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 11/16/2021

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 STANDARD SURVEY: CENSUS: 143 SAMPLE: 50 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. In addition, a COVID-19 Focused Infection Control Survey was conducted.	F0000		
F0604 SS = E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0604	Criteria 1: The facility failed to ensure that residents were free from NJ Exec Order 26.4b1 as indicated by the use of NJ Exec Order 26.4b1 to the bed for five residents, #134, #25, #96, #133 and #89. For each identified resident, physician orders were reviewed and revised as needed, care plans were updated as needed, assessments were completed and consents were obtained. Criteria 2: All residents are at risk for this deficient practice. Criteria 3: Policies and procedures were reviewed and revised as necessary. Staff were provided education to ensure that each resident has a side rail assessment/consent for use/physician's order, and that they are followed and indications for use are documented on the resident care plan. Criteria 4: The DON or designee will conduct weekly audits to ensure that physician's orders, assessments, and consents for side rail use are implemented and indications for use are followed on the resident care plan. Results of audits will be reviewed during the facility QAPI meetings monthly	12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 1 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure residents were free from NJ Exec Order 26.4b1, which included the use of [redacted] to the bed, for five (Resident #134, Resident #25, Resident #96, Resident #133, and Resident #89) of twelve residents reviewed for NJ Exec Order 26.4b1. Findings included: 1. The facility admitted Resident #134 with diagnoses of NJ Exec Order 26.4b1 [redacted] A review of Resident #134's quarterly Minimum Data Set (MDS), dated NJ Exec Order 26.4b1, revealed Resident #134's NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1. Resident #134 required NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1. A further review of Resident #134's MDS revealed a NJ Exec Order [redacted] was not used. A review of Resident #134's care plan, dated NJ Exec Order 26.4b1, revealed a focus of NJ Exec Order 26.4b1 with an intervention in place to use NJ Exec Order 26.4b1 when in bed. A review of Resident #134's physician's consolidated orders, dated NJ Exec Order [redacted], revealed an order started on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 to be up on the bed for NJ Exec Order 26.4b1 An observation on 11/08/2021 at 10:30 AM revealed Resident #134 lying on their NJ Exec Order 26.4b1. A NJ Exec Order [redacted]	F0604	Continued from page 1 for three months and quarterly thereafter.	12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 2 NJ Exec Order 26.4b1 was in place on both sides of Resident #134. There was a pad in place over each NJ Exec Order 26.4b1 An observation on 11/08/2021 at 10:45 AM revealed Resident #134 lying on their NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 while in bed. A NJ Exec Order 26.4b1 was in place on both sides of Resident #134. There was a pad in place over each NJ Exec Order 26.4b1 An observation on 11/09/2021 at 12:15 PM revealed Resident #134 lying on their NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 while in bed. A full NJ Exec Order 26.4b1 was in place on both sides of Resident #134. There was a pad in place over each NJ Exec Order 26.4b1. A review of Resident #134's medical record revealed there was no consent or assessment completed for the use of NJ Exec Order 26.4b1 During an interview on 11/09/2021 at 12:35 PM, Certified Nurse Aide (CNA) #1 stated Resident #134 was NJ Exec Order 26.4b1 during care and NJ Exec Order 26.4b1 while in bed. Resident #134 could NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 while in bed, and the NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 CNA #1 further stated they did not know if Resident #134 NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 but had not tried to NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 During an interview on 11/09/2021 at 2:10 PM, CNA #2 stated Resident #134's NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 because the resident was so NJ Exec Order 26.4b1 and would NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 were in place to NJ Exec Order 26.4b1 Resident #134 from NJ Exec Order 26.4b1 of bed. CNA #2 then stated there was an NJ Exec Order 26.4b1 pointing up on the NJ Exec Order 26.4b1 of Resident #134's NJ Exec Order 26.4b1 telling staff the NJ Exec Order 26.4b1, but there was not an NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 CNA #2 did not know why NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 while Resident #134 was in the bed. During an interview on 11/09/2021 at 2:35 PM, Registered Nurse (RN) #1 stated Resident #134 had NJ Exec Order 26.4b1 while in bed because Resident #134 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 while in bed. Resident #134 did NJ Exec Order 26.4b1 of bed or NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1, but Resident #134 was a NJ Exec Order 26.4b1 risk. During an interview on 11/09/2021 at 3:25 PM, the	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 3 US FOIA (b)(6) stated all residents were screened for NJ Exec Order 2 upon admission. US FOIA (b)(6) screened for NJ Exec Order 26.4b1 and nursing determined if NJ Exec Order 2 were up when a resident was in bed and if NJ Exec Order 26.4b1 were used. NJ Exec did not determine a resident's NJ Exec Order use. NJ Exec Order 26 would be up when a resident was in bed to keep a resident from NJ Exec Orde The US FOIA then stated residents had NJ Exec O to NJ Exec Or NJ Exec O the NJ Exec Order 26 and there was always the potential for NJ Exec Or with NJ Exec O There were no consents or formal assessments done to determine NJ Exec Order usage. During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no NJ Exec Order 26.2 in the building. The US FOIA (b)(6) then stated nursing should do a siderail assessment for NJ Exec Order use; this assessment was implemented starting NJ Exec Order 26.4b1 because NJ Exec Order 2 were being investigated. The US FOIA (b)(6) further stated two NJ Exec Order 26 in the up position would be a NJ Exec Order 26 if they were stopping a resident from NJ Exec Order 26.4b1 They were not coding NJ Exec Order 26 as a NJ Exec Order 26 because residents used them for NJ Exec Order NJ Exec Order 2 use should be in the care plan and reviewed monthly. Resident #134 should have NJ Exec Order 26.4b1 in the up NJ Exec Order 2 for NJ Exec Order 26.4b1 when in the bed. During an interview on 11/10/2021 at 12:00 PM, the US FOIA (b)(6)) stated there were no consents for NJ Exec Order 26 and they had no NJ Exec Order 26.2 in the building. The US FOIA then stated a NJ Exec Order 26 was anything that NJ Exec Order 26 a resident's NJ Exec Order 2 , and NJ Exec Order 26.4b1 would only be a NJ Exec Order 26 if they were preventing a resident from NJ Exec Order 26.4b1 If a resident attempted to NJ Exec O NJ Exec O NJ Exec Order or NJ Exec Order 2 a NJ Exec Order 2 it could be more NJ Exec Order 26.4b1 than if the NJ Exec Order was not there. During an interview on 11/10/2021 at 12:12 PM, the US FOIA (b)(6)) stated facility staff should not put NJ Exec Order 26.4b1 in the NJ Exec Order 26.4 n because a resident could NJ Exec Or themself on the NJ Exec Order 26 Some CNAs would put both NJ Exec Order 26 up for resident safety, but that was a NJ Exec Order 26 Resident #134 should have NJ Exec Order 26.4b1 up for NJ Exec Order 26.4b1 During an interview on 11/10/2021 at 1:26 PM, the US FOIA (b) stated they were not aware the facility did not have a system to assess residents, get consents, and monitor NJ Exec Order use. This was important for consistency and resident safety, and a resident	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 4 should be able to move around. During an interview on 11/10/2021 at 1:40 PM, the US FOIA (b)(6) stated a NJ Exec Order 26.4 was anything that NJ Exec Order 26.4 a resident's NJ Exec Order 26.4b1. The facility just implemented a NJ Exec Order assessment on NJ Exec Order 26.4b1 and would start getting consents for NJ Exec Order use. The US FOIA (b)(6) then stated it was important to assess residents and get consents so the resident and family could know the risks and benefits of NJ Exec Order use. They needed to make sure a NJ Exec Order 2 was the safest recommendation for each resident. A review of the undated facility policy titled, "Policy and Procedures for Restraints," revealed the facility's "processes will address the use of restraints. These processes will recognize and protect residents' rights and ensure that when used, the restraints are safe and appropriate based upon a documented medical symptom. These processes utilize the key elements of care planning and delivery of the individually established plan of care that includes thorough assessments by interdisciplinary team member." A review of the facility's policy titled, "Department of Nursing: Side Rails," dated 02/26/2009, revealed, "All residents will be assessed by the nurse for safe use of side rails upon admission and readmission." 2. The facility admitted Resident #25 with diagnoses of NJ Exec Order 26.4b1 A review of Resident #25's annual Minimum Data Set (MDS), dated NJ Exec Order 26.4b1, revealed a Brief Interview of Mental Status (BIMS) score of NJ E indicating NJ Exec Order 26.4b1. Resident #25 required NJ Exec Order 26.4b1 with NJ Exec O A further review of Resident #25's MDS revealed a NJ Exec Order 2 was not used. A review of Resident #25's care plan, dated NJ Exec Order 26.4b1, revealed a focus of activities of daily living (ADL) function. Resident #25 required NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and an intervention of NJ Exec Order 26.4b1 when in NJ Exec to NJ Exe in NJ Exec Order 26.4b1	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 5 A review of Resident #25's care plan, dated NJ Exec Order 26.4b1 revealed a focus of history of NJ Exec O Resident #25 was a NJ Exec Order 26 for NJ Exec due to NJ Exe assessment, NJ Exec Order 26.4b1, and NJ Exec Order 26 with an intervention of NJ Exec Order 26.4b1 when in NJ Exec to NJ Exec Orde in NJ Exec Order 26.4b1 A review of Resident #25's physician's orders, dated NJ Exec Order 26 revealed an order started on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 An observation on 11/09/2021 at 12:14 PM revealed Resident #25 lying in bed, NJ Exec Order 2 to the NJ Exec Order 2, and NJ Exec Order 26.4b1 were in the NJ Exec Orde NJ Exec Order 2 on NJ Exec Order 26.4b of Resident #25. The bed was in the NJ Exec Order 26.4b1, with NJ Exec Order 26.4b on each NJ Exec of the NJ Exec O During an interview on 11/09/2021 at 12:40 PM, Certified Nurse Aide (CNA) #1 stated Resident #25 NJ Exec Order 26.4b1 the NJ Exec and NJ Exec Order 26.4b1, which is why the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b were in place for the resident's safety. An observation on 11/09/2021 at 2:08 PM revealed Resident #25 lying in bed, NJ Exec Order 2 to the NJ Exec Order 2. NJ Exec Order 26.4b1 were in the NJ Exec Order 26.4b1 on each NJ Exec of the resident. Resident #25's NJ Exec Orde were NJ Exec O and NJ Exec Order on the NJ Exec Order 26.4b1. A review of Resident #25's medical record revealed there was no consent or assessment completed for the use of NJ Exec Order 26. During an interview on 11/09/2021 at 2:11 PM, CNA #2 stated that when Resident #25 was in bed, the NJ Exe were in the NJ Exec Order 26.4b1 and NJ Exec Order 26 were on the NJ Exec O because Resident #25 NJ Exec Order 26.4b1 of bed. The NJ Exec Order 26 kept Resident #25 in the bed. CNA #2 further stated Resident #25 tried to NJ Exec O over the NJ Exec Order 26 and would NJ Exec O to the NJ Exec of the bed to NJ Exec Order 26.4b1 between the end of the NJ Exec Order 2 and the NJ Exec Order 26.4 of the bed. CNA #2 further stated a resident's care plan reflects whether a resident should have NJ Exec Order 26.4b1. There was an NJ Exec Orde on either the NJ Exec O or NJ Exec Order 2 of the NJ Exec Order 26.4b1 telling staff which NJ Exec Order needed to be NJ Exec Orde CNA #2 further stated they did not know why	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 6 both [NJ Exec Order 26.4b1] were in the [NJ Exec Order 26.4b1], when Resident #25 had only [NJ Exec Order 26.4b] on the [NJ Exec Order 26.4] of the [NJ Exec Order 26.4b1] During an interview on 11/09/2021 at 2:35 PM, Registered Nurse (RN) #1 stated Resident #25 had a NJ Exec Order 26.4b1 on the [NJ Exec O] next to the bed because the resident [NJ Exec Order 26.4b1]. Resident #25 would also [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1 between the [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4b] RN #1 further stated Resident #25 had been [NJ Exec Or] on the [NJ Exec O] at the [NJ Exec] of the [NJ Exec] but had NJ Exec Order 26.4b1 . Although staff indicated Resident #25 had [NJ Exec O] over the [NJ Exec Order 26] and [NJ Exec Order 26.4b], a review of the resident's medical record did not indicate that occurred. Incident reports from the previous 90 days were reviewed and there had been no incidents related to Resident #25. During observations from NJ Exec Order 26.4b1 , the resident was not seen NJ Exec Order 26.4b1 . During an interview on 11/09/2021 at 3:25 PM, the US FOIA (b)(6) stated all residents were screened for [NJ Exec Order 2] upon admission. [NJ Exec Order 26] screened for [NJ Exec Order 26.4b1] and nursing determined if [NJ Exec Order 2] were [NJ Ex] when a resident was in bed and if [NJ Exec Order 26.4b1] were used. [NJ Ex] did not determine a resident's [NJ Exec Order 26.4b1] [NJ Exec Order 26] would be [NJ Ex] when a resident was in bed to [NJ Exec O] a resident from [NJ Exec Orde] The [US FOIA (b)] then stated residents had [NJ Exec O] and there was always the potential for [NJ Exec Or] with [NJ Exec O] There were no consents or formal assessments done to determine [NJ Exec Order 26.4b1]. During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had [NJ Exec Order 26.4b1] in the building. The US FOIA (b)(6) then stated nursing should do a [NJ Exec Order] assessment for [NJ Exec Order] use; this assessment was implemented starting [NJ Exec Order 26.4b1] because [NJ Exec Order 2] were being investigated. The US FOIA (b)(6) further stated two [NJ Exec Order 26] in the up position would be a [NJ Exec Order 2] if they were stopping a resident from [NJ Exec Order 26.4b1] [NJ Exec Order 2] They were not [NJ Exec Order 26.4b1] as a [NJ Exec Order 2] because residents used them for [NJ Exec Order 26.4b1] [NJ Exec Order 2] use should be in the care plan and reviewed monthly. Resident #25 should have [NJ Exec Order 26.4b1] in the up [NJ Exec Order 2] for [NJ Exec Order 26.4b1] when in the bed.	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 7 During an interview on 11/10/2021 at 12:00 PM, the US FOIA (b)(6) stated there were no consents for NJ Exec Order 26 and they had no NJ Exec Order 26.4 in the building. The US FOIA (b) then stated a NJ Exec Order 26 was anything that NJ Exec Order 26 a resident's NJ Exec Order would only be a NJ Exec Order 26 if they were NJ Exec Order 26.4b1 a resident from NJ Exec Order 26.4b1. If a resident NJ Exec Order 26.4b1 , it could be more NJ Exec Order 26.4b1 than if the NJ Exec Order was not there. During an interview on 11/10/2021 at 12:12 PM, the US FOIA (b)(6)) stated facility staff should not put NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 because a resident could NJ Exec Ord themself on the NJ Exec Order 26 Some CNAs would NJ Exec Order 26.4b1 for resident safety, but that was a NJ Exec Order 26 Resident #25 NJ Exec Order 26.4b1 and had a history of NJ Exec O so the CNAs would put NJ Exec Order 26.4b1 NJ Exe During an interview on 11/10/2021 at 1:26 PM, the US FOIA (b) stated they were not aware the facility did not have a system to assess residents, get consents, and NJ Exec Order 26.4b1 use. This was important for consistency and resident safety, and a resident NJ Exec Order 26.4b1 . During an interview on 11/10/2021 at 1:40 PM, the US FOIA (b)(6) stated a NJ Exec Order 26 was anything that NJ Exec Order 26.4 a resident's NJ Exec Order 26.4b1. The facility just implemented a NJ Exec Order assessment on NJ Exec Order 26.4b1 and would start getting consents for NJ Exec Order use. The US FOIA (b)(6) then stated it was important to assess residents and get consents so the resident and family could know the risks and benefits of NJ Exec Order use. They needed to make sure a NJ Exec Order 26 was the safest recommendation for each resident. A review of the undated facility policy titled, "Policy and Procedures for Restraints," revealed the facility's "processes will address the use of restraints. These processes will recognize and protect residents' rights and ensure that when used, the restraints are safe and appropriate based upon a documented medical symptom. These processes utilize the key elements of care planning and delivery of the individually established plan of care that includes thorough assessments by	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 8 interdisciplinary team member." A review of the facility's policy titled, "Department of Nursing: Side Rails," dated 02/26/2009, revealed, "All residents will be assessed by the nurse for safe use of side rails upon admission and readmission." 3. The facility admitted Resident #96 with diagnoses of NJ Exec Order 26.4b1 [redacted] A review of Resident #96's quarterly Minimum Data Set (MDS), dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] indicating NJ Exec Order 26.4b1. A further review of Resident #96's MDS revealed a [redacted] was not used. A review of Resident #96's care plan, dated [redacted] revealed a focus of [redacted] with an intervention of a [redacted] to the [redacted] when in bed. A review of Resident #96's physician's orders, dated [redacted] revealed an order started on [redacted] for [redacted] for [redacted] An observation on 11/08/2021 at 10:30 AM revealed Resident #96 lying in bed with [redacted] in the [redacted]. Resident #96 was [redacted] their [redacted] on [redacted] of the [redacted] with [redacted] present on the [redacted] An observation on 11/08/2021 at 12:15 PM revealed Resident #96 lying in bed with [redacted] in the [redacted]. An observation on 11/08/2021 at 3:07 PM revealed Resident #96 lying in bed with [redacted] in the [redacted]. A review of Resident #96's medical record revealed there was no consent or assessment completed for the use of [redacted]	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 9 During an interview on 11/09/2021 at 12:28 PM, Certified Nurse Aide (CNA) #1 stated the two [redacted] were in the [redacted] to [redacted] Resident #96 from NJ Exec Order 26.4b1. Resident #96 had never tried to [redacted] the [redacted]. During an interview on 11/09/2021 at 1:05 PM, CNA #7 stated the [redacted] were in the [redacted] because Resident #96 was [redacted] and would try to NJ Exec Order 26.4b1. During an interview on 11/09/2021 at 2:15 PM, CNA #2 stated Resident #96 NJ Exec Order 26.4b1 [redacted] and the [redacted] were in the [redacted] for safety. An observation on 11/09/2021 at 2:27 PM revealed no [redacted] on either [redacted] of the [redacted] indicating which [redacted] to be in the [redacted]. During an interview on 11/09/2021 at 2:35 PM, Registered Nurse (RN) #1 stated the [redacted] were in the [redacted] because Resident #96 tried to NJ Exec Order 26.4b1. RN #1 further stated [redacted] determined if a resident used [redacted], and the [redacted] were in place because if a resident [redacted] on the NJ Exec Order 26.4b1, it could cause [redacted] or [redacted]. During an interview on 11/09/2021 at 3:25 PM, the US FOIA (b)(6) stated all residents were screened for [redacted] upon admission. [redacted] screened for [redacted] and nursing determined if [redacted] were [redacted] when a resident was in bed and if [redacted] were used. [redacted] did not determine a resident's [redacted] use. [redacted] would be [redacted] when a resident was in bed to [redacted] a resident from [redacted]. The [redacted] then stated residents had tried to NJ Exec Order 26.4b1, and there was always the potential for [redacted] with [redacted]. There were no consents or formal assessments done to determine [redacted] usage. During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no restraints in the building. The US FOIA (b)(6) then stated nursing should do a [redacted] assessment for [redacted] use; this assessment was implemented starting [redacted] because [redacted] were being	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 10 investigated. The US FOIA (b)(6) further stated two NJ Exec Order 26 in the NJ Exec Order 26.4b1 would be a NJ Exec Order 26 if they were NJ Exec Order 26.4b1 They were not coding NJ Exec Order 26 as a NJ Exec Order 26 on the MDS because residents used them for NJ Exec Order 26.4b1 NJ Exec Order 26 use should be in the care plan and reviewed monthly. Resident #134 and Resident #25 should have NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 when in the bed. The US FOIA (b)(6) further stated Resident #96 had NJ Exec Order 26.4b1 in the up NJ Exec Order 26 for safety reasons because Resident #96 NJ Exec Order 26.4b1. During an interview on 11/10/2021 at 12:00 PM, the US FOIA (b)(6) stated there were no consents for NJ Exec Order 26 and they had no NJ Exec Order 26.4b1 in the building. The US FOIA (b) then stated a NJ Exec Order 26 was anything that NJ Exec Order 26 a resident's NJ Exec Order and full NJ Exec Order 26 would only be a NJ Exec Order 26 if they were NJ Exec Order 26.4b1 a resident from NJ Exec Order 26.4b1. If a resident attempted to NJ Exec O NJ Exec O or around a NJ Exec Order 2 it could be more dangerous than if the NJ Exec Order was not there. During an interview on 11/10/2021 at 12:12 PM, the US FOIA (b)(6)) stated facility staff should not put NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 because a resident could injure themself on the NJ Exec Order 26 Some CNAs would put NJ Exec Order 26.4b1 for resident safety, but that was a NJ Exec Order 26 Resident #134 should have NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 Resident #25 NJ Exec Order 26.4b1 and had a history of NJ Exec O so the CNAs would put both NJ Exec Order 26.4b1 Resident #96 was at risk for NJ Exec and should only have NJ Exec Order 26.4b1 up in bed. During an interview on 11/10/2021 at 1:26 PM, the US FOIA (b) stated they were not aware the facility did not have a system to assess residents, get consents, and monitor NJ Exec Order use. This was important for consistency and resident safety, and a resident NJ Exec Order 26.4b1 . During an interview on 11/10/2021 at 1:40 PM, the US FOIA (b)(6) stated a NJ Exec Order 26 was anything that NJ Exec Order 26.4 a resident's NJ Exec Order 26.4b1. The facility just implemented a NJ Exec Order assessment on NJ Exec Order 26.4b1 and would start getting consents for NJ Exec Order use. The US FOIA (b)(6) then stated it was important to assess residents and get consents so the resident and family could know the risks and benefits of NJ Exec Order use. They needed to make sure a	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 11 NJ Exec Order 2 was the safest recommendation for each resident. A review of the undated facility policy titled, "Policy and Procedures for Restraints," revealed the facility's "processes will address the use of restraints. These processes will recognize and protect residents' rights and ensure that when used, the restraints are safe and appropriate based upon a documented medical symptom. These processes utilize the key elements of care planning and delivery of the individually established plan of care that includes thorough assessments by interdisciplinary team member." A review of the facility's policy titled, "Department of Nursing: Side Rails," dated 02/26/2009, revealed, "All residents will be assessed by the nurse for safe use of side rails upon admission and readmission." 4. The facility admitted Resident #89 with diagnoses that included NJ Exec Order 26.4b1 [redacted]. NJ Exec Order 26 were not indicated for use on the MDS. The NJ Exec Order 26.4b1 computerized physician orders (CPO) revealed and order with a start date of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 in bed for NJ Exec Order 26.4b1 The revised care plan, updated NJ Exec Order 26.4b1 revealed the resident had a NJ Exec Order 26.4b1 and NJ Exec Order [redacted] Interventions included NJ Exec to both NJ Exec Ord [redacted] and NJ Exec Order 26 for safety and monitor for complications caused by NJ Exec Order 26.4b1. Resident #89 was observed on 11/08/2021 at 9:24 AM, 11:02 AM, and 2:26 PM with both NJ Exec Order 26.4b1 while the resident was in bed. Both NJ Exec Order 26.4 were NJ Exec Order 2 Only one NJ Exec Order 2 was ordered for use.	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 12 Observations on 11/09/2021 at 10:00 AM and 2:30 PM revealed both [NJ Exec Order 26.4b] were [NJ Exec Order 2] and [NJ E] while the resident was in bed. Only [NJ Exec Order 26.4b1] was ordered for use. On 11/08/2021 at 2:30 PM, [NJ Exec Order 26.4b1] was observed on the [NJ Exec Order 26.4] of the bed, indicating to floor staff that only the right [NJ Exec Order 2] should be used when the resident was in bed. A [NJ Exec Order 2] assessment, dated [NJ Exec Order 26.4b1], revealed the [NJ Exec] were used for [NJ Exec Order 26.4b1] and only one was needed for the resident. During a resident group meeting, held with five (Residents #2, #13, #26, #68, and #118) [NJ Exec Order 26.4b1] residents, on [NJ Exec Order 26.4b1] at 11:00 AM, revealed they all had [NJ Exec Order 26] on their beds when they first came to the facility. Resident #13 and Resident #68 said they currently had [NJ Exec Order 26] on their beds. Resident #13 said the [NJ Exec Order 26] kept them in bed, but they required staff assistance to [NJ Exec Or] Resident #68 said they [NJ Exec Order 2] with their [NJ Exec Order 26.4b1] and needed [NJ Exec Order 26.4b1] from staff to [NJ Exec Order 26.4b1]. Neither resident said they signed a consent form for the use of [NJ Exec Order 26] on their beds. An interview with Certified Nurse Aide (CNA) #5, on 11/09/2021 at 2:32 PM, revealed [NJ Exec Order 26] were used for many of their residents. The CNA said the residents were assessed by nursing for the need and use of [NJ Exec Order 26], and the family signed waivers for their use. CNA #5 said the number of [NJ Exec Order 26.4] each resident used was indicated by [NJ Exec Order 26.4b] on the [NJ Exec] of the [NJ Exec Order 26.4b1] the [NJ Exec] were supposed to be used on. CNA #5 said Resident #89 used one bed [NJ Ex] on the right side of the bed. The CNA said Resident #89 should not have [NJ Exec Order 26.4b1]. They said the [NJ Exec Order 26.4b1] was to help the resident [NJ Exec Order 26.4b] themself. An interview with CNA #6, on 11/09/2021 at 2:37 PM, revealed [NJ Exec Order 26] were ordered by the physician and indicated for use by [NJ Exec Orde] on the [NJ Exec Order 26.4b1] of each resident. The CNA said if both [NJ Exec Order 26] were used, there should be a consent waiver in the medical chart of the resident. CNA #6 said nursing and [NJ Exec Order 26.4b1] assessed the residents for [NJ Exec Order 2] use. They said [NJ Exec Order 26] were	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 13 used for residents who had a history of [NJ Exec] or a NJ Exec Order 26.4b1. CNA #6 was not sure if Resident #89 should have NJ Exec Order 26.4b1. The CNA said the resident had used the [NJ Exec Order 26.] for [NJ Exec Order 26.4b1] They said the [NJ Exec Order 26.] were [NJ Exec Order 2] to protect the resident if they NJ Exec Order 26.4b1 They said the nurse informed them of changes to the residents and the number of [NJ Exec Order 26] ordered for use. An interview with Licensed Practical Nurse (LPN) #4, on 11/09/2021 at 2:43 PM, revealed [NJ Exec Order 26] were used for residents who had NJ Exec Order 26.4b1 or [NJ Exec Order 26.4] LPN #4 said some residents used [NJ Exec Order 26] [NJ Exec Ord] [NJ Exec Order 2] on the side of the [NJ Exec Order 26.4b1] that indicated which [NJ Exec Order] to have [NJ Exec Order] They said physician orders and consent were needed for residents to use [NJ Exec Order 26]. They said nursing and the therapy department assessed the resident's need for [NJ Exec] . They said [NJ Exec Order 26] were included in the resident's care plan and included the reason for and number of [NJ Exec Order 26]. LPN #4 said Resident #89 had a NJ Exec Order 26.4b1 and had orders for [NJ Exec Order 26.4b1] to be [NJ Ex] for [NJ Exec Order 26.4b1] They said the resident should not have NJ Exec Order 26.4b1. LPN #4 was not able to find the consent form in the resident's chart. LPN #4 said they did not know where the consent forms were kept since they were not in the medical chart. On 11/09/2021 at 2:43 PM, LPN #4 went to check the [NJ Exec Order 26] of Resident #89. As LPN #4 entered the room, CNA #6 exited the room. CNA #6 said they had forgotten to put the NJ Exec Order 26.4b1 after providing [NJ Exec Order 26.4b1] care to the resident after lunch. CNA #6 said they just [NJ Exec Order 26.4b1] the resident and NJ Exec Order 26.4b1. The [NJ Exec Order 2] on the [NJ Exec Order 26.4b] the bed was observed to be [NJ Exec Order 26] During an interview on 11/09/2021 at 3:25 PM, the US FOIA (b)(6) stated all residents were screened for therapy upon admission. [NJ Exec Order 26] screened for [NJ Exec Order 26.4b1] and nursing determined if siderails were up when a resident was in bed and if [NJ Exec Order 26.4b1] were used. [NJ Ex] did not determine a resident's [NJ Exec Order] use. [NJ Exec Order 26] would be up when a resident was in bed to keep a resident from [NJ Exec Orde] The [US FOIA (b)] then stated residents had tried to NJ Exec Order 26.4b1, and there was always the potential for injury with [NJ Exec] There were no consents or formal assessments done to determine [NJ Exec Order] usage.	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 14 During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no restraints in the building. The US FOIA (b)(6) then stated nursing should do a NJ Exec Order assessment for NJ Exec Order use; this assessment was implemented starting NJ Exec Order 26.4b1 because NJ Exec Order 26 were being investigated. The US FOIA (b)(6) further stated NJ Exec in the NJ Exec Order 26.4b1 would be a NJ Exec Order 26 if they were stopping a resident from NJ Exec Order 26.4b1 They were not coding NJ Exec Order 26 as a NJ Exec Order 26 on the MDS because residents used them for NJ Exec Order 26.4b1 NJ Exec Order 2 use should be in the care plan and reviewed monthly. During an interview on 11/10/2021 at 12:00 PM, the US FOIA (b)(6)) stated there were no consents for NJ Exec Order 26 and they had NJ Exec Order 26.4b1 in the building. The US FOIA (b) then stated a NJ Exec Order 26 was anything that NJ Exec Order 26 a resident's NJ Exec Order , and NJ Exec Order 26.4b1 would only be a NJ Exec Order 26 if they were NJ Exec Order 26.4b1 a resident from NJ Exec Order 26.4b1. If a resident attempted to NJ Exec O it could be more dangerous than if the NJ Exec Order was not there. During an interview on 11/10/2021 at 12:12 PM, the US FOIA (b)(6)) stated facility staff should not put NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 because a resident could injure themself on the NJ Exec Order 26 Some CNAs would put both NJ Exec Order 26 up for resident safety, but that was a NJ Exec Order 26 During an interview on 11/10/2021 at 1:26 PM, the US FOIA (b) stated they were not aware the facility did not have a system to assess residents, get consents, and monitor NJ Exec Order use. This was important for consistency and resident safety, and a resident NJ Exec Order 26.4b1 . During an interview on 11/10/2021 at 1:40 PM, the US FOIA (b)(6) stated a NJ Exec Order 26 was anything that NJ Exec Order 26.4b1 . The facility just implemented a NJ Exec Order assessment on NJ Exec Order 26.4b1 and would start getting consents for NJ Exec Order use. The US FOIA (b)(6) then stated it was important to assess residents and get consents so the resident and family could know the risks and benefits of NJ Exec Order use. They needed to make sure a NJ Exec Order 2 was the safest recommendation for each resident.	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 15 A review of the undated facility policy titled, "Policy and Procedures for Restraints," revealed the facility's "processes will address the use of restraints. These processes will recognize and protect residents' rights and ensure that when used, the restraints are safe and appropriate based upon a documented medical symptom. These processes utilize the key elements of care planning and delivery of the individually established plan of care that includes thorough assessments by interdisciplinary team member." A review of the facility's policy titled, "Department of Nursing: Side Rails," dated 02/26/2009, revealed, "All residents will be assessed by the nurse for safe use of side rails upon admission and readmission." 5. The facility admitted Resident #133 with diagnoses that included NJ Exec Order 26.4b1 The significant change Minimum Data Set (MDS), dated NJ Exec Order 26.4b1, revealed the resident's Brief Interview for Mental Status (BIMS) score was NJ Exec Or which indicated NJ Exec Order 26.4b1. The resident required NJ Exec Order 26.4b1 The resident had NJ Exec Order during the NJ Exec Order 26.4b1 but was an identified NJ Ex risk. NJ Exec use was not indicated on the MDS. The NJ Exec Order 26.4b1 computerized physician orders (CPO) revealed an order with a start date of NJ Exec Order 26.4b1 The revised care plan, updated NJ Exec Order 26.4b1, revealed NJ Exec Order 26 were not included in the resident's care plan as a focus or intervention. There had been no update to the care plan to include NJ Exec Order use for the resident following the physician's order on NJ Exec Order 26.4b1 Resident #133 was observed on 11/08/2021 at 9:26 AM, 11:00 AM, and 2:28 PM with both NJ Exec Order 26.4b1 while the resident was in bed. Observations on 11/09/2021 at 10:03 AM and 2:32 PM revealed both NJ Exec Order 26.4b1 while the resident	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 16 was in bed. On 11/09/2021 at 2:32 PM, NJ Exec Order 26.4b1 were observed on either side of the bed, indicating to floor staff that both NJ Exec Order 26 should be used when the resident was in bed. Observations on 11/10/2021 at 9:03 AM and 2:18 PM revealed both NJ Exec Order 26.4b1 while the resident was in bed. Resident #133 had no assessment or consents for the use of NJ Exec Order 26 in their medical chart or electronic medical record. During a resident group meeting, held with five (Residents #2, #13, #26, #68, and #118) cognitively intact residents, on NJ Exec Order 26.4b1 at 11:00 AM, revealed they all had NJ Exec Order 26 on their beds when they first came to the facility. Resident #13 and Resident #68 said they currently had NJ Exec Order 26 on their beds. Resident #13 said the NJ Exec Order 26 kept them in bed, but they required staff NJ Exec Order 26.4b1 to NJ Exec Orde [redacted] Resident #68 said they felt NJ Exec O [redacted] with their NJ Exec Order 26.4b1 and needed NJ Exec Order 26.4b1 from staff to NJ Exec Order 26.4b1 Neither resident said they signed a consent form for the use of NJ Exec Order 26 on their beds. An interview with Certified Nurse Aide (CNA) #5, on 11/09/2021 at 2:32 PM, revealed NJ Exec Order 26 were used for many of their residents. The CNA said the residents were assessed by nursing for the need and use of NJ Exec Order 26, and the family signed waivers for their use. CNA #5 said the number of NJ Exec Order 26.4b each resident used was indicated by NJ Exec Order 26.4b1 on the side of the NJ Exec Order 26.4b1 the NJ Exec were supposed to be used on. CNA #5 said Resident #133 used both NJ Exec Order 26.4b CNA #5 said the family requested the use of NJ Exec O so the resident did not NJ Exe when the resident NJ Exec Order 26.4b1. The CNA said the resident had a history of NJ Exec O They said the resident had NJ Exec Order while residing at the facility. An interview with CNA #6, on 11/09/2021 at 2:37 PM, revealed NJ Exec Order 26 were ordered by the physician and indicated for use by NJ Exec Orde on the NJ Exec Order 26.4b1 of each resident. The CNA said if both NJ Exec Order 26 were used, there should be a consent waiver in the medical chart of the resident. CNA #6	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 17 said nursing and physical therapy assessed the residents for [NJ Exec Order 26] use. They said [NJ Exec Order 26] were used for residents who had a history of [NJ Exec] or a [NJ Exec Order 26.4b1] condition. They said the nurse informed them of changes to the residents and the number of [NJ Exec Order 26] ordered for use. CNA #6 said Resident #133 used both [NJ Exec Order 26] at the request of the family. CNA #6 said the resident was a [NJ Exec] risk and would try to [NJ Exec Order 26.4b1] if the [NJ Exec Order 26] were not [NJ Exec] CNA #6 said the family signed a waiver that was in the medical chart. She said the resident had not suffered a [NJ Exec] since residing at the facility. An interview with Licensed Practical Nurse (LPN) #4, on 11/09/2021 at 2:43 PM, revealed [NJ Exec Order 26] were used for residents who had NJ Exec Order 26.4b1 or [NJ Exec Order 26] LPN #4 said some residents used one [NJ Exec] They said there were [NJ Exec Order] on the side of the [NJ Exec Order 26.4b1] that indicated which [NJ Exec Order] to have raised. They said physician orders and consent were needed for residents to use [NJ Exec Order 26]. They said nursing and the therapy department assessed the resident's need for [NJ Exec] They said [NJ Exec Order 26] were included in the resident's care plan and included the reason for and number of [NJ Exec Order 26]. LPN #4 said Resident #133 was a [NJ Exec] risk and would try to NJ Exec Order 26.4b1 They said the family of the resident requested the use of [NJ Exec Order 26] for the safety of the resident. LPN #4 said the resident had suffered no [NJ Exec] while residing at the facility. They said the consent signed by the family should be in the medical chart. LPN #4 was not able to find the consent form in the resident's chart. LPN #4 said they did not know where the consent forms were kept since they were not in the hard chart. During an interview on 11/09/2021 at 3:25 PM, the US FOIA (b)(6) stated all residents were screened for therapy upon admission. [NJ Exec Order 26] screened for [NJ Exec Order 26.4b1] and nursing determined if [NJ Exec Order 26] were [NJ Ex] when a resident was in bed and if [NJ Exec Order 26.4b1] were used. [NJ Exec] did not determine a resident's [NJ Exec Order] use. [NJ Exec Order 26] would be [NJ Ex] when a resident was in [NJ Exec] to keep a resident from [NJ Exec Order] The [US FOIA (b)] then stated residents had tried to [NJ Exec Or] over the [NJ Exec Order 26] and there was always the potential for [NJ Exec Or] with [NJ Exec O] There were no consents or formal assessments done to determine [NJ Exec Order] usage. During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no [NJ Exec Order 26] in the	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 18 building. The US FOIA (b)(6) then stated nursing should do a NJ Exec Order assessment for NJ Exec Order use; this assessment was implemented starting NJ Exec Order 26.4b1 because NJ Exec Order 26 were being investigated. The US FOIA (b)(6) further stated two NJ Exec Order 26 in the NJ Exec Order 26.4b1 would be a NJ Exec Order 26 if they were stopping a resident from NJ Exec Order 26.4b1 They were not coding NJ Exec Order 26 as a NJ Exec Order 26 on the MDS because residents used them for NJ Exec Order 26.4b1 NJ Exec Order use should be in the care plan and reviewed monthly. During an interview on 11/10/2021 at 12:00 PM, the US FOIA (b)(6)) stated there were no consents for NJ Exec Order 26 and they had NJ Exec Order 26.4b1 in the building. The US FOIA (b)(6) then stated a NJ Exec Order 26 was anything that NJ Exec Order 26 a resident's NJ Exec Order , and NJ Exec Order 26.4b1 would only be a NJ Exec Order 26 if they were preventing a resident from NJ Exec Order 26.4b1. If a resident attempted to NJ Exec Order , it could be more dangerous than if the NJ Exec Order was not there. During an interview on 11/10/2021 at 12:12 PM, the US FOIA (b)(6) stated facility staff should not put NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 because a resident could injure themself on the NJ Exec Order 26 Some CNAs would put both NJ Exec Order 26.4b1 for resident safety, but that was a NJ Exec Order 26 During an interview on 11/10/2021 at 1:26 PM, the US FOIA (b) stated they were not aware the facility did not have a system to assess residents, get consents, and monitor NJ Exec Order 26.4b1. This was important for consistency and resident safety, and a resident NJ Exec Order 26.4b1 . During an interview on 11/10/2021 at 1:40 PM, the US FOIA (b)(6) stated a NJ Exec Order 26 was anything that restricted a resident's NJ Exec Order 26.4b1. The facility just implemented a NJ Exec Order assessment on NJ Exec Order 26.4b1 and would start getting consents for NJ Exec Order use. The US FOIA (b)(6) then stated it was important to assess residents and get consents so the resident and family could know the risks and benefits of NJ Exec Order use. They needed to make sure a NJ Exec Order 2 was the safest recommendation for each resident. A review of the undated facility policy titled, "Policy and Procedures for Restraints," revealed the	F0604		12/15/2021

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 11/16/2021

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
F0604 SS = E	Continued from page 19 facility's "processes will address the use of restraints. These processes will recognize and protect residents' rights and ensure that when used, the restraints are safe and appropriate based upon a documented medical symptom. These processes utilize the key elements of care planning and delivery of the individually established plan of care that includes thorough assessments by interdisciplinary team member." A review of the facility's policy titled, "Department of Nursing: Side Rails," dated 02/26/2009, revealed, "All residents will be assessed by the nurse for safe use of side rails upon admission and readmission." New Jersey Administrative Code 8:39-4.1(a) 6	F0604		12/15/2021
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F0656	Criteria 1: The facility failed to develop and implement a comprehensive care plan for 5 residents #134, #25, #96, #133 and #89 as evidenced by not indicating in the care plan the number of side rails in use. Care plans were reviewed and revised as necessary and staff education was provided. Criteria 2: All residents are at risk for this deficient practice. Criteria 3: Policies and procedures were reviewed and revised as necessary. Staff were provided education to ensure that each resident has a comprehensive care plan in place and that it is followed to meet each resident individual needs. MDS Coordinator, or designee, will review all resident care plans on admission and quarterly thereafter for compliance. Criteria 4: The Director of Nursing, or designee will conduct audits on all new admissions to ensure that care plans are in place and are followed. Additionally, the Director of Nursing, or designee, will conduct monthly audits to ensure care plans are in place, up to date and followed. These results will be reviewed during the facility's QAPI meetings monthly for three months and quarterly thereafter.	12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 20 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to develop and implement a comprehensive care plan for five (Resident #134, Resident #25, Resident #96, Resident #133, and Resident #89) of 30 residents reviewed for care planning. Findings included: 1. The facility admitted Resident #134 with diagnoses of, NJ Exec Order 26.4b1 [redacted] A review of Resident #134's quarterly Minimum Data Set (MDS), dated NJ Exec Order 26.4b1, revealed Resident #134's NJ Exec Order 26.4b1 [redacted]. Resident #134 required NJ Exec Order 26.4b1 [redacted]. Further review of Resident #134's MDS revealed a NJ Exec Order[illegible] was not used. A review of Resident #134's care plan, dated NJ Exec Order 26.4b1, revealed a focus of NJ Exec Order 26.4b1 with an intervention in place to use NJ Exec Order 26.4b1 when in bed. The use of NJ Exec Order 26 was not listed as a focus or intervention on the care plan. A review of Resident #134's physician's consolidation of orders, dated NJ Exec Order 26.4 revealed an order started on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 on the bed for NJ Exec Order 26.4b1.	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 21 An observation on 11/08/2021 at 10:30 AM revealed Resident #134 lying on their back in bed. A NJ Exec Order 2 was in place on both sides of Resident #134. There was a NJ Exec in place over each NJ Exec Order 26 An observation on 11/08/2021 at 10:45 AM revealed Resident #134 lying on their back, NJ Exec Order to the NJ Exe. A NJ Exec Order 26.4b1 was in place on both NJ Exec Or of Resident #134. There was a NJ Exec in place over each NJ Exec Order 26 An observation on 11/09/2021 at 12:15 PM revealed Resident #134 lying on their back, NJ Exec Order to the NJ Exec A NJ Exec Order 26.4b1 was in place on both sides of Resident #134. There was a NJ Exec in place over each NJ Exec Order 2. During an interview on 11/09/2021 at 12:35 PM, Certified Nurse Aide (CNA) #1 stated Resident #134 was NJ Exec Order 26.4b during care and NJ Exec Order 26.4b1 Resident #134 could NJ Exec Order 26.4b to NJ Exec while in NJ Exec O and the NJ Exec Order 26.4b were NJ Exec Order 2 for NJ Exec Order 26.4b from NJ Exec Ord CNA #1 further stated they did not know if Resident #134 NJ Exec Order 26.4b1, but the resident had NJ Exec Order 26.4b1 the NJ Exec Order 2 During an interview on 11/09/2021 at 2:10 PM, CNA #2 stated Resident #134's NJ Exec Order 26 were NJ Exec Order 2 because the resident was so NJ Exec Order 26.4b and would NJ Exec Ord while in NJ Exec O The NJ Exec Order 26.4b1 were in place to protect Resident #134 from NJ Exec Order 26.4b1. CNA #2 then stated there was an NJ Exec Order 26.4b1 on the NJ Exec Order 2 of Resident #134's NJ Exec Order 26.4b1 telling staff the NJ Exec Order 26.4b1 needed to be NJ Exe but there was not an NJ Exec Ord on the NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 CNA #2 did not know why NJ Exec Order 26.4b1 were NJ Ex while Resident #134 was in the bed. During an interview on 11/09/2021 at 2:35 PM, Registered Nurse (RN) #1 stated Resident #134 had NJ Exec Order 26.4b1 while in bed because Resident #134 was NJ Exec Order 2 and NJ Exec Order 26.4b1. Resident #134 did not try NJ Exec Order 26.4b1, but Resident #134 was a NJ Exec Order 2 risk. During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no NJ Exec Order 26.4 in the building. The US FOIA (b)(6) then stated nursing	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 22 should do a [NJ Exec Order] assessment for siderail use; this assessment was implemented starting [NJ Exec Order 26.4b1] because [NJ Exec Order 26] were being investigated. They were not coding [NJ Exec Order 26] as a [NJ Exec Order 26] on the MDS because residents used them for [NJ Exec Order 26.4b1]. The US FOIA (b)(6) stated [NJ Exec Order] use should have its own care plan but sometimes it was just listed in the interventions for other focus care areas. During an interview on 11/10/2021 at 2:45 PM at 2:45 PM, the US FOIA (b)(6)) stated they expected a resident's care plan to be up to date and followed. The individualized care plan was in place so staff could recognize resident needs and provide individualized care based on personalized needs and preferences. During an interview on 11/10/2021 at 2:50 PM, the US FOIA (b)(6) stated the expectation was that a resident's care plan was followed to ensure the best quality of care. Care plans needed to be individualized to each resident to ensure the physician's orders were followed to maintain optimum health. A review of the facility's policy titled, "Department of Nursing: Care Planning," dated 08/13/2009, revealed, "All residents will have an interdisciplinary care plan in conjunction with all MDS assessments." 2. The facility admitted Resident #25 with diagnoses of NJ Exec Order 26.4b1 A review of Resident #25's annual Minimum Data Set (MDS), dated [NJ Exec Order 26.4b1] revealed a Brief Interview of Mental Status (BIMS) score of [NJ E] indicating NJ Exec Order 26.4b1. Resident #25 required NJ Exec Order 26.4b1 with [NJ Exec O]. Further review of Resident #25's MDS revealed a [NJ Exec Order] was not used. A review of Resident #25's care plan, dated [NJ Exec Order 26.4b1] revealed a focus of activities of daily living (ADL) function. Resident #25 required NJ Exec Order 26.4b1 with [NJ Exec Order 26.4b1] with an intervention of [NJ Exec Order 26.4b1] when in bed to aid in [NJ Exec Order 26.4b1]	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 23 A review of Resident #25's care plan, dated [redacted], revealed a focus of history of [redacted]. Resident #25 was a [redacted] assessment, [redacted], and [redacted] with an intervention of [redacted] when in bed for [redacted]. A review of Resident #25's physician's orders, dated [redacted] revealed an order started on [redacted] for [redacted] for [redacted]. An observation on 11/09/2021 at 12:14 PM revealed Resident #25 lying in bed, [redacted] to the [redacted], and [redacted] were in the [redacted] on each side of Resident #25. The bed was in the [redacted], with [redacted] on each [redacted] of the bed. During an interview on 11/09/2021 at 12:40 PM, Certified Nurse Aide (CNA) #1 stated Resident #25 [redacted], which was why the [redacted] and [redacted] were in place for the resident's safety. An observation on 11/09/2021 at 2:08 PM revealed Resident #25 lying in bed, [redacted] to the [redacted] were in the [redacted] on each [redacted] of the resident. Resident #25's [redacted] were [redacted] and [redacted] on the [redacted]. During an interview on 11/09/2021 at 2:11 PM, CNA #2 stated when Resident #25 was in bed, the [redacted] are in the [redacted] and [redacted] are on the floor because Resident #25 tried to [redacted] of bed. The [redacted] kept Resident #25 in the bed. CNA #2 further stated Resident #25 tried to [redacted] of the bed [redacted] between the end of the [redacted] and the [redacted] of the bed. CNA #2 further stated a resident's care plan reflects whether a resident should have [redacted]. There was an [redacted] on either the [redacted] or [redacted] of the [redacted] telling staff which [redacted] needed to be raised. CNA #2 further stated they did not know why both [redacted] were in the [redacted] when Resident #25 had only [redacted] on the [redacted] of the [redacted]. During an interview on 11/09/2021 at 2:35 PM,	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 24 Registered Nurse (RN) #1 stated Resident #25 had a NJ Exec Order 26.4b1 Resident #25 would also NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 through the NJ Exec Order 26.4b1 of the NJ Exec Order and the NJ Exec Order 26.4b RN #1 further stated Resident #25 had been found on the NJ Exec O at the NJ Exec of the NJ Exec but had NJ Exec Order 26.4b1 During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no restraints in the building. The US FOIA (b)(6) then stated nursing should do a NJ Exec Order assessment for NJ Exec Order use; this assessment was implemented starting NJ Exec Order 26.4b1 because NJ Exec Order 26 were being investigated. They were not coding NJ Exec Order 26 as a NJ Exec Order 26 on the MDS because residents used them for NJ Exec Order 26.4b1 The US FOIA (b)(6) stated NJ Exec Order use should have its own care plan but sometimes it was just listed in the interventions for other focus care areas. During an interview on 11/10/2021 at 2:45 PM at 2:45 PM, the US FOIA (b)(6)) stated they expected a resident's care plan to be up to date and followed. The individualized care plan was in place so staff could recognize resident needs and provide individualized care based on personalized needs and preferences. During an interview on 11/10/2021 at 2:50 PM, the US FOIA (b)(6) stated the expectation was that a resident's care plan was followed to ensure the best quality of care. Care plans needed to be individualized to each resident to ensure the physician's orders were followed to maintain optimum health. A review of the facility's policy titled, "Department of Nursing: Care Planning," dated 08/13/2009, revealed, "All residents will have an interdisciplinary care plan in conjunction with all MDS assessments." 3. The facility admitted Resident #96 with diagnoses of NJ Exec Order 26.4b1 .	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 25 A review of Resident #96's quarterly Minimum Data Set (MDS), dated [NJ Exec Order 26.4b1] revealed a Brief Interview for Mental Status (BIMS) score of [NJ] indicating NJ Exec Order 26.4b1. Further review of Resident #96's MDS revealed a [NJ Exec Order 2] was not used. A review of Resident #96's care plan, dated [NJ Exec Order 26.4b1], revealed a focus of [NJ Exec Order 26.4b1] with an intervention of a [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b1] when in bed. The use of [NJ Exec Order 26] was not listed as a focus or intervention on the care plan. A review of Resident #96's physician's orders, dated [NJ Exec Order 26.] revealed an order started on [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1] An observation on 11/08/2021 at 10:30 AM revealed Resident #96 lying in bed with [NJ Exec Order 26.4b1] in the [NJ Exec Order 26.4b1]. Resident #96 was [NJ Exec Order] their [NJ Exec O] on [NJ Exec] of the [NJ Exec Order 26.], and no [NJ Exec Order 26] was present on the [NJ Exec O]. An observation on 11/08/2021 at 12:15 PM revealed Resident #96 lying in bed with [NJ Exec Order 26.4b1] in the [NJ Exec Order 26.4b1]. An observation on 11/08/2021 at 3:07 PM revealed Resident #96 lying in bed with [NJ Exec Order 26.4b1] in the [NJ Exec Order 26.4b1]. During an interview on 11/09/2021 at 12:28 PM, Certified Nurse Aide (CNA) #1 stated the [NJ Exec Order 26] were in the [NJ Exec Order 26.4b1] to prevent Resident #96 from NJ Exec Order 26.4b1. Resident #96 had never tried to NJ Exec Order 26.4b1. During an interview on 11/09/2021 at 1:05 PM, CNA #7 stated the [NJ Exec Order 26.4b1] were in the [NJ Exec Order 26.4b1] because Resident #96 was [NJ Exec Order 26.] and would try to NJ Exec Order 26.4b1. During an interview on 11/09/2021 at 2:15 PM, CNA #2 stated Resident #96 NJ Exec Order 26.4b1 on their own, and the [NJ Exec Order 26.4b1] were in the [NJ Ex] for safety.	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 26 An observation on 11/09/2021 at 2:27 PM revealed [redacted] on either side of the [redacted] indicating which [redacted] was to be in the [redacted]. During an interview on 11/09/2021 at 2:35 PM, Registered Nurse (RN) #1 stated the [redacted] were in the [redacted] because Resident #96 tried to [redacted]. RN #1 further stated the [redacted] were in place because if a resident [redacted] on the [redacted]. During an interview on 11/10/2021 at 10:24 AM, the [redacted] stated they had no restraints in the building. The [redacted] then stated nursing should do a [redacted] assessment for [redacted] use; this assessment was implemented starting [redacted] because [redacted] were being investigated. They were not coding [redacted] as a [redacted] on the MDS because residents used them for [redacted]. The [redacted] stated [redacted] use should have its own care plan but sometimes it was just listed in the interventions for other focus care areas. During an interview on 11/10/2021 at 2:45 PM at 2:45 PM, the [redacted]) stated they expected a resident's care plan to be up to date and followed. The individualized care plan was in place so staff could recognize resident needs and provide individualized care based on personalized needs and preferences. During an interview on 11/10/2021 at 2:50 PM, the [redacted] stated the expectation was that a resident's care plan was followed to ensure the best quality of care. Care plans needed to be individualized to each resident to ensure the physician's orders were followed to maintain optimum health. A review of the facility's policy titled, "Department of Nursing: Care Planning," dated 08/13/2009, revealed, "All residents will have an interdisciplinary care plan in conjunction with all MDS assessments." 4. The facility admitted Resident #89 with diagnoses that included [redacted]. The admission Minimum Data Set (MDS), dated [redacted], revealed the resident's Brief Interview	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 27 for Mental Status (BIMS) score was [redacted] which indicated NJ Exec Order 26.4b1. The resident required NJ Exec Order 26.4b1 [redacted] were not indicated for use on the MDS. The NJ Exec Order 26.4b1 computerized physician orders (CPO) revealed and order with a start date of [redacted] for NJ Exec Order 26.4b1 in bed for [redacted] The revised care plan, updated [redacted], revealed the resident had a NJ Exec Order 26.4b1 and [redacted] Interventions included pad to [redacted] used and NJ Exec Order 26.4b1 and monitor for complications caused by NJ Exec Order 26.4b1. The care plan did not specify how many [redacted] to use according to the physician's orders. Resident #89 was observed on 11/08/2021 at 9:24 AM, 11:02 AM, and 2:26 PM with NJ Exec Order 26.4b1 while the resident was in bed. Both [redacted] Only [redacted] was ordered for use. Observations on 11/09/2021 at 10:00 AM and 2:30 PM revealed NJ Exec Order 26.4b1 were [redacted] and [redacted] while the resident was in bed. Only [redacted] was ordered for use. On 11/08/2021 at 2:30 PM, NJ Exec Order 26.4b1 was observed on the [redacted] of the bed, indicating to floor staff that only the NJ Exec Order 26.4b1 should be used when the resident was in bed. An interview with Licensed Practical Nurse (LPN) #4, on 11/09/2021 at 2:43 PM, revealed [redacted] were used for residents who had NJ Exec Order 26.4b1 or [redacted] LPN #4 said some residents used [redacted]. They said there were [redacted] stickers on the side of the [redacted] that indicated which [redacted] to have [redacted]. They said physician orders and consent were needed for residents to use bed rails. LPN #4 said nursing and the [redacted] department assessed the resident's need for [redacted] They said [redacted] were included in the resident's care plan and included the reason for and number of [redacted]. LPN #4 said Resident #89 had a	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 28 NJ Exec Order 26.4b1 and had orders for NJ Exec Order 26.4b1 to be up for NJ Exec Order 26.4b1. They said the resident should not have NJ Exec Order 26.4b1. During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no NJ Exec Order 26.4 in the building. The US FOIA (b)(6) then stated nursing should do a NJ Exec Order assessment for NJ Exec Order use; this assessment was implemented starting NJ Exec Order 26.4b1 because NJ Exec Order 26 were being investigated. They were not coding NJ Exec Order 26 as a NJ Exec Order 26 on the MDS because residents used them for NJ Exec Order 26.4b1. The US FOIA (b)(6) stated NJ Exec Order use should have its own care plan but sometimes it was just listed in the interventions for other focus care areas. During an interview on 11/10/2021 at 2:45 PM at 2:45 PM, the D US FOIA (b)(6) stated they expected a resident's care plan to be up to date and followed. The individualized care plan was in place so staff could recognize resident needs and provide individualized care based on personalized needs and preferences. During an interview on 11/10/2021 at 2:50 PM, the US FOIA (b)(6) stated the expectation was that a resident's care plan was followed to ensure the best quality of care. Care plans needed to be individualized to each resident to ensure the physician's orders were followed to maintain optimum health. A review of the facility's policy titled, "Department of Nursing: Care Planning," dated 08/13/2009, revealed, "All residents will have an interdisciplinary care plan in conjunction with all MDS assessments." 5. The facility admitted Resident #133 with diagnoses that included NJ Exec Order 26.4b1. The significant change Minimum Data Set (MDS), dated NJ Exec Order 26.4b1, revealed the resident's Brief Interview for Mental Status (BIMS) score was three, which indicated NJ Exec Order 26.4b1. The resident required NJ Exec Order 26.4b1. The resident had NJ Exec Order during the previous quarter but was an identified NJ Exe risk. Bed rail use was not indicated on the resident's MDS.	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 29 The NJ Exec Order 26.4b1 computerized physician orders (CPO) revealed and order with a start date of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 in bed for NJ Exec Order 26.4b1 every day. The revised care plan, updated NJ Exec Order 26.4b1, revealed NJ Exec Order 26 were not included in the resident's care plan as a focus or intervention. Resident #133 was observed on NJ Exec Order 26.4b1 at 9:26 AM, 11:00 AM, and 2:28 PM with both NJ Exec Order 26.4b1 while the resident was in bed. Observations on 11/09/2021 at 10:03 AM and 2:32 PM revealed NJ Exec Order 26.4b1 while the resident was in bed. On 11/09/2021 at 2:32 PM, two arrow stickers were observed on either side of the bed, indicating to floor staff that both NJ Exec Order 26 should be used when the resident was in bed. Observations on 11/10/2021 at 9:03 AM and 2:18 PM revealed both NJ Exec Order 26.4b1 while the resident was in bed. An interview with Licensed Practical Nurse (LPN) #4, on 11/09/2021 at 2:43 PM, revealed NJ Exec Order 26 were used for residents who had NJ Exec Order 26.4b1 LPN #4 said some residents used NJ Exec Order 26 . They said there were NJ Exec Ord stickers on the side of the NJ Exec Order 26.4b1 that indicated which NJ Exec Order 2 to have NJ Exec Order They said physician orders and consent were needed for residents to use NJ Exec Order 26. LPN #4 said nursing and the therapy department assessed the resident's need for NJ Exec They said NJ Exec Order 26 were included in the resident's care plan and included the reason for and number of NJ Exec Order 26. LPN #4 said Resident #133 was a NJ Exe risk and would NJ Exec Order 26.4b1 They said the family of the resident requested the use of NJ Exec Order 26 for the safety of the resident. LPN #4 said the resident had suffered no NJ Exec while residing at the facility. During an interview on 11/10/2021 at 10:24 AM, the US FOIA (b)(6) stated they had no NJ Exec Order 26.4 in the	F0656		12/15/2021

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 11/16/2021

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
F0656 SS = E	Continued from page 30 building. The US FOIA (b)(6) then stated nursing should do a NJ Exec Order assessment for siderail use; this assessment was implemented starting NJ Exec Order 26.4b1 because NJ Exec Order 2 were being investigated. They were not coding NJ Exec Order 26 as a restraint on the MDS because residents used them for NJ Exec Order 26.4b1 The US FOIA (b)(6) stated siderail use should have its own care plan but sometimes it was just listed in the interventions for other focus care areas. During an interview on 11/10/2021 at 2:45 PM at 2:45 PM, the US FOIA (b)(6)) stated they expected a resident's care plan to be up to date and followed. The individualized care plan was in place so staff could recognize resident needs and provide individualized care based on personalized needs and preferences. During an interview on 11/10/2021 at 2:50 PM, the US FOIA (b)(6) stated the expectation was that a resident's care plan was followed to ensure the best quality of care. Care plans needed to be individualized to each resident to ensure the physician's orders were followed to maintain optimum health. A review of the facility's policy titled, "Department of Nursing: Care Planning," dated 08/13/2009, revealed, "All residents will have an interdisciplinary care plan in conjunction with all MDS assessments." New Jersey Administrative Code 8:39-11.1	F0656		12/15/2021
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:	F0880	Criteria 1: The facility failed to properly clean the NJ Exec Order 26.4b1 used for residents #64 and #82. The nurse involved was educated on NJ Exec Order 26.4b1 cleaning protocols and the NJ Exec Order 26.4b1 in question was cleaned properly. The facility failed to maintain the clean area as evidenced by a nursing assistant exiting the isolation area without doffing PPE. The nursing assistant was re-educated on the proper use of PPE donning and doffing. Criteria 2: All residents are at risk for these deficient practices. Criteria 3: All infection control policies and procedures related to PPE usage and glucometer cleaning were reviewed and revised as necessary.	12/15/2021

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 11/16/2021

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
F0880 SS = E	Continued from page 31 §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 services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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.	F0880	Continued from page 31 All staff were re-educated on donning and doffing of PPE and when/where to use PPE to mitigate the transmission of infection. All licensed nursing personnel were educated on the proper cleaning of glucometers. Criteria 4: The Infection Control Preventionist or designee will conduct weekly PPE usage audits for all departments and of licensed personnel properly cleaning glucometers. Results of both of these audits will be reviewed during the facility's QAPI meetings monthly for three months and quarterly thereafter. Additionally, a Directed Plan of Correction has been submitted to NJ DOH. Directed In-service Training has been provided to staff as outlined below: Module 1-Infection Prevention and Control Program for Topline Staff. Keep Covid-19 Out!-for all staff Use PPE Correctly for Covid-19-all staff Module 5 Outbreaks-Topline staff Module 11B-Environmental Cleaning and Disinfection-all staff Module 6B-Principles of Transmission Based Precautions-all staff Module 11A-Preprocessing Reusable Resident Care Equipment-all staff A Root Cause Analysis has been conducted and submitted to NJ DOH. Identified Problem: 1. During DOH Federal Recertification and Covid-19 Focused Infection Control Survey was completed on 11/16/2021 it was identified by the surveyor that the nurse failed to clean the [redacted] NJ Exec Order 26.4b1 used to test [redacted] NJ Exec Order 26.4b1 for two of two residents during med pass. The surveyors found this to be deficient practice and cited the facility with a level E deficiency in the area of Infection Control. 2. During the same time period the facility failed to maintain the integrity of the clean area of an isolation unit by CNA exiting the isolation area	12/15/2021

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 11/16/2021

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
F0880 SS = E	Continued from page 32 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 and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews, it was determined that the facility failed to clean the [redacted] used to test [redacted] for two of two residents (Resident #64 and Resident #82) during medication pass. The facility also failed to maintain the integrity of a clean area of the unit by exiting the isolation area without discarding their personal protective equipment (PPE) and by removing resident's water pitchers for one of one isolation unit observed (second floor). This deficient practice occurred during the [redacted] and had the potential to affect all residents. Findings included: 1. The facility admitted Resident #82 on [redacted] with diagnoses that included [redacted]. Review of the current physician's orders included directions for the staff to check the resident's [redacted] before meals and at bedtime. On 11/09/2021 at 8:33 AM, Registered Nurse (RN) #1 was observed taking the [redacted] out of the medication cart. Taking the [redacted] to Resident #82 with gloves on, the nurse performed the [redacted] for Resident #82. RN #1 then took the [redacted] and placed the [redacted] onto the medication cart top. She removed her gloves and placed the gloves and the [redacted] into the sharps container. RN #1 then donned gloves, removed an alcohol pad from the medication cart, opened the pad and cleaned the [redacted] She placed the [redacted] on the top of the medication cart and disposed of the gloves. When interviewed at this time, RN #1 stated she was unsure of what bacteria and viruses the alcohol wipe killed. RN #1 stated this was her normal way of cleaning the [redacted] RN #1 was then observed going into Resident #64's room. RN #1 took the [redacted] into Resident	F0880	Continued from page 32 without discarding their PPE and by removing the residents water pitcher for one of one isolation units. The surveyors found this to be deficient practice and cited the facility with a level E deficiency in the area of Infection Control. RCA Performance Team Members: Administrator, Medical Director, Assistant Administrator, Director of Nursing, Infection Control Preventionist, Assistant Director of Nursing, CNA, Nurse Investigation: 1. Daughters of Israel concluded that the staff member in question was deficient in following the guidelines for proper use, cleaning, and maintenance of [redacted] Staff member stated that she is aware of procedure but was [redacted] while under observation by surveyor and did not follow protocols for cleaning the [redacted] All other staff members interviewed were aware of proper procedure. All licensed staff were re-educated and in-serviced on proper protocols and practice. 2. Daughters of Israel concluded that the staff member in question was deficient in following the guidelines for proper use of PPE, despite being educated and knowing the proper procedures. She thought that she could leave the area briefly as long as she was quick about it. Nursing assistant was notified that this was a deficient and unacceptable practice and she received disciplinary action. All staff were reeducated on proper protocols and practice and in-serviced that breaks in infection control could have serious outcomes for our residents and would not be tolerated. All other staff members interviewed were aware of proper procedure and understanding of rationale behind them. Corrective Action: 1. Daughters Infection Control Committee reviewed and revised its policies and procedures for glucometer use, proper cleaning of medical equipment. All licensed staff have been in-serviced with this procedure. 2. The identified nurse was educated 1:1 on the proper policy and procedure for glucometer use, cleaning and maintenance. 3. Daughters Infection Control Committee reviewed and revised its polices and procedures for PPE use; proper donning and doffing of PPE to maintain the integrity of the clean area. All staff have the been in-serviced with this procedure. 4. The identified C.N.A. that was not following the guidelines of maintaining the integrity of the clean area was educated and disciplined for her deficient practice. Measure of Success: 1. The Infection	12/15/2021

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 11/16/2021

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
F0880 SS = E	Continued from page 33 #64's room, completed the NJ Exec Order 26.4b1 test, and then placed the NJ Exec Order 26.4b1 on top of the medication cart. RN #1 removed her gloves and then donned a clean set of gloves. The nurse wiped the NJ Exec Order 26.4b1 with two alcohol wipes and then placed the NJ Exec Order 26.4b1 back on top of the medication cart. After removing the gloves, RN #1 placed the NJ Exec Order 26.4b1 in the top drawer of the medication cart. Licensed Practical Nurse (LPN) #5 was interviewed on 11/10/2021 at 10:30 AM. LPN #5 stated a special cleaning wipe stored in a purple plastic tub was used to clean NJ Exec Order 26.4b1 The LPN removed the plastic tub of wipes from the bottom drawer of the medication cart and showed a tub of Germicidal Disinfectant wipes and explained the wipes had bleach in them. LPN #5 stated after using a NJ Exec Order 26.4b1 the staff were expected to wipe the NJ Exec Order 26.4b1 with the disinfectant cloth, cover the NJ Exec Order 26.4b1 with the cloth for a specified amount of time, but could not give the specified time, and then allow the NJ Exec Order 26.4b1 to dry before using it on another resident. The US FOIA (b)(6)) was interviewed on 11/10/2021 at 12:12 PM. The US FOIA (b)(6) identified themself as the US FOIA (b)(6) for the facility. The US FOIA (b)(6) stated staff were expected to use the wipes containing bleach when cleaning the NJ Exec Order 26.4b1 The US FOIA (b)(6) added after cleaning the NJ Exec Order 26.4b1 staff should allow the NJ Exec Order 26.4b1 to air dry before completing a NJ Exec Order 26.4b1 test on the next resident. The US FOIA (b)(6) stated alcohol wipes should not be used since the alcohol wipes were an antiseptic agent (a cleaning agent used to reduce organisms and reduce the chance of infection) and not a germicidal agent (a cleaning agent that kills bacteria and viruses). The US FOIA (b)(6)) was interviewed on 11/11/2021 at 9:48 AM. The US FOIA (b) stated staff had been taught and were expected to use wipes that contained bleach to clean glucometers. The US FOIA (b) stated since NJ Exec Or could not always be visualized on the NJ Exec Order 26.4b1 an agent that killed germs needed to be used. The US FOIA (b) stated an alcohol wipe would not be effective in cleaning the NJ Exec Order 26.4b1 The US FOIA (b)(6) was interviewed on 11/11/2021 at 10:30 AM. She stated her expectation included staff following the facility's policy to clean NJ Exec Order 26.4b1	F0880	Continued from page 33 Control Preventionist or designee will perform weekly observations of licensed staff maintaining proper infection control protocols with glucometer use, maintenance, and cleaning. Any corrections needed will take place on the spot. Results of these observations will be reported to the facility's QAPI committee monthly for three months and quarterly thereafter. 2. The Infection Control Preventionist or designee will perform weekly observation when infection control guidelines dictate that PPE and donning and doffing correctly. Any corrections needed will take place on the spot. Results of these observations will be reported to the facility's QAPI committee monthly for three months and quarterly thereafter.	12/15/2021

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 11/16/2021

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
F0880 SS = E	Continued from page 34 Review of the facility's policy, "Extended Precautions", revised July 2019 indicated, "shared equipment (Accucheck [glucometer] machine, pulse oximeter, etc.) must be cleaned and disinfected (with Dispatch---see policy and procedure) according to the manufacturer's recommendation, prior to use with another resident." Review of the "Assure Platinum Blood Glucose Monitoring System" user instruction manual indicated on page 47, that the glucometer could be cleaned and disinfected using a "commercially available EPA-registered disinfectant detergent or germicidal wipe". 2. On 11/08/2021, 11/09/2021, 11/10/2021, and 11/11/2021, a plastic barrier curtain with a zippered opening was observed on the second floor on the right side of the elevator entrance. On the plastic curtain were signs that indicated the resident care area behind the plastic zippered curtain was an isolation area. Signs on the plastic barrier curtain indicated all personal protective equipment (PPE) should be used. A cart with PPE was observed sitting at the edge of the closed curtain. The cart was filled with gowns available for staff use. On the resident care side of the plastic zippered barrier was a large trash receptacle that was easily available for staff use. Observations were made during the initial tour of the isolation unit on 11/08/2021 of staff going in and out of the plastic barrier curtain without removing their PPE although there was a trash can on the "dirty" side of the plastic curtain. On 11/09/2021 at 2:45 PM, observations were made of Certified Nursing Assistant (CNA) #9 going from the resident care isolation area through the plastic zippered barrier without removing her gown. The CNA was observed going to the kitchen area of the unit and returned to the resident care isolation unit with the gown remaining in place. On 11/10/2021 at 9:26 AM, CNA #9 was observed leaving the resident isolation unit wearing her isolation gown. The CNA had a resident's water pitcher in her hand. The CNA unzipped the plastic barrier and took the water pitcher to the kitchen area of the unit and then returned through the plastic	F0880		12/15/2021

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 11/16/2021

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
F0880 SS = E	Continued from page 35 barrier and into the resident isolation area. At this time, the CNA acknowledged she had removed a resident's water pitcher from the isolation area of the unit, taken the pitcher to the kitchen which was not included in the isolation area, filled the pitcher with ice and water and returned. CNA #9 was able to explain the plastic zippered barrier was placed to separate the isolation area from the area that was not on isolation. The CNA was able to explain the trash bin was there for staff to use for PPE. CNA #9 stated they had been taught the only time PPE had to be removed was when staff left the second floor and went to another floor. The CNA was unable to remember who had taught that. On 11/10/2021 at 9:30 AM, CNA #2 was seen wearing PPE as they unzipped the plastic barrier and exited to the kitchen area. On return, the CNA did not use hand sanitizer and was carrying a box of cereal and a spoon they retrieved from the kitchen area. The CNA stated the plastic barrier was to keep the germs from the isolation area apart from the rest of the unit and the trash bin was for disposal of PPE prior to leaving the unit. When asked, the CNA stated a nurse (could not identify the nurse) had told the CNA that PPE was okay to wear beyond the plastic barrier and into the kitchen and then return to the isolation unit. Licensed Practical Nurse (LPN) #5 was interviewed on 11/10/2021 at 10:30 AM. LPN #5 reported having worked several days in the residential isolation unit. The LPN stated the plastic barrier with a zipper had been placed due isolation initiation after a co-worker had tested NJ Exec Order 26.4b1. The nurse stated the trash bin was by the curtain so PPE could be disposed of before leaving the unit. LPN #5 added all gowns should be removed before exiting the isolation unit, even if the staff were going to the kitchen area of the unit that was outside the curtain. On return, staff were expected to don a new gown and use hand sanitizer before entering the isolation unit. The US FOIA (b)(6) was interviewed on 11/10/2021 at 12:12 PM. The US FOIA (b)(6) stated they functioned as the US FOIA (b)(6) (IP) for the facility as well. The [redacted] stated the zippered plastic barrier had been installed to provide isolation after the residents had a NJ Exec Order 26.4b1 to a staff member with NJ Exec Order 26.4b1 The US FOIA (b)(6) added the purpose of the plastic barrier was to provide a division between the "dirty" area where the	F0880		12/15/2021

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 11/16/2021

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
F0880 SS = E	Continued from page 36 residents lived and the "clean" area which was where the dining area and kitchen were located. The [redacted] added the expectation was for staff to doff their gowns prior to leaving the isolation unit and dispose of the gowns in the trash bin by the curtain. On return to the isolation unit staff should don a new gown and use hand sanitizer. The [redacted] stated as the facility's [redacted] the expectation was that staff follow the generally accepted practice for donning and doffing PPE in an isolation area. The [redacted] was interviewed on 11/11/2021 at 9:48 AM. The [redacted] stated the isolation unit started as staff walked through the zippered plastic barrier. The [redacted] added that gowns were available as soon as staff arrived on the unit and staff were expected to have gowns on before entering through the zippered plastic barrier. On exiting the unit, the [redacted] stated staff were expected to remove the gown and place the gown in the trash bin before passing through the zippered plastic barrier. The [redacted] added residents' water pitchers should not be taken outside of the isolation area since this would contaminate the clean area including the dining area and the kitchen. The [redacted] was interviewed on 11/11/2021 at 10:30 AM and verbalized the expectation that staff were to follow the infection control policy and guidelines for isolation. New Jersey Administrative Code § 8:39-19.4(a)1-6	F0880		12/15/2021
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	F0761	Criteria 1: The facility failed to keep medications separated by route of administration. All medications in question were properly re-placed in the medication cart. All medication carts were audited and medications were placed in the proper sections for storage. Criteria 2: All residents are at risk for this deficient practice. Criteria 3: All policies and procedures pertaining to medication storage were reviewed and revised as necessary. All licensed nursing personnel were re-educated on proper medication storage. Criteria 4: Weekly random audits of proper labeling and storage of medications will be conducted by the	12/10/2021

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 11/16/2021

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
F0761 SS = D	Continued from page 37 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 observations, interviews, and facility policy review, it was determined that the facility failed to keep medications separated by route of administration in two of four medication carts observed (cart 2A and cart 2B). Findings included: 1. During a concurrent observation and interview regarding medication cart A on 11/09/2021 at 8:19 AM, a container of suppositories was seen placed on top of a box of medication to be taken by mouth. Registered Nurse (RN) #1 stated that she always stored medications of different routes this way. On 11/09/2021 at 8:50 AM, an observation was made of the drawers inside medication cart B. Section 1 of cart B contained: - Ophthalmic (eye) ointment - Oral drops - Eye drops Section 2 of cart B contained: - Caltrate soft chews (calcium supplement) - Bioene mouth spray (for dry mouth)	F0761	Continued from page 37 ADON/designee for three months and monthly thereafter. The pharmacy consultant will continue monthly audits related to proper labeling and storage of medications. All audits will be reported to the facility's QAPI committee by the DON/designee monthly for three months and quarterly thereafter.	12/10/2021

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 11/16/2021

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
F0761 SS = D	Continued from page 38 - Restasis eye drops (for dry eyes) - Ocusoft lid scrub (to cleanse the eye lid) - Flonase nasal spray (for allergies) - Vitamin B12 for intramuscular injection (vitamin supplement) RN #2 was interviewed at the time of the observation and stated she had been taught medications should be stored by route of administration. RN #2 added that all nurses were responsible to make sure the different routes of medication were stored separately and stated she did not have time that morning to make sure the medication cart was in good order. The US FOIA (b)(6)) was interviewed on 11/10/2021 at 12:12 PM. The US FOIA (b)(6) stated medications should be stored in the medication cart by route of administration. She added that all eye drops should be stored together, all nasal sprays together and suppositories should be kept in the treatment cart and not with oral medications. The US FOIA (b)(6) stated she had seen the condition of the medication carts A and B and had arranged the medications by route after she had been notified by RN #1 and RN #2. The US FOIA (b)(6) was interviewed on 11/11/2021 at 9:58 AM. The US FOIA (b) stated she expected medications to be stored in different sections of the cart and grouped by route of administration. The US FOIA (b)(6) was interviewed on 11/11/2021 at 10:30 AM and stated she expected nursing staff to follow the facility's policy related to medication storage. Review of the facility's policy, "Medication Storage", with a review date of 11/2019, indicated "orally administered medications are kept separate from externally used medications such as suppositories,	F0761		12/10/2021

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 11/16/2021

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
F0761 SS = D	Continued from page 39 liquids, lotions and tablets. Eye medications are kept separate from ear medications." New Jersey Administrative Code § 8:39-5.1(a)	F0761		12/10/2021
F0812 SS = D	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, policy review, and review of the New Jersey Administrative Code (NJAC) 8:24 for food sanitation, it was determined that the facility failed to handle food in a sanitary and safe manner on one of the four observed halls (B hall-second floor) during the lunch meal. Facility staff were observed handling ready-to-eat food with their bare hands. Findings included: Reference: NJAC 8:24-3.3 Protection from contamination after receiving "(a) Requirements for preventing contamination from	F0812	Criteria 1: The facility failed to handle food in a safe and sanitary manner as evidenced by a nursing assistant serving without gloves. The nursing assistant in question was in-serviced on deficient practice and educated on safe food handling. Criteria 2: All residents are at risk for this deficient practice. Criteria 3: All policies and procedures were reviewed and revised as necessary and all staff were educated on safe food handling practices. New employee orientation will include safe food handling education and protocols. Food handling education and protocols will be added to the annual mandatory education in-service calendar. Criteria 4: The Infection Control Preventionist or Food Service Director or designee will conduct safe food handling audits two times per week via direct observation during meal service. The results will be reviewed during the facility's QAPI meetings monthly for three months and quarterly thereafter.	12/15/2021

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 11/16/2021

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
F0812 SS = D	Continued from page 40 hands include the following: 2. Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment, except when washing fruits and vegetables ..." 1. The facility admitted Resident #104 on 01/14/2019 with diagnoses that included NJ Exec Order 26.4b1 Resident #104's NJ Exec Order 26.4b1 the resident had NJ Exec Order 26.4b1 , scoring NJ E on the Brief Interview for Mental Status exam. The resident was identified on the MDS as requiring NJ Exec Order 26.4b1. On 11/09/2021 at 1:15 PM, Certified Nursing Assistant (CNA) #8 was observed serving the lunch meal to Resident #104. CNA #8 uncovered the resident's plate and then using their bare hand, passed Resident #104 a sandwich. CNA #8 was interviewed on 11/09/2021 while leaving Resident #104's room. CNA #8 stated they had washed their hands prior to going into the room and before touching the food. The CNA stated since they had washed their hands before going into the room, they saw no problem with touching Resident #104's sandwich with their bare hands. CNA #8 reported not receiving any training that indicated needing to wear gloves when touching other people's food. An interview was held with Registered Nurse (RN) #2 on 11/09/2021 at 1:35 PM. RN #2 stated any time residents' food was touched by staff serving the food, gloves should be worn. RN #2 stated it was never ok to touch another person's food with your bare hands because you would not want to cause cross contamination of germs. The US FOIA (b)(6)) was interviewed on 11/10/2021 at 12:12 PM. The US FOIA (b)(6) identified themself as the US FOIA (b)(6)) for the facility. The US FOIA (b)(6) stated bare hands should not be used to touch residents' food. The US FOIA (b)(6) added even if a staff member washed their hands prior to serving food, touching another person's food with bare hands was not acceptable. The US FOIA (b)(6) added touching another person's food with bare hands increased the risk of bacteria and virus transmission.	F0812		12/15/2021

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 11/16/2021

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
F0812 SS = D	Continued from page 41 The US FOIA (b)(6)) was interviewed on 11/11/2021 at 9:44 AM. The US FOIA (b) stated when food was touched, gloves should always be worn. The US FOIA (b)(6) was interviewed on 11/11/2021 at 10:30 AM. The US FOIA (b)(6) stated the expectation was for staff to follow the facility's policy on food handling. The facility's policy titled, "Food Handling Guidelines", revised 01/2021, indicated, "single use gloves are worn when preparing foods that will not be cooked again and while serving food". New Jersey Administrative Code 8:39-17.2(g)	F0812		12/15/2021

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 11/16/2021

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
S0000	Initial Comments No Information	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) (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 interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined the facility failed to maintain direct care staff-to-resident ratios as mandated by New Jersey State Law. This was evident for six out of 14 day shifts reviewed. This had the potential to affect all residents. Findings included: Reference: NJDOH memo, dated 01/28/2021, "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 nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid to every eight residents for the day shift. 1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 10/24/2021 - 11/06/2021, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: 10/24/2021: 14 CNAs for 137 residents on the day shift.	S0560	Criteria 1: The facility failed to maintain direct care staff to resident ratios. No residents were affected by this deficient practice on any of the identified days. Criteria 2: All residents have the potential to be affected by this deficient practice. Criteria 3: Facility will continue to advertise open positions, schedule interviews, and will continue to engage with staffing agencies to supplement staff as needed. Will also continue to converse with local educational institutions. Criteria 4: Staffing ratios will be reviewed by the DON or HR director on a daily basis. Results will be presented at the facility's QAPI meeting on a monthly basis for three months and quarterly thereafter.	12/15/2021

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: 030703	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/16/2021

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
S0560	Continued from page 1 10/25/2021: 16 CNAs for 137 residents on the day shift. 10/26/2021: 16 CNAs for 137 residents on the day shift. 10/29/2021: 17 CNAs for 137 residents on the day shift. 11/01/2021: 17 CNAs for 140 residents on the day shift. 11/03/2021: 17 CNAs for 141 residents on the day shift. During an interview with the Director of Nursing (DON), on 11/11/2021 at 11:26 AM, the DON stated Human Resources was offering incentives and higher pay, they were going to nursing schools to recruit, and the facility had signs posted in the community. She stated it had been difficult during the pandemic to retain nursing staff.	S0560		12/15/2021

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 **11/16/2021**

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
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 on 11/16/2021, and Daughters of Israel Pleasant Valley Home 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 Occupancies. Daughters of Israel Pleasant Valley Home is a 2 story Type II Protected building that was built in 1961. The skilled nursing facility is divided into 42 smoke zones.	K0000		

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 11/16/2021

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
E0000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E0000		

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