex Order 26.4(b) status. All active employees identified in the survey with incomplete NJ Ex screening, (Employee #2, #5, #7, #8, #9, #11, #12, #13, #14, #15, #18, #19, #20, #27 & #28) were given the required NJ Ex Order 26.4(b)(1) test process by nursing administration, or received appropriate alternative screening (i.e,; NJ Ex Order 26.4(b)(1) test, such as NJ Ex Order 26.4(b)(1) if applicable) Employees #16, #22, & #26 are terminated and no longer active at the facility. Criteria 2: Education has been provided to nursing supervisors by the DON and Assistant Administrator on proper TB requirements. Policies and procedures related to pre-employment onboarding have been reviewed and revised as needed. Criteria 3: All new employees have the potential to be at risk	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030703	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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S1410	Continued from page 6 [NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) test performed before the Date of Hire (DOH). It was identified in 18 of 28 new employees (Staff #2, 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 26, 27, and #28). This deficient practice was evidenced by the following: The surveyor reviewed 28 newly hired employee files. A review for NJ Ex screening upon hire for 18 of the 28 new employees revealed the following: Staff #2, a driver hired on NJ Ex Order 26, completed the first step of a NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 No additional documentation was in the file to indicate that the step NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #5, a housekeeper (HK) hired on NJ Ex Order 26.4 completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order 26 No additional documentation was in the file to indicate that the step NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #7, an accountant hired on NJ Ex Order 26.4(completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order 26 No additional documentation was in the file to indicate that the step NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #8, a Dietary Aide (DA) hired on NJ Ex Order 26, completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order 26. No additional documentation was in the file to indicate that the step NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #9, a DA hired on NJ Ex Order 26, had a history of a NJ Ex Order 26.4(b)(1) on file. Still, there was no additional documentation in the file to indicate that any NJ Ex Or test or alternative NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #11, an Activity Assistant (AA), hired on	S1410	Continued from page 6 by this practice. Criteria 4: Audits of all new hires will be conducted by the Assistant Administrator/designee for proper TB testing requirements. Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

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S1410	Continued from page 7 NJ Ex Order 26, completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4. No additional documentation was in the file to indicate that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #12, a Certified Nursing Assistant (CNA), hired on NJ Ex Order 2 completed the first step of NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(No additional documentation was in the file to indicate that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #13, an AA, hired on NJ Ex Order 26, completed the first step of NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(No additional documentation was in the file to indicate that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #14, an admission director, hired on NJ Ex Order 26.4(completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order 2 No additional documentation was in the file to indicate that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #15, a nursing supervisor, hired on NJ Ex Order 26.4. There was no additional documentation in the file to indicate that NJ Ex Order 26.4(b)(1) test or an alternative NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #16, a CNA, hired on NJ Ex Order 26.4(There was no additional documentation in the file to indicate that a NJ Ex Order 26.4(b)(1) test or an alternative NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #18, a CNA, hired on NJ Ex Order 26.4 completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order . No additional documentation was in the file to indicate that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #19, a cook, hired on NJ Ex Order 26.4 completed the first step of NJ Ex Order 26.4(b)(1) or NJ Ex Order 26 No additional documentation was in the file to indicate that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #20, a CNA, hired on NJ Ex Order 26 completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order . No additional documentation was in the file to indicate	S1410		04/17/2026

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S1410	Continued from page 8 that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #22, a DA, hired on NJ Ex Order 26, completed the first step of NJ Ex Order 26.4(b)(1) on NJ Ex Order 2. No additional documentation was in the file to indicate that the NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #26, a CNA, hired on NJ Ex Order 26. There was no additional documentation in the file to indicate that a NJ Ex Order 26.4(b)(1) test or an alternative NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #27, a social worker, hired on NJ Ex Order 26.4(. There was no additional documentation in the file to indicate that NJ Ex Order 26.4(b)(1) test or an alternative NJ Ex Order 26.4(b)(1) was completed upon hire. Staff #28, an HK, hired on NJ Ex Order 26. There was no additional documentation in the file to indicate that a NJ Ex Order 26.4(b)(1) test or an alternative NJ Ex Order 26.4(b)(1) was completed upon hire. On 3/10/26 at 12:10 PM, the surveyor interviewed the Registered Nurse (RN)/Supervisor, who stated that if there is a new hire who has been out of the country and at risk, they do the 1st NJ Ex Or and then annually. She confirmed that they only do the 1st step as per human resources (HR) and did not provide further information. On 3/10/26 at 12:40 PM, the surveyor interviewed an RN/Infection Preventionist (IP), who stated that the new hire, if they are NJ Ex Order 26.4 for 1st NJ Ex Ord can start to work, and they do not do the 2nd NJ Ex Ord step. On 3/10/26 at 1:59 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Assistant LNHA. The Asst. LNHA stated that her responsibility is the new hire, HR portion, licenses, and background checks. Their process for the new hire is that if they have had a NJ Ex Or from the previous year, the new hire can bring the results, and they accept it. No further information was provided. A review of the facility policy title "Mantoux Testing	S1410		04/17/2026

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S1410	Continued from page 9 for All New Employees" with a revised date of December 2025 under Policy: A. [Name redacted] requires all new employees to complete a health history and receive an examination performed by an MD or designee prior to the first day of employment. B. All new employees, including the medical staff employed by the facility, will receive a one-step Mantoux tuberculin test with five tuberculin units of purified protein derivative (PPD). The only exceptions will be the employees with documented Mantoux skin test (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (ten or more millimeters of induration, employees who received appropriate medical treatment for tuberculosis, or when medically contraindicated."	S1410		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/04/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 05/04/2026 in relation to the 03/12/2026 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 03/10/26 to 03/12/2026 and Daughters of Israel 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 Occupancy. Daughters of Israel Pleasant Valley Home is a two-story building with a partial basement that was built in 1961 with an addition that was built in 1980. It is composed of Type II (111) construction. The facility is divided into 24 - smoke zones. RHP (first floor), has 41 rooms and has been closed for approximately 5 years. WLP (second floor), located above the sub-acute unit has 56 beds and has been closed approximately 3 years. BP (basement), located above the LP unit has 47 beds and has been closed for approximately 9 years. The facility current census was 107 The facility has 3 diesel powered emergency backup generators: [redacted] 400KW generator provides power to the RHP, LP, HP, and BP units. [redacted] 150 KW generator provides power to the Admin and OT/PT areas. Rental 150KW generator provides power to the SP and WLP units.	K0000		04/17/2026

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: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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K0321 SS = F Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/10/2026 in the presence of the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted] it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0321	Criteria 1: The self closer on the laundry dryer room door was immediately repaired. Criteria 2: All residents are found to be at risk due to this practice Criteria 3: Building Services staff were in-serviced regarding areas separated from other spaces by smoke resistant partitions and doors, that doors should be self closing or automatic by the Director of Building Services. The Director of Building Services/designee will conduct monthly audits of all doors to ensure the self closing devices are functioning properly. Criteria 4: The Director of Building Services/designee will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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K0321 SS = F Bldg. 01	Continued from page 2 An observation on at 10:10 AM revealed that laundry dryer room door was not self-closing or automatic closing. In interview at the time, the [redacted] and the [redacted] confirmed the observation. The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 3/12/2026 at 1:00 PM. N.J.A.C 8:39-31:2(e).	K0321		04/17/2026
K0331 SS = F Bldg. 01	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This STANDARD is NOT MET as evidenced by: Based on observations and interview on 03/10/2026 and 03/11/2026 in the presence of the [redacted], [redacted]), it was determined that the facility failed to ensure that the fixed interior wall surfaces have a flame spread rating of Class A or B in accordance with NFPA 101:2012, 10.2.3* and 10.2.8.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 03/10/2026 from 9:30AM to 2:10PM in the HP unit exit/egress corridor, revealed carpet on the lower section of the walls. The carpet measured approximately 33-inches up from the floor and the flame spread rating could not be determined. In interview at the time, the [redacted] and the [redacted] confirmed the observation.	K0331	Criteria 1: Carpet rating for the lower section of wall on the HP unit/egress, the LP unit egress, and the main exit/egress corridors was obtained. Criteria 2: All residents are found to be at risk due to this practice. Criteria 3: Building Services staff were in-serviced regarding interior surfaces of building surfaces should have a flame spread rating of Class A or Class B by the Director of Building Services. The Director of Building Services will conduct audits of all carpeted areas to ensure documentation of fire rating. Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052

(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
K0331 SS = F Bldg. 01	Continued from page 3 The U.S. FOIA (b was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. Observations on 03/11/2026 from 9:21AM to 1:121PM in the LP unit exit/egress corridor, revealed carpet on the lower section of the walls. The carpet measured approximately 33-inches up from the floor and the flame spread rating could not be determined. In interview at the time, the U.S. FOIA (b and the U.S. FOI confirmed the observation. The U.S. FOIA (b was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. Further observations in the Main exit/egress corridor revealed carpet on the lower section of the walls. The carpet measured approximately 18-inches up from the floor and the flame spread rating could not be determined. In interview at the time, the U.S. FOIA (b and the U.S. FOI confirmed the observation. The U.S. FOIA (b was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. In an interview with the U.S. FOIA (b on 03/12/2026 at 9:21AM, He stated that the facility could not provide records for flame spread rating for the carpets on the walls, no further documentation was provided. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 1:00 PM. N.J.A.C 8:39-31:2(e).	K0331		04/17/2026
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:	K0345	Criteria 1: A sensitivity testing of smoke detectors of the fire alarm system has been scheduled by the facility's fire alarm vendor. Documentation of the testing will be forwarded once completed Criteria 2: All residents are found to be at risk due to this practice	04/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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K0345 SS = F Bldg. 01	Continued from page 4 Based on documentation review and interview on 03/12/2026 in the presence of the [U.S. FOIA (b) (6)] [redacted], U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the sensitivity testing of smoke detectors was conducted every alternate year in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and were evidenced by the following: A documentation review revealed there was no current documentation of sensitivity testing for smoke detectors. In an interview at 10:30 AM, [U.S. FOIA (b)] [redacted] stated the facility was unable to provide any documentation of a recent inspection of the fire alarm sensitivity testing of smoke detectors. [U.S. FOIA (b)] [redacted] could not provide documentation that indicates when the last sensitivity testing was conducted by the facility fire alarm vendor. The facility's [U.S. FOIA (b) (6)] [redacted] was notified of the deficient practice at the Life Safety Code exit conference at 1:00 PM. NJAC 8:39-31.1(c),31.2(e) NFPA 70,72.	K0345	Continued from page 4 Criteria 3: Building Services staff were in-serviced regarding fire alarm sensitivity testing by the Director of Building Services. The Director of Building Services/designee will conduct monthly audits of the fire smoke detectors for appropriate testing. Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee for three months and then quarterly thereafter.	04/24/2026
K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K0351	Criteria 1: Fire alarm vendor has installed sprinkler heads in ice cream walk in freezer. Please see attached. Criteria 2: All residents are at risk due to this practice. Criteria 3: Building Services staff were in-serviced sprinkler systems requirements in accordance with NFPA 13. The Director of Building Service will conduct monthly sprinkler audits. Criteria 4:	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

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K0351 SS = F Bldg. 01	Continued from page 5 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/10/2026 in the presence of the U.S. FOIA (b) (6) , U.S. FOIA (b) (6)), it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations in the kitchen area at approximately 11:13AM revealed that the Ice Cream Walk-In Freezer was not provided with fire sprinkler coverage. In interview at the time, the U.S. FOIA (b and the U.S. FOI confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 3/12/2026 at 1:00 PM. N.J.A.C 8:39-31:2(e). NAPA13.	K0351	Continued from page 5 The Director of Building Services will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter.	05/01/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K0353	Criteria 1: A five year hydrostatic inspection was conducted by the facility's fire alarm vendor. Please see attachments. Criteria 2: All residents are found to be at risk by this practice. Criteria 3: Building Services staff were educated on automatic sprinkler system inspection requirements in accordance with NFPA 25 The Director of Building Services will conduct monthly audits of all fire alarm testing.	05/01/2026

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K0353 SS = F Bldg. 01	Continued from page 6 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on documentation review and interview on 03/12/2026 in the presence of the U.S. FOIA (b) (6) [redacted]), U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all residents and was evidenced by the following: Record review at 11:14 AM revealed that Fire Department Connection 5- Year Hydrostatic inspection report was not among the documents provided by the U.S. FOIA (b [redacted] for review. No further documentation was provided. In an interview at the time, U.S. FOIA (b [redacted] confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 1:00 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 25.	K0353	Continued from page 6 Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee for three months and then quarterly thereafter.	05/01/2026
K0531 SS = F Bldg. 01	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for	K0531	Criteria 1: The car lighting, emergency lights, emergency signals and communication, firefighter service, phase 1 and 2, travel cable in elevator #3 were repaired as per elevator vendor maintenance protocol The emergency signal communication, door closers/interlock and accessories rated unsatisfactory in the hydraulic elevator #1 was repaired as perelevator vendor maintenance protocol The annual inspection documentation for elevator #2 was requested Elevator vendor has contacted the NJ Ex Order 26.4(b)(1) [redacted] Inspector who will be issuing cleared certificates of	04/17/2026

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K0531 SS = F Bldg. 01	Continued from page 7 firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: REPEATED DEFICIENCY: Based on documentation review and interview on 03/12/2026 in the presence of the [U.S. FOIA (b) (6) redacted], it was determined that the facility failed to ensure that elevators maintained in safe operating condition in accordance with NFPA 101:2012 Edition, Sections 19.5.3, 9.4.2,9.4.3 and ASME A 17.1, and A 17.3. This deficient practice had the potential to affect all residents and is evidenced by the following: At 11:10 AM Review of the Elevator Safety Unit Annual Inspection Report dated June 11, 2025, for the hydraulic elevator #3 indicated several components were rated Unsatisfactory. The unsatisfactory items include car lighting/standard and emergency lighting, emergency signals and communication, firefighter service Phase I & Phase II, and traveling cable and wiring. At 11:13 AM Review of the Elevator Safety Unit Annual Inspection Report dated June 11,2025 for the hydraulic elevator #1 identified multiple components rated Unsatisfactory. The Unsatisfactory items include Emergency signal and communication, Door closers\interlock and accessories, Pit stop switch and light. At 11:15AM The Elevator Safety Unit Annual Inspection Report for the hydraulic elevator #2 was not provided for review. Further documentation review at 12:10pm provided by the [U.S. FOIA (b) redacted] revealed the Temporary Certificate of occupancy /compliance for 3 of 3 elevators were good until 12/08/2025, and the attached DCA notice of violation and Order to Terminate was due on 12/8/2025. Documentation for corrections or repairs was not provided for review. In an interview at the time, [U.S. FOIA (b redacted] confirmed the	K0531	Continued from page 7 occupancy for all elevators within a week. Will forward certificate once received. Criteria 2: All residents have the potential to be affected by this practice. Criteria 3:Building Services staff were in-serviced elevator inspections and maintenance by the Director of Building Services. The Director of Building Services/designee will conduct monthly audits of the elevator inspections. Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter.	04/17/2026

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K0531 SS = F Bldg. 01	Continued from page 8 findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 1:00 PM. N.J.A.C 8:39-31:2(e) ASME A 17.1, A 17.3	K0531		04/17/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: REPEATED DEFICIENCY: Based on documentation review, observations, and	K0918	Criteria 1 Rental generator has been replaced and load bank test conducted on replacement, see attachments. The manual stop station for the NJ Ex Order 26 KW was relocated. See attachments. Fuel quality tests have been completed for 3 0f 3 emergency generators by the fuel oil company, see attachments. As advised by rental generator company referencing remote annunciator and e-stop capabilities, see attachment. NJ DOH Memo 6/29/18 re: Emergency Generators attached. Section 1.3.2.3 paragraph three indicates annunciator required according to generator's capabilities. Criteria 2: All residents have the potential to be affected by this practice. Criteria 3: Building Services staff were in-serviced on maintenance and testing of emergency generators by the Director of Building Services. Director of Building Services/designee will conduct monthly audits of the generators. Criteria 4 Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	05/01/2026

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K0918 SS = F Bldg. 01	Continued from page 9 interview between 03/11/2026 and 03/12/2026, it was determined that the facility failed to ensure that emergency generators were provided and maintained in accordance with NFPA 99:2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: REPEATED DEFICIENCY: Observation on 03/11/2026 from 9:21AM to 1:21PM revealed the following The 150 KW generator located in the blue room had not functioned for three years and a rental 150 KW generator was being utilized in its place. The emergency generator did not have an annunciator panel in a continuously occupied area, and the generator was not provided with a remote manual stop station. The [NJ Ex Order 2] 400 KW emergency generator was provided with a manual stop station on the unit steel cabinet NOT REMOTE from the unit. In interviews at the times, The [U.S. FOIA (b)] confirmed the observations Documentation review on 03/12/2026 revealed that the annual diesel fuel quality testing for 3 of 3 emergency generators was not completed. Further review revealed the load bank test was not completed for the rental emergency generator. In an interview at the time, [U.S. FOIA (b)] confirmed the findings. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at the Life Safety Code exit conference at 1:00 PM. N.J.A.C 8:39-31:2(e) NFPA 99 This deficient practice was previously cited during the last standard recertification survey conducted on 10/16/2024	K0918		05/01/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements	K0921	Criteria 1: All patient care related equipment, fixed and portable, have been inspected and identified with an inspection sticker.	04/17/2026

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K0921 SS = F Bldg. 01	Continued from page 10 The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/10/2026,03/11/2026 and 03/12/2026 in the presence of the[U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3,10.5.2.1,10.5.2.1.2,10.5.2.5, 10.5.3, 10.5.6, and 10.5.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations from 03/10/26 to 03/11/26 revealed that all fixed and portable patient-care related equipment (PCREE) did not have a current inspection sticker throughout the facility. In an interview at the time, [U.S. FOIA (b)] stated he checked all PCREE equipment but could not provide a policy and procedures for testing of the equipment or evidence of annual testing and maintenance program for PCREE.	K0921	Continued from page 10 Criteria 2: All residentsts are found to be at risk due to this practice. Criteria 3: Policies and procedures related to patient care equipment have been reviewed and revised as necessary. Building Services staff have been in-serviced regarding testing and maintenance of patient care electrical equipment. by the Director of Building Services. Director of Building Services will conduct monthly patient equipment rounds to ensure that all equipment has been inspected and identified as such. Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter.	04/17/2026

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K0921 SS = F Bldg. 01	Continued from page 11 The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 03/12/26 at 1:00 PM. NJAC 8:39-31.2(e) NFPA 99	K0921		04/17/2026
K0521 SS = E Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 03/11/2026 in the presence of the [redacted]), it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect 14 of 107 residents and was evidenced by the following: Observations between 9:18 AM and 1:10 PM, revealed that the bathroom ventilation in room# 49 to room#55 on the LP unit were not functioning when tested the [redacted] In interviews at the time the [redacted] confirmed the observations. The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 03/12/2026 at 1:00 PM. N.J.A.C 8:39-31.2(e)	K0521	Criteria 1 The bathroom ventilation in room 49 and 55 on the LP unit have been repaired. Criteria 2: All residents are found to be at risk due to this practice. Criteria 3: Building Services staff were in-serviced regarding heating and ventilation by the Director of Building Services. The Director of Building Services/designee will conduct monthly audits of the bathroom ventilation. Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter.	04/17/2026
K0222 SS = D Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors	K0222	Criteria 1: The thumb turn latch on the Atrium door was removed.	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	**1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052**

(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
K0222 SS = D Bldg. 01	Continued from page 12 Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K0222	Continued from page 12 Criteria 2: 15 of 107 residents have the potential to be affected by this practice. Criteria 3: Building service staff were in-serviced regarding doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side by the Director of Building Services. The Director of Building Services/designee will conduct monthly audits of all identified exit door to ensure they do not contain a thumb latch. Criteria 4 The Director of Building Services will report the results of these audits to the facility's QAPI committee monthly for three months and then quarterly thereafter for one year.	04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY , WEST ORANGE, New Jersey, 07052

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K0222 SS = D Bldg. 01	Continued from page 13 ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/10/2026 in the presence of the U.S. FOIA (b) (6) U.S. FOIA (b) (6)) it was determined that the facility failed to ensure that doors in a required means of egress were not equipped with a latch or lock. This deficient practice had the potential to affect 15 of 107 residents and was evidenced by the following: An observation at 9:021 AM revealed that Atrium Exit Door #1was equipped with a thumb turn latch. In an interview at the time, the U.S. FOIA (b) confirmed the observation, latched the door shut and unsuccessfully attempted to exit the building. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 3/12/2026 at 1:00 PM. N.J.A.C 8:39-31:2(e).	K0222		04/17/2026
K0281 SS = D Bldg. 01	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/10/2026 in the presence of the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), it was determined that the facility failed to provide illumination for the means of egress that was either continuously in operation or capable of automatic	K0281	Criteria 1 The lighting in the auditorium on the path of egress was modified so that it remains illuminated at all times. Criteria 2: All residents have the potential to be affected by this practice. Criteria 3: Building Services staff were in-serviced regarding all means of egress including exit discharge shall be continuously illuminated by the Director of Building Services. The Director of Building Services will conduct	04/17/2026

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K0281 SS = D Bldg. 01	Continued from page 14 operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect 21 of 107 residents and was evidenced by the following: An observation at 9:19 AM revealed that the lighting in the Auditorium, along the path of egress from Exit Door #1 to Exit Door #2 leading to the outside of the building, was controlled by a wall mounted light switch. When the [U.S. FOIA (b)] switched the lights to the OFF position, the area became completely dark, leaving the egress path without illumination. In an interview at the time, the [U.S. FOIA (b)] and the [U.S. FOI] confirmed the observation. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at the Life Safety Code exit conference on 03/12/2026 at 1:00 PM. N.J.A.C 8:39-31:2(e)	K0281	Continued from page 14 monthly rounds of all means of egress to ensure that all means of egress remain illuminated. Criteria 4: Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly thereafter.	04/17/2026
K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and interview on 03/10/2026 in the presence of the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)]), it was determined that the facility failed to ensure that penetrations through smoke/fire barriers are protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6,8.3.5, This deficient practice had the potential to affect 21 of	K0372	Criteria 1: Penetration above the smoke barrier door near room 318 has been repaired. Criteria 2: All residents are at risk due to this practice. Criteria 3: Building services staff were in-serviced regarding smoke barriers and penetrations in accordance with NFPA 101:2012 by the Director of Building Services. The Director of Building Services will conduct monthly audits of all smoke barriers to ensure there are no penetrations. Criteria 4: The Director of Building Services will report the results of these audits to the facility's QAPI committee for three months and then quarterly thereafter.	04/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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K0372 SS = D Bldg. 01	Continued from page 15 107 residents and was evidenced by the following: An observation at 10:25 AM revealed the smoke barrier assembly near room 318 had unsealed wire/pipe penetrations through the wall above the smoke barrier doors. In interview at the time, the U.S. FOIA (b confirmed the Finding. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 3/12/2026 at 1:00 PM. N.J.A.C 8:39-31:2(e).	K0372		04/24/2026

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 03/10/2026,03/11/2026 and 03/12/2026. Daughters of Israel was found to be in compliance with 42 CFR 483.73.	E0000		04/17/2026

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: 315029	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/04/2026**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 05/05/2026 in relation to the 03/12/2026 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 Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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