STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY WEST ORANGE, NJ 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
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 08/07/23- 08/10/23 Survey Census: 93 Sample Size: 24 No deficiencies were related to Intakes NJ161942, NJ165247, NJ155039, and NJ157241. A deficiency was related to Intake NJ155661 at F677.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		9/12/23

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

Electronically Signed | 08/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to promote the dignity and independence for three of three residents (Resident (R)88, R47 and R9) reviewed for dining in a total sample of 24 residents. Specifically, R88 and R47 were observed being assisted with [redacted] by staff standing throughout the meal service. Additionally, R9 was observed to sit and wait for lunch to be served while other residents were already served. Findings include:	F 550	Criteria #1 The facility failed to promote the dignity and independence for residents #88, #47, and #9 as evidenced by staff members standing while providing [redacted] assistance and resident #9 was not served his meal timely. Staff was provided education on feeding which included that staff should be seated and at eye level and that residents should be served timely. Criteria #2 All residents are at risk for this deficient practice.	

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F 550	Continued From page 2 1. Review of R88's "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab, revealed R10 was admitted to the facility on EX Order 26 § 4b1 with diagnoses that included EX Order 26 § 4b1 [redacted] Review of R88's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/03/23, located in the resident's EMR under the "MDS" tab indicated the facility assessed R88 to have a "Brief Interview for Mental Status (BIMS)" score was EX Order 2 out of 15, indicating R88 was EX Order 26 § 4b1 The "MDS" also indicated R88 required EX Order 26 § [redacted] Review of R88's "Physician's Orders," located in the resident's EMR under the "Orders" tab, revealed R88 was ordered a EX Order 26 § 4b1 EX Order 26 § 4b [redacted]. 2. Review of R47's "Admission Record," located in the resident's EMR under the "Profile" tab, revealed R47 was admitted to the facility on EX Order 26 § 4b1 with diagnoses that including, EX Order 26 § [redacted] Review of R47's quarterly MDS" with an ARD of 06/26/23, located in the resident's EMR under the "MDS" tab indicated the facility assessed R47 to have a BIMS" score was EX Order 2 out of 15, indicating R47 was EX Order 26 § 4b1 . The "MDS" also indicated R47 require Ex.Order 26.4(b)(1) [redacted].	F 550	Criteria #3 Policies and procedures were reviewed and revised when necessary. Staff were provided education to ensure that residents dignity be maintained during mealtime. Criteria #4 The Director of Nursing or designee will conduct random audits to ensure that residents dignity is being maintained during meals. Results of these audits will be reported to the facility's QAPI committee monthly for three months, then quarterly thereafter for twelve months.	

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F 550	Continued From page 3	F 550		

Review of R47's "Physician's Orders," located in the resident's EMR under the "Orders" tab, revealed R47 was ordered a Ex.Order 26.4(b)(1) [redacted]

3. Review of R9's "Admission Record" located in the resident's EMR under the "Profile" tab, revealed R9 was admitted to the facility on EX Order 26 § 4b1 [redacted] with diagnoses that included EX Order 26 § 4b1 [redacted]

Review of R9's quarterly MDS with an ARD of 07/06/23, located in the resident's EMR under the "MDS" tab indicated the facility assessed R9 to have a " BIMS" score of EX Order 2 [redacted] of 15 which indicated the resident was EX Order 26 § 4b1 [redacted]. The MDS also indicated R9 Ex.Order 26.4(b)(1) [redacted].

Review of R9's "Physician's Orders," located in the resident's EMR under the "Orders" tab, revealed R22 was ordered a regular EX Order 26 § 4b1 [redacted].

During an observation of the lunch meal on 08/07/23 at 12:55 PM - 1:30 PM, Certified Nursing Aide (CNA)1 was observed to be standing while feeding R88 their lunch in the dining area.

During an observation of the breakfast meal on 08/08/23 at 9:10 AM - 9:20 AM, Activities Coordinator (AC) was observed to be standing while feeding R47 their breakfast in the dining area.

During an observation of the lunch meal on

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08/08/23 at 1:01 PM - 1:30 PM, R9 was observed to be sitting at the table for 29 minutes without their meals while other residents had been served their meal. Staff were observed to ask R9 were they hungry at 1:29 PM, R9 observed nodding head "yes."

During an interview on 08/07/23 at 1:15 PM, CNA1 stated they normally sit when assisting with meals, but they did not have a chair. CNA1 stated it was important to sit while assisting to ensure the residents felt comfortable.

During an interview on 08/09/23 at 1:20 PM, the AC stated they did not have any feeding assistance training prior to assisting with meals. The AC stated they were told to go assist with meals by a supervisor and just did it. The AC stated they were in-serviced after the meal observed on 08/08/23 by the Director of Nursing (DON) and instructed to sit or be at eye level when assisting with meals.

During an interview on 08/09/23 at 1:42 PM, the DON stated that her expectations were for the residents to be served at the same time or at least around the same time as others. The DON stated if there was more than one resident that required assistance with feeding, they would have expected staff to assist residents two at a time. DON stated they also expect staff to be seated when assisting with feeding. The DON stated sitting would make the meal a more pleasurable interaction.

Review of the facility's policy titled, "Assisting/Feeding Residents Their Meals," revised date 11/21, revealed " ...4. For residents that need to be feed: a. sit next to the resident

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F 550	Continued From page 5 and do not stand and feed the resident ..." NJAC 8:39-4.1(a)12	F 550		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		9/12/23

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F 655	Continued From page 6 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of facility policy, the facility failed to provide a baseline care plan within 48 hours of admission for one resident (Resident (R)98) of one resident reviewed for base line care plans out of 24 sampled residents. Findings include: Review of R96's "Face Sheet" located in the resident's electronic medical records (EMR) section titled "Print Face Sheet" revealed the resident was admitted to the facility on EX Order 26 § 4b1 with diagnoses that included EX Order 26 § 4b1 [redacted]. Review of R96's "Baseline Care Plan" located in the resident's EMR section titled "Care Plans" revealed the resident had a baseline care plan dated 07/21/23. The care plan identified the resident had the following problems identified: Ex.Order 26.4(b)(1) [redacted]. The care plan was unsigned by the resident.	F 655	Criteria #1 Resident #98 that was identified to not have a copy of their baseline care plan, was presented with a copy of their baseline care plan and was reviewed with the resident. Criteria #2 All residents admitted are at risk for this deficient practice. Criteria #3 Policies and procedures were reviewed and revised as necessary. Social Service and Nursing Administration staff were provided education to ensure that residents receive their baseline care plan and that it is documented in the residents medical record. Criteria #4 The Director of Nursing or designee will conduct random audits to ensure that documentation is present for new admissions that state the resident has been presented with a copy of their baseline care plan. Results of these audits will be reported to the facility's QAPI committee monthly for three months and then quarterly thereafter, for twelve months.	

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F 655	Continued From page 7 During an interview on 08/07/23 at 2:30 PM R96 revealed that she did not receive a copy of the baseline care plan within 48 hours after admission to the facility. The resident stated she signed several forms upon admission to the facility but did not remember receiving a document that described the care that she would receive. During an interview on 08/09/23 at 9:20 AM Registered Nurse (RN)2 revealed any nurse could develop and revise a care plan but usually the interdisciplinary team was responsible for developing care plans. The baseline care was started by the floor nurse but it was Social Services who was responsible for issuing the base line care plan to the resident. During an interview on 08/10/23 at 9:35 AM the Social Services Director (SSD) revealed that she or the per diem social service person was responsible for issuing the base line care plans to the resident. The base line care plan was signed by the resident and a copy given to the resident. The SSD also stated a note was written in the resident progress notes documenting this action. The SSD reviewed the resident's progress notes and could not find any documentation that the resident had received her base line care plan. Review of a facility policy title "Care Plans" with a revision date 11/21 reads in part " ...Have an initial interdisciplinary Care Plan initiated within 48 for those residents found to be at risk for [redacted] NJAC 8:39-11.2(c)(d)	F 655		

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F 677	Continued From page 8	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide timely morning (AM) care for one of one resident (Resident (R)40) reviewed for Activities of Daily Living (ADLs) out of a total sample of 24 residents. Findings include: Review of the resident's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/18/23 revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated the resident was EX Order 26 § 4b1 . R40's functional status was EX Order 26 § 4b1 R40 was documented as a one-person EX Order 26 § 4b1 . Review of R40's care plan dated 01/19/23 in section under Focus: revealed that the resident has been care planned for the following interventions by the staff: "To be assisted out of bed by 7:30 AM. To call for assistance prior to transferring. To offer to assist to bathroom every two hours. To offer and assist with AM care by 8AM. To provide Ex.Order 26.4(b)(1) as needed for Ex.Order 26.4(b)(1). To provide assistance with EX Order 26 § 4b1 , requiring at least one person assistance."	F 677	Criteria #1 The facility failed to follow ADL care plan and provide timely AM care for resident #40 whose care plan indicated that they preferred to be up early. Staff was educated on following residents care plans. Resident #40 care plan was reviewed and updated with current preferences. Criteria #2 All residents are at risk for this deficient practice. Criteria #3 Policies and procedures were reviewed and revised when necessary. Nursing staff was provided with education on how to follow care plans to ensure that ADL ad person-centered goals and preferences are met. Criteria #4 The Director of Nursing or designee will conduct random audits to ensure that residents care plans are being followed and residents' needs are being met. Results of these audits will be reported to the facility's QAPI committee monthly for three months, then quarterly thereafter for twelve months.	9/12/23

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Initial observation of R40 on 08/07/23 at 10:00 AM revealed EX Order 26 § 4b1 [redacted]

Observation on 08/09/23 at 9:56 AM revealed R40 was getting a bed bath by CNA2 while resident was sitting on the toilet. CNA2 was found with a towel, cleaning R40 while R40 was sitting on the toilet, without any clothing on. CNA2 stated she was giving R40 a bed bath instead of R40 getting a shower.

Observation on 08/09/23 at 10:34 AM revealed R40 was sitting in the dining room finishing a late breakfast meal.

Review of the "Resident CNA Documentation Record" from 08/01/23 to 08/10/23 under the "Task" section for "[redacted]", revealed that R40 did not have any documented toileting for August 1, August 5 and for August 9, 2023, on the 7:00 AM - 3:00 PM shift. It was also revealed that this section of the record did not show that the resident was on every two-hour toileting schedule.

During an interview on 08/07/23 at 4:40 PM R40 revealed Ex.Order 26.4(b)(1) [redacted]. She stated she used to [redacted] a lot of times for long periods of time when she lived in a different area of the facility.

During an interview on 08/08/23 at 1:05 PM CNA4 revealed that she was very familiar with R40 and had been caring for her since the resident was re-located from the 2nd floor. She stated the resident could clearly communicate her needs verbally, required one-two person to assist with her EX Order 26 § 4b1 [redacted], which

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included Ex.Order 26.4(b)(1) CNA4 stated she was aware that R40 had a [redacted] and that Ex.Order 26.4(b)(1) were usually every one-two hours for those residents.

During an interview on 08/09/23 at 9:56 AM CNA2 and R40 revealed that R40 was supposed to be getting her shower today but CNA2 stated the resident did not want a shower. However the resident expressed that she did want her shower today which was part of her ADL care to have showers two times a week.

During an interview on 08/10/23 at 9:50 LPN2 revealed she was not aware that R40 had not been cared for yet or had her breakfast. She stated R40 was usually awake early and already cared for by this time.

During an interview on 08/09/23 at 10:30 AM CNA4 revealed R40 did not usually refuse her showers, that she did indeed want her shower today, and CNA4 was able to give her a shower.

During an interview on 08/10/23 at 2:30 PM CNA2 acknowledged that she was late getting R40 up the morning of 08/09/23 and admitted she may have spent too long getting other residents ready for their day. She stated this may have delayed getting R40 ready for her day with her shower as part of her ADL and Ex.Order 26.4(b)(1) [redacted] needs.

A telephone interview with R40's daughter on 08/09/23 at 11:05 AM revealed that R40 used to live in a different area of the facility and became more dependent on staff after having a [redacted], at times in April 2022. She stated R40 had not fully returned to her prior level of function and required

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assistance from the staff more than she used to. She stated R40 Ex.Order 26.4(b)(1) and that she found her Ex.Order 26.4(b)(1) a few times and reported her concerns immediately to the DON and staff. She stated her mother was not always Ex.Order 26.4(b)(1), but she could Ex.Order 26.4(b)(1) in a timely manner. She stated she asked the facility to place the resident on a Ex.Order 26.4(b) schedule, which she stated had not been done. She believed that if her mother was offered a Ex.Order 26.4(b)(schedule and that if the staff had better time management, that this would have been very helpful for her mother's Ex.Order 26.4(b)(1) care.

During an interview on 08/10/22 at 11:22 AM the DON revealed R40 suffered a second Ex.Order 26.4 in April 2022 and used to live in an "unpopulated" section of the facility up until June 2022. The DON revealed that the unpopulated area was for more independent residents than R40, who could mostly care for themselves. The DON believed that R40 was mostly independent. The DON also revealed that the unpopulated area was difficult for staff to attend too because most of the residents were in the more populated area and therefore acknowledges that it was possible the staff did not get to R40 in a timely manner to address her needs.

Review of the facility's policy titled "CNA [Certified Nurse Aide] Care Plan" revealed that all residents will have a CNA care plan that reflects the resident's care needs and issues. It also revealed that the care will be updated by the licensed nurse whenever there was a change in a resident's condition and that the assigned CNA would check the care plan at the beginning of each shift in order to determine a resident's needs.

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DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY WEST ORANGE, NJ 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
F 677	Continued From page 12 NJAC 8:39-4.1(a)22 NJAC 8:39-27.2(d)(h)	F 677		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication error rate of less than 5%. Medication errors were noted for two out of 25 medications observed, affecting two residents (Resident (R)70 and R12) for a medication error rate of 8%. Findings Include: 1. Review of R70's annual MDS with an ARD of 06/12/23, found in the EMR under the "MDS" tab, revealed R70 was admitted to the facility on [redacted] and had a BIMS score of [redacted] out of 15, which indicated R70 was not [redacted]. The MDS also indicated R70 had a diagnosis of but not limited to [redacted]. Review of R70's "Physician Orders," dated 08/04/23, found in the EMR under the "Orders" tab, revealed [redacted]	F 759	Criteria #1 The facility failed to ensure a medication error rate of less than five percent as evidence by resident #70 receiving [redacted] outside of one hour before and one hour after the window, and by Resident #12 receiving an [redacted] at the end of the vial and not being able to verify receipt of a full drop per physicians orders. Medication times were reviewed for resident #70 to ensure that medication can be given 1 hour before and 1 hour after window. Ordering process with pharmacy reviwed. Physician was made aware of medication errors and LPN #6 received one to one training. Criteria #2 All residents are at risk for this deficient practice. Criteria #3 Policies and procedures were reviewed and revised when necessary. Nursing staff was provided with education on proper med pass policies and procedures.	9/12/23

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F 759	Continued From page 13 During an observation on 08/08/23 at 4:20 PM, Licensed Practical Nurse (LPN)6 stated, "I won't administer these until around 7:00 PM because the resident can't hold his head over good when sitting up in the chair." LPN6 documented on the Medication Administration Record (MAR) the following for these Ex.Order 26.4(b)(1) : "admin (administer) at 7:20 PM" for the date of 08/08/23. During an interview on 08/09/23 at 3:00 PM, the Director of Nurses (DON) stated, "The nurse should had given the Ex.Order 26.4(b)(1) an hour before or an hour after the time that the physician had ordered it to be given." Review of the policy titled, "Administration of Medications Procedure," revised 11/21, read in part " ... Medications will be passed 1 hour before or 1 hour after the administration time ..." 2. Review of R12's annual MDS with an ARD of 07/09/23, found in the EMR under the "MDS" tab, revealed R12 was admitted to the facility on EX Order 26 § 4b1 and had a BIMS score of EX O out of 15, which indicated R12 was EX Order 26 § 4b1 . The MDS also indicated R12 had a diagnosis of but not limited t EX Order 26 § 4b1 Review of R12's "Physician Orders," dated 06/19/19, found in the EMR under the "Orders" tab, revealed EX Order 26 § 4b1 LPN6 administered Ex.Order 26.4(b)(1) as ordered by the physician. Then the nurse attempted to administer Ex.Order 26.4(b)(1) in the EX Order 26 § 4b1 When this happened, a mist was observed to spray into the Ex.Order 26.4(b)(1) instead of Ex.Order 26.4(b)(1) as ordered by the physician. LPN6 stated, "EX Order 26 § 4b1	F 759	Criteria #4 The Director of Nursing or designee will conduct random audits to ensure that medications from pharmacy are completed timely to ensure medication availability. Results of these audits will reported to the facility's QAPI committee monthly for three months, then quarterly thereafter, for twelve months.	

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F 759	Continued From page 14 EX Order 26 § 4b1 [redacted] During an interview on 08/09/23 at 3:00 PM, the DON stated, "the nurse should had felt how light the bottle was and obtained a new bottle prior to administering the right amount to be given to this resident." NJAC 8:39-29.2(d)	F 759		
F 761 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.	F 761		9/12/23

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F 761	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to ensure two of two medication carts on the secured unit were locked while unattended. This had the potential to affect two (Resident (R)3 and R37) of 16 residents who were in the dining room on the secured unit while the med carts were observed unlocked. R3 and R37 could ambulate/self-propel themselves while in the dining room. Findings include: Review of R3's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab of the electronic medical record (EMR) and with an Assessment Reference Date (ARD) of 06/03/23, revealed R3 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated R3 was EX Order 26 § 4b1 [redacted]. R3 was coded as only requiring EX Order 26 § 4b1 [redacted]. Review of R3's Care Plan located in the EMR under the "Care Plan" tab, dated 06/03/2023, revealed the resident could ambulate independently with supervision as needed. Review of R37's quarterly MDS with an ARD of 06/15/2023, revealed a BIMS score of [redacted] out of 15 indicating EX Order 26 § 4b1. R37 was coded as requiring Ex.Order 26.4(b)(1) [redacted]. An observation was made on 08/09/2023 at 2:00 PM of R37 self-propelling [redacted] a little at a time in the dining room.	F 761	Criteria #1 The facility failed to ensure that the medication carts on the secure unit were locked while unattended in the presence of residents #3 and #37, who have the ability to self ambulate/self propel their [redacted]. The med carts in question were locked immediately upon notice. LPN #6 and LPN #1 received one to one training on proper storage and securing of med carts. Criteria #2 All residents are at risk for this deficient practice. Criteria #3 Policies and procedures were reviewed and revised when necessary. Nursing staff was provided with education on proper med pass policies and procedures which included proper storage and securing of medications. Criteria #4 The Director of Nursing or desginee will conduct random audits to ensure that medication carts are locked when not in use/in direct line of sight. Results of these audits will be reported to the facility's QAPI committee monthly for three months, then quarterly thereafter for twelve months.	

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F 761	Continued From page 16 During an observation/interview on 08/07/23 at 12:42 PM in the secured unit, Medication Cart A was left in the dining room unlocked by Licensed Practical Nurse (LPN)3. On 08/07/23 at 1:00 PM, LPN3 stated, "I am to lock the med cart when I am not around the cart. I am pulled in so many ways I forget to do this." R3 and R37 were in the dining room while the med cart was observed unlocked. During an observation/interview on 08/09/2023 at 12:18 PM Medication Cart B was left unlocked in the dining room on the secured unit. LPN1 stated "I should had locked the Med Cart when I leave it. When I came back to it, I noticed that it was unlocked so I locked it back." During an interview on 08/10/2023 at 9:00 AM the DON stated, "The medication carts are to be left locked." Review of the policy titled "Medication Storage" dated 11/21 revealed "...Medication rooms, carts and medication supplies are to be locked at all times or attended by persons with authorized access ..."	F 761		
F 809 SS=E	NJAC 8:39-29.4(h) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		9/12/23

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F 809	Continued From page 17 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to provide meals at regular times. Specifically, the facility failed to deliver resident meals in a timely manner, for three of three (Residents (R)24, R42, and R62) reviewed for meal service. This had the potential to affect residents receiving room trays, and residents eating in the LP unit's "back" dining room. Findings include: In an interview with the Dietary Manager (DM) on 08/07/23 at 9:30 AM, he stated the mealtimes for all dining rooms were as follows: 8:30 AM breakfast; 12:30 PM lunch; and 5:15 PM dinner. The food was prepared in the main kitchen and transported, via a heated cart, to each of the "pantry" kitchenettes to be served to the residents. The food arrived 45 minutes prior to each meal service and was placed on the "pantry" steam tables to be kept hot.	F 809	Criteria #1 Residents that were identified to not have their meals at the same time were immediately served their meals. Criteria #2 All residents are found to be at risk for this deficient practice. Criteria #3 All policies and procedures for food prep, delivery and meal service were reviewed and revised as necessary. All staff responsible for meal prep, delivery and service were educated. Criteria #4 The Food Service Director or designee will conduct random dining room observation audits. Results of these audits will be reported to the facility's QAPI committee monthly for three months, then quarterly thereafter for twelve months.	

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F 809	Continued From page 18	F 809		

1. The following observations of the lunch meal service occurred on 08/09/23:

The meal was identified to be BBQ chicken or grilled hotdog on a bun, coleslaw, corn on the cob and fresh watermelon slice.

Observation of the "back" dining room at 11:45 AM, revealed individual coleslaw cups and watermelon slices in the refrigerator. Corn on the cob, diced carrots, mechanical soft meats, and pureed meats were in containers on the steam table. Hotdogs were being grilled outside by the kitchen staff.

Twelve residents were seated outside, under the canopy, at 11:50 AM, waiting for lunch to be served. All other residents were either in their respective dining rooms or in their rooms awaiting their meals.

At 12:30 PM, the BBQ chicken was placed on the outside grill to be cooked.

At 12:50 PM, a container of grilled hotdogs was delivered to the "back" dining room. The Dietary Aide (DA)1 said she was waiting for the grilled BBQ chicken before serving the six residents seated at the tables for lunch.

At 12:52 PM, the residents seated outside were served.

At 12:54 PM, the first meal was served in the "front" dining room to a resident who chose a hotdog. The BBQ chicken was delivered to the "front" dining room at 12:58 PM and by 1:00 PM, all residents in the "front" dining room had been served their meals.

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F 809	Continued From page 19	F 809		

At 1:02 PM, the "back" dining room had not started meal service as DA1 said she did not have pureed carrots, required for the pureed diets. DA1 said "I cannot serve the residents until I have all the right food for the purees." At 1:10 PM, the Registered Dietician (RD) retrieved the pureed carrots from the main kitchen.

At 1:23 PM, all residents in the "back" dining room were eating, and the last room tray was delivered on the LP wing, 53 minutes after the 12:30 PM posted mealtime.

In an interview with resident (R)62, at 1:30 PM, while eating her corn on the cob, R62 said she really liked the corn on the cob, but "some things are cold," at meals in reference to the long wait to be served.

When asked, none of the remaining five residents in the "back" dining room said the food was cold. It was stated that the smell of the BBQ made them hungry.

2. The following observations of the breakfast meal service occurred on 08/10/23:

At 8:15 AM, observation of the "back" dining room "pantry" kitchenette on the LP unit revealed scrambled eggs, hashbrown patties, and oatmeal on the steam table.

At 8:29 AM, no residents had arrived in the dining room for breakfast.

At 8:34 AM, two residents were at the tables for breakfast.

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F 809	Continued From page 20	F 809		

At 9:00 AM, all residents in the dining room had been served breakfast, however the DA3 had to request more milk for residents who requested cold cereal, bagels for resident room trays, and more scrambled eggs as she had run out of what had been initially sent.

At 9:15 AM, the last room tray was delivered on the LP unit, 45 minutes after the posted mealtime of 8:30 AM.

In an interview with R42, at 9:20 AM, he said the food temperature was "ok," but the trays "do come late sometimes." R42 ate his breakfast in his room, in bed.

In an interview with R24, at 9:25 AM, he said the breakfast was "pretty good, but sometimes it's cold." R24 ate his breakfast in his room, in bed.

In an interview with the DM on 8/10/23 at 9:20 AM, he said the DA1 could have served the diced carrots, "just mash them, she didn't have to delay the meal service." The DM could not state why the BBQ chicken was being cooked at the time the meal should have been served.
In response to the dietary staff having to ask for additional food items which delayed the meal service for breakfast, the DM said they did not supply "extra food" on the carts, they had the staff "call the kitchen" for requests.

In an interview with the Clinical Nutrition Manager/RD on 08/09/23 at 2:48 PM, she stated the previous BBQ had run very well without delays in meal service. She could not state why it was so late on 08/09/23.

Review of the facility's policy titled, "Resident

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F 809	Continued From page 21 Food Services," updated 01/18, revealed "Monitor delivery of meals to residents to ensure timeliness and appropriateness of service." NJAC 8:39-17.2(f)	F 809		
F 812 SS=E	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: Based on observations, interviews, and facility policy review, the facility failed to keep the food storage bins clean and failed to ensure opened food was dated, labeled, and sealed. This had the potential to affect 91 of 93 residents who resided in the facility and consumed food prepared from the facility's kitchen. Findings include:	F 812	Criteria All food items identified during the survey that were open and/or unlabeled were discarded. All areas identified in the kitchen as soiled were cleaned. Criteria #2 All residents who eat from the facility kitchen have the potential be affected by this deficient practice.	9/12/23

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F 812	Continued From page 22 During an initial tour of the kitchen on 08/07/23 at 9:30 AM, with the interim Dietary Manager (DM) present, the following observations were made: Dry Storage and Freezer: a. Four large bins, containing flour, sugar, breadcrumbs, and rice respectively, were observed to have dirt and grime on the top and sides of each container. b. An open container of peanut butter was observed on a shelf. There was no date identifying when the peanut butter was opened. c. A box of baking powder, open to air, was observed on the shelf. The baking powder had no date to identify when it had been opened, nor was the box sealed in a plastic bag or container. d. A bag of pancake mix, open to air, was observed on a shelf. The pancake mix had no date identifying when it was opened nor was it sealed in a plastic bag or container. e. A bag of chocolate cake mix was observed, sealed in plastic wrap, with no date identifying when it had been opened. f. A large toaster was observed, uncovered, on a food preparation table. The toaster was observed to have crumbs, dirt, and a white substance on the inside of the machine as well as dry pasta noodles underneath. g. Fish fillets, left open to air in the freezer and subject to freezer burn, were observed inside an open box.	F 812	Criteria #3 The Food Service Director or designee will conduct random weekly Sanitation Audits in accordance with Federal Regulations for kitchen sanitation in long term care. Policies and procedures pertaining to food storage and cleaning schedules were reviewed and revised as needed. All food service staff were re-educated on both kitchen sanitation and food storage. Criteria #4 Results of these sanitation and food storage audits will be reported to the facility's QAPI committee monthly for three months, then quarterly thereafter for twelve months.	

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F 812	Continued From page 23	F 812		

h. Undated Blitzes, were observed uncovered and subject to freezer burn, on top of a box in the freezer.

The DM confirmed the observations and said, "the large containers should have been cleaned on Sunday, I do not know what happened." The DM said the toaster had not been used, however he did not know why it had not been cleaned and covered.

Review of the facility's cleaning schedule for the kitchen revealed "back of the house" cleaning duties as well as "front of the house" cleaning duties identified as "daily," "weekly," and "when used." The large bins in the dry storage area were not listed on the cleaning schedule.

Review of the facility's policy titled "Food and Supply Storage," dated 01/19, revealed "All food, non-food items and supplies used in food preparation shall be stored in such a manner as to Prevent contamination to maintain the safety and wholesomeness of the food for human consumption." ... "Cover, label and date unused portions and open packages. Use the Unidine green label, Medvantage label or Ecolab Prep N Print label; complete all sections on the label. Products are good through the close of business on the date noted on the label." ... "Use food grade plastic bags for food storage. Do not use garbage can liners." ... "Store bulk materials in NSF [National Sanitation Foundation] approved containers that have tight fitting lids. Label both the bin and the lid."

NJAC 8:39-17.2(g)
NJAC 8:39-19.7(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY WEST ORANGE, NJ 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
F 919	Continued From page 24	F 919		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure four residents (Residents (R)24, R37, R42 and R56) of 24 sample residents had their call lights within reach when in their rooms, specifically when they were in their beds. This failure created the potential for the residents not to have a means of directly contacting caregivers. Findings include: 1. Review of R24's "Admission Record," located under the "ADT" [Admission, Discharge, Transfer] tab of the electronic medical record (EMR) revealed R24 was admitted on EX Order 26 § 4b1 with diagnoses including EX Order 26 § 4b1 [redacted]. Review of R24's quarterly "Minimum Data Set (MDS)", located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 06/29/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted]	F 919	Criteria #1 The facility failed to ensure that residents #24, #37, #42 and #56 had their call lights in reach when in their rooms. This created the potential for the residents of not having a means to directly contact care givers. All resident rooms were audited to ensure proper placement of call lights so they are accessible to residents. Criteria #2 All residents are at risk for this deficient practice. Criteria #3 Polices and procedures were reviewed and revised when necessary. Nursing staff was provided with education on proper placement and monitoring of call lights when residents move from bed to chair/chair to bed to ensure that all residents have the ability to easily reach devices and contact the staff when needed. Criteria #4 The Director of Nursing or designee will conduct random audits to	9/12/23

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	315029	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 919	Continued From page 25 out of 15, indicating the resident was Ex.Order 26.4(b)(1) [redacted]. Per the MDS, R24 required Ex.Order 26.4(b)(1) [redacted] with personal care. During an observation on 08/07/23 at 3:08 PM, R24's call light was observed to be tied to the right siderail, which was down. The call light was out of reach of the resident who was in bed. During an observation on 08/08/23 at 9:14 AM, R24's call light was observed to be tied to the right siderail which was down. The call light was behind the resident, who was in bed, and out of reach of R24. During this observation, R24 stated "I don't need it anyway." R24 said "I don't want to be bothered to try to reach it (call light)," when asked. During an observation on 08/09/23 at 9:25 AM, R24's call light was tied to the right bedrail, out of reach of the resident, who was in bed. The bedrail was down. R24 said [redacted] wanted the siderail up at night because [redacted] was afraid of falling out of bed if [redacted] turned over. When asked if R24 could reach the call light to call for assistance where it was tied to the siderail, [redacted] said "no, I'll fall out for sure [while trying to reach the call light]." The call light was observed tied to the siderail on 08/09/23 at 10:05 AM and 10:43 AM, out of reach of the resident who was in bed during the observations. On 08/10/23 at 9:30 AM, while R24 was in bed, [redacted] call light was observed to be tied on the right bedrail. The bedrail was down, and the call light was out of reach of the resident. R24 said [redacted] "been hollering for someone to bring me cream for my coffee." When asked, R24 said [redacted] didn't know where the call light was, "I usually just yell,	F 919	ensure that call lights are accessible to residents at all times. Results of these audits will be reported to the facility's QAPI committee monthly for three months then quarterly thereafter for twelve months.	

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	315029	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 919	Continued From page 26	F 919		

but you're the only who heard me."

In an interview with a Certified Nursing Assistant (CNA)3, on 08/10/23 at 11:31 AM, she said "we always put the call lights on the bed." When asked about R24's call light being tied to the siderail, CNA3 said "I thought it was on the bed." In an interview with the Registered Nurse (RN)1, on 08/10/23 at 11:18 AM, she said, "the call lights need to be in reach" and that she would" need to make sure the CNAs are putting the call lights where the residents could reach them."

2. Review of R42's "Admission Record," located under the "ADT" tab of the EMR revealed R42 was admitted on [redacted] with diagnoses including [redacted].

Review of R42's annual "MDS," located in the EMR under the "MDS" tab with an ARD of 06/08/23, revealed the resident had a "BIMS" score of [redacted] out of 15, indicating the resident had [redacted]. Per the "MDS," R42 required [redacted]

During an observation of R42 on 08/07/23 at 10:56 AM, while in bed, the resident's call light was observed on the floor on the left side of the bed. R42 said [redacted] was unable to use [redacted] left side. R42 said [redacted] did not know the call light was on the floor.

During an observation on 08/08/23 at 9:10 AM, R42 was sitting up in bed eating his breakfast. The resident's call light was on the bed, on [redacted] left side. When asked, the resident said [redacted] thought [redacted] could reach it with [redacted] left hand but was unable

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	315029	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 919	Continued From page 27	F 919		

when [redacted] tried.

During an observation on 08/09/23 at 9:23 AM, R42 was observed in bed eating [redacted] breakfast. The resident's call light was observed to be on [redacted] left side, closer to [redacted] pillows. The resident said [redacted] is unable to use [redacted] left side.

During an observation on 08/10/23 at 9:30 AM, R42 was in bed eating breakfast. The resident was observed to have two pillows behind [redacted] head. The call light was observed to be clipped to the sheet, behind the two pillows, on the resident's left side. When asked how [redacted] would call for assistance, R42 said "I don't know." The resident confirmed that [redacted] could not reach across [redacted] body, behind the pillows, to reach the call light.

3. Review of R56's "Admission Record," located under the "ADT" tab of the EMR revealed R56 was admitted on [redacted] with diagnoses including EX Order 26 § 4b1 [redacted].

Review of R56's quarterly "MDS," located in the EMR under the "MDS" tab with and ARD of 05/20/23 revealed the resident had a "BIMS" score of [redacted] out of 15, indicating [redacted]. Per the "MDS," R56 required Ex.Order 26.4(b)(1) with personal care.

During an observation of R56 on 08/07/23 at 11:13 AM, while in bed, the resident's call light was observed on the floor behind the resident's bed. The resident stated that [redacted] had had a stroke and was not able to use [redacted] left hand/arm. On 08/07/23 at 4:02 PM, R56 was observed in bed with the call light on the floor behind the bed.

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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, NJ 07052

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F 919	Continued From page 28	F 919		

During an observation of R56 on 08/08/23 at 9:30 AM, the resident was observed in bed eating [Ex.Order] breakfast. The call light was observed on the left side of the bed toward [Ex.Order] pillow. When asked, R56 demonstrated that [Ex.Order] could not reach across [Ex.Order] body to reach the call light with [Ex.Order] right hand. When asked how [Ex.Order] would call for assistance if needed, R56 said [Ex.Order] "would wait" for someone to come in.

During an observation on 08/09/23 at 9:30 AM, R56 was observed in bed. CNA4 came into the room to deliver the resident's breakfast. The resident's call light was observed on [Ex.Order] left side near [Ex.Order] pillow. CNA4 said [Ex.Order] did not realize the call light should be on the resident's right side because [Ex.Order] cannot use [Ex.Order] left hand. CNA4 did not indicate that R56 could not use the call light if it was accessible on [Ex.Order] right side. CNA4 did not move the call light to the resident's right side.

On 08/10/23 at 11:18 AM, R56 was observed while asleep in bed. The call light was observed on the resident's left side.

During an interview with CNA3 on 08/10/23 at 11:31 AM, CNA3 said the call lights would extend to the right side for the residents who needed that. CNA3 did not indicate that R56 could not use the call light if it was accessible on [Ex.Order] right side.

In an interview with the Director of Nurses (DON) on 08/10/23 at 12:00 PM, she said all CNAs were trained regarding call light placement for the residents and that the nurses should be checking to see if they are placed correctly for each resident.

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F 919	Continued From page 29	F 919		

On 08/10/23 at 2:09 PM, R56 was observed in bed. The call light was observed on [Ex.Order] left side close to the pillow, out of reach of the resident.

4. Review of R37's EMR, located on the "Profile" tab, revealed R37 was admitted on [EX Order 26 § 4b1]. Additional review of the EMR, "Diagnosis List" located under the "Profile" tab revealed the following diagnoses of but not limited to [EX Order 26 § 4b1]

Review of R37's quarterly MDS with an ARD of 06/15/23, revealed a BIMS score of [Ex.Or] indicating R37 is [EX Order 26 § 4b1]. Further review of the MDS revealed R37 required [EX Order 26 § 4b1].

During an observation made on 08/07/23 at 10:35 AM, the call light cord was located behind the headboard of the bed lying on the floor. Asked resident how [Ex.Order] would call for the Nurse/CNA if [Ex.Orde] needed them. The resident stated, "I would just yell loud until someone came to help me."

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	315029	A. BUILDING _____ B. WING _____	C 08/10/2023

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

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F 919	Continued From page 30	F 919		

On 08/08/23 at 9:20 AM, the call bell cord was observed on the floor behind the headboard of the bed, lying on the floor. An unidentified CNA came while this surveyor was still in the room. The CNA picked up the breakfast tray and left without checking to see if the resident's call bell was in reach.

On 08/09/23 9:10 AM, during the Medication Pass observation with Licensed Practical Nurse (LPN)5, the surveyor observed the call bell cord on the floor behind the headboard. LPN5 and CNA were in the room with the surveyor. LPN5 and CNA left the room with the surveyor and the staff members did not put the call bell in an area the resident would be able to reach.

During an interview on 08/09/23 at 10:00 AM, LPN5 stated "I did not even look to see if Ex.Order call bell was in place or not."

During an interview on 08/09/23 at 3:00 PM the DON stated, "No it (call light) wouldn't be where they could get it."

Review of the facility's, undated, policy titled, "Call Bell Monitoring and Responsibility," revealed "Call bells are to be left within reach at all times."

NJAC 8:39-31.8(c)9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030703	A. BUILDING: _____ B. WING _____	C 08/10/2023

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

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	Criteria #1 The facility failed to maintain a minimum direct care staff ratio. No residents were directly affected by this deficient practice. Staffing schedules were reviewed by the Director of Nursing for compliance. Criteria #2 All residents have the potential to be affected by this deficient practice. Criteria #3 All nursing administration staff will be educated regarding maintaining staffing levels to ensure that staffing mandate requirements are met. Criteria #4 Staffing ratios will be reviewed daily by the Director of Nursing. Results	9/12/23

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

Electronically Signed | 08/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030703	A. BUILDING: _____ B. WING _____	C 08/10/2023

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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 CNA and perform CNA duties. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on day shifts as follows: For the 2 weeks of Complaint staffing from 02/19/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -02/21/23 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -02/22/23 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -02/23/23 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -02/24/23 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -02/27/23 had 13 CNAs for 111 residents on the	S 560	will be presented to the facility's QAPI committee monthly for three months, then quarterly thereafter for twelve months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030703	A. BUILDING: _____ B. WING _____	C 08/10/2023

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S 560	Continued From page 2 day shift, required at least 14 CNAs. -02/28/23 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -03/03/23 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -03/04/23 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. For the 2 weeks of Complaint staffing from 06/18/2023 to 07/01/2023, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -06/26/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. For the 2 weeks of staffing prior to survey, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -07/25/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -07/30/23 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -08/05/23 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315029 Y1	A. Building B. Wing Y2	9/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0655	Correction	ID Prefix F0677	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	09/12/2023	LSC	09/12/2023	LSC	09/12/2023
ID Prefix F0759	Correction	ID Prefix F0761	Correction	ID Prefix F0809	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(f)(1)-(3)	Completed
LSC	09/12/2023	LSC	09/12/2023	LSC	09/12/2023
ID Prefix F0812	Correction	ID Prefix F0919	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.90(g)(1)(2)	Completed	Reg. #	Completed
LSC	09/12/2023	LSC	09/12/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/10/2023	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315029 Y1	A. Building B. Wing Y2	9/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0677	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.24(a)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/12/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/10/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030703 Y1	A. Building B. Wing Y2	9/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/12/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	C **08/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	**1155 PLEASANT VALLEY WAY** **WEST ORANGE, NJ 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
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/09/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/09/23 and 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 protected construction. The facility is divided into 24 - smoke zones. The RHP (first floor), WLP (second floor), and the BP (basement) are no longer in use. The generator does approximately 100 % of the building as per the Director of Building Services. The current occupied beds are 90 of 303. .	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		9/11/23

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

Electronically Signed | 08/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	C **08/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	**1155 PLEASANT VALLEY WAY** **WEST ORANGE, NJ 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
K 918	Continued From page 1 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 REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the three-year load bank test was	K 918	Criteria #1 The generator identified is scheduled to have a load bank test on September 7 and September 8, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	C **08/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	**1155 PLEASANT VALLEY WAY** **WEST ORANGE, NJ 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
K 918	Continued From page 2 completed on the existing emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had the potential to affect all 90 residents. Findings include: A document review of the generator reports for 2023 provided by the Director of Building Services revealed a three-year load bank test had not been completed for the emergency generator. During an interview on 08/09/23 at 1:35 PM, the Director of Building Services confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Criteria #2 All residents are found to be at risk for this deficient practice. Criteria #3 All policies and procedures for generator testing were reviewed and revised to inlcude a three-year load bank test. Criteria #4 The Director of Building Services will report generator testing,, both monthly and three-year load testing, to the facility's QAPI committee for three months and quarterly thereafter, for twelve months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315029 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/13/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTERS OF ISRAEL PLEASANT VALLEY HOME	1155 PLEASANT VALLEY WAY WEST ORANGE, NJ 07052

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	09/11/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO