STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING _____ B. WING _____	C 10/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #s NJ 167267, 177553 STANDARD SURVEY: 10/10-10/18/24 CENSUS: 104 SAMPLE SIZE: 21+1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 577		12/15/24

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

Electronically Signed | 10/31/2024

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

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F 577	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the prior year's State of New Jersey (State) inspection results and post the location of those results in an area that was readily accessible to residents, families, and the public. The deficient practice was evidenced by the following. The surveyor conducted a group meeting on 10/16/24 at 11:00 AM with 6 alert and oriented residents chosen by the facility. Six of 6 residents stated they did not know where to find the State inspection results. The surveyor looked for the most recent State inspection results (8/10/23) on each of the 3 nursing units (LP, SP, HP) on 10/17/24 at 9:00 AM. The LP Nursing Station had a plastic binder holder affixed to the front wall of the station. The binder contained 2017 and 2018 State inspection results. The HP Nursing Station had no visible binder available at the station. The surveyor asked the nurse supervisor for the binder. The nurse looked for the binder and was unable to locate it. A few minutes later she located the binder in a closed closet behind the nursing station. The	F 577	POC F577 Criteria 1: The facility failed to maintain the prior year□s State of New Jersey inspection results and post the location of those results in an area that was readily accessible to residents, families and the public. Current survey books were placed in acrylic holders at wheelchair height on each unit as well as at the front desk. Criteria 2: All residents have the potential to be affected by this deficient practice Criteria 3: Policies and procedures were reviewed and revised, when necessary, All staff received education where the NJ state inspection results are located. Criteria 4: Units and front desk will be audited weekly by DON or designee for the accessibility of survey binders to ensure that guidelines are being met and results will be presented at the facility□s QAPI meetings monthly for three months and then quarterly thereafter for 1 year.	

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F 577	Continued From page 2 binder contained 2019 inspection results. The surveyor returned the binder to the nurse. She placed the book back into the closed closet behind the nursing station. The surveyor showed the binders to the U.S. FOIA (b) (6) [redacted]) on 10/17/24 at 9:15 AM while in the HP day room. The U.S. FOIA (b confirmed the most recent inspection results of 8/10/23 were not posted in the books. She stated she would update the binders. The U.S. FOIA (b returned to the surveyor on 10/17/24 at 9:30 AM. She stated the U.S. FOIA (b) (6) found current inspection reports on the nursing units in a pile of other binders on the counter of the nursing stations. The surveyor did not observe binders with current inspection results in an area that would be accessible to residents, families, or the public.	F 577		
F 658 SS=D	NJAC 8:39-9.4(b)(c) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure staff follow the physician's order for the use of NJ Ex Order 26.4(b)(1 for 1 of 21 residents, (Resident #56) and b.) ensure staff follow the physician's order according to the	F 658	POC F658 Criteria 1: The facility failed to ensure that staff follow the physician□s order,(a)Resident #56, for the use of NJ Ex Or [redacted] on a resident and by (b) not	12/15/24

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F 658	Continued From page 3 facility's policies and standards of clinical practice for 1 of 3 nurses, Licensed Practical Nurse (LPN)), for 1 of 9 Residents (Resident #252) observed during medication administration. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.On 10/10/24 at 10:45 AM, the surveyor observed Resident #56 in bed with his/her eyes open with NJ Ex Order 26.4(b)(1) in use. The resident did not respond to the surveyor and the	F 658	taking a NJ Ex Order 26.4(b)(1) within 15 minutes of administering the medication with parameters on another resident #252. (a) Physician order was received, family consent signed by POA for use of NJ Ex Order 26 [redacted] and care plan updated. (b) U.S. FOIA [redacted] was educated 1:1 on Physician Orders and following parameters and remaining nursing staff received education on following physician orders. Criteria 2: All residents have the potential to be affected by this deficient practice Criteria 3: Policies and procedures were reviewed and revised, when necessary, Nursing staff received education on following and maintaining physician orders . Criteria 4: The DON or designee will conduct weekly audits to ensure that physician orders are being followed and results will be presented at the facility□s QAPI meetings monthly for three months and then quarterly thereafter for 1 year.	

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F 658	Continued From page 4 surveyor was unable to interview the resident. On 10/18/24 at 10:35 AM, the surveyor observed Resident #56 in bed with their eyes closed. The surveyor observed NJ Ex Order 26.4(b)(1) in use. The surveyor reviewed Resident #56's Admission Record which reflected that the resident was admitted to the facility with the diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) The surveyor reviewed the Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b) which assessed Resident #56 had a brief interview for mental status score of "NJ out of 15" which indicated NJ Ex Order 26.4(b)(1) . Further review of the MDS revealed Resident #56 was dependent on staff for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) from the bed to the chair. A review of Resident #56's care plan (CP) reflected a focus area for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) effective date NJ Ex Order 26.4(b) that included an intervention that the resident will be provided NJ Ex Or in bed for NJ Ex Order 26.4(b)(1) A review of the current physician's orders (PO) reflected a PO for NJ Ex Order 26.4(b)(1) when in bed for NJ Ex Order 26.4(b)(1) The CP had an original order date of NJ Ex Order 26.4(b) and a renewal date of NJ Ex Order 26.4(b) A review of the NJ Ex Order 26.4(b)(1) Assessment dated NJ Ex Order 26.4(b)(indicated ... NJ Ex Order 26.4(b)(1) are indicated and serve as an enabler to promote NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1) ... NJ Ex Order 26.4(b)(1) are not considered a NJ Ex Order 26.4(b)(device ...provide NJ Ex Order 26.4(b)(1) in bed for NJ Ex Order 26.4(b)(1) ...	F 658		

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F 658	Continued From page 5 A review of Resident #56's [NJ Ex Order 26.4(b)(1)] Assessment dated [NJ Ex Order 26.4(b)] indicated ... [NJ Ex Order 26.4(b)(1)] are indicated and serve as an enabler to promote [NJ Ex Order 26.4(b)(1)] in [NJ Ex Order 26.4(b)(1)] ... [NJ Ex Order 26.4(b)(1)] are not considered a [NJ Ex Order 26.4(b)(1)] ...provide [NJ Ex Order 26.4(b)(1)] in bed for [NJ Ex Order 26.4(b)(1)] ... A review of Resident #56's Consent form for the use of [NJ Ex Order 26.4(b)(1)] was signed by the resident's daughter and facility [U.S. FOIA (b) (6)] and dated [NJ Ex Order 26.4(b)]. On 10/17/24 at 11:42 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] who stated that the facility ordered the [NJ Ex Order 26.4(b)(1)] from the original manufacturer of the bed frame. He further stated that he ordered standard [NJ Ex Order 26.4(b)(1)] On 10/18/24 at 10:36 AM, the [U.S. FOIA (b) (6)]) accompanied the surveyor to resident #56's room and the [U.S. FOIA (b)] and surveyor together observed Resident #56 was in bed with [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)] confirmed that the PO was for [NJ Ex Order 26.4(b)(1)], a [NJ Ex Order 26.4(b)(1)] Assessment should have been completed quarterly and a PO should have been obtained prior to the use of [NJ Ex Order 26.4(b)(1)] A review of the facility policy entitled, "Physician Orders" dated/revised 7/10/24 reflected ...A licensed professional nurse will carry out and follow orders written by the physician. 2.) On 10/16/24 at 9:47 AM, the surveyor observed the [U.S. FOIA] prepare medications for Resident #252 that included a physician order	F 658		

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F 658	Continued From page 6	F 658		

(PO) for [redacted]) tablet, give 1 tablet by oral route once daily at 9:00 AM, for [redacted] with Parameters to hold for [redacted] and a PO for [redacted] give 1 tablet by oral route once daily, give with meals every day at 9:00 AM, with parameters to hold for [redacted] and to hold for [redacted]. The [redacted] stated that he had already taken Resident #252's vital signs earlier that morning. The surveyor asked the [redacted] what time he had taken them. The [redacted] replied, "about an hour ago", and proceeded to administer the two [redacted] medications.

On 10/16/24 at 1:06 PM, the surveyor interviewed the [redacted] in the presence of another surveyor who acknowledged that he should have taken Resident #252's vital signs within 15 minutes of administering the [redacted] medications per facility policy.

On 10/16/24 at 1:34 PM, the survey team met with the [redacted] and [redacted] to discuss the above observations and concerns. The [redacted] stated that the [redacted] should have retaken the vital signs prior to administering the medications.

A review of the facility policy, Administration of Medications Procedure dated/revised 4/24, included ...vital signs should be taken no more than 15 minutes prior to removal of medications from the unit dose package or bottle ...after taking the vital signs necessary, the medications may be removed ...offer a full glass of water or juice with the medication and ensure the resident has swallowed the medications.

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F 658	Continued From page 7 No further information was provided by the facility.	F 658		
F 677 SS=D	NJAC 8:39-27.1(a), 29.2(d) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that residents dependent on staff for NJ Ex Order 26.4(b)(1) [redacted] received NJ Ex Order 26.4(b)(1) care in accordance with the facility policy. This deficient practice was identified for 1 of 1 resident (Resident #22,) reviewed for NJ Ex Orde care and was evidenced by the following: On 10/10/24 at 10:49 AM, the surveyor observed Resident #22 in bed with the US FOIA (b)(6) [redacted] assigned to their care in their room. The surveyor observed the resident's NJ Ex Order 26.4(b)(1) to be NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) [redacted]. Resident #22 stated that he/she would like to go to the NJ Exec Orde to have their NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) The CNA told the resident she would see if the resident was "on the list" to go to NJ Ex Order 26.4(b)(1) On 10/16/24 at 12:00 PM, the surveyor observed Resident #22 in the NJ Exec front dining room seated in a wheel chair. The surveyor observed the	F 677	POC F677 Criteria 1: The facility failed to ensure that residents dependent on staff for NJ Ex Order 26.4(b)(1) [redacted] received NJ Ex Order 26.4(b)(1) [redacted] in accordance with facility policy. NJ Ex Order 26.4(b)(1) was provided for resident #22 and staff was educated on providing NJ Ex Order 26.4(including NJ Ex Order 26.4(b)(1) Criteria 2: All residents are at risk for this deficient practice Criteria 3: Policies and procedures were reviewed and revised when necessary. Nursing staff was provided with education on how to follow care plans to ensure that ADL□s and personal hygiene needs were met. Criteria 4: The DON or designee will conduct weekly audits to ensure that residents care plans are being followed and residents□ needs are being met with results reviewed during the facility□s	12/15/24

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F 677	Continued From page 8 resident's NJ Ex Order 26.4(b)(1) to be NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . On 10/17/24 at 9:53 AM, the surveyor observed Resident #22 in bed. The surveyor observed the resident's NJ Ex Order 26.4(b)(1) to be NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . On 10/17/24 at 10:15AM, the surveyor, in the presence of another surveyor, interviewed the US FOIA (b)(6) The US FOIA (b) stated that CNAs were only responsible for NJ Ex Order 26.4(b)(1) the residents NJ Ex Order but the activity staff were responsible for NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). The surveyor showed the US FOIA (b) Resident #22's NJ Ex Order The US FOIA (b) acknowledged that they were NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) The surveyor asked the US FOIA (b) why she hadn't NJ Ex Order 26.4(b) Resident #22's NJ Ex Order 26.4(b)(1) The US FOIA (b) did not respond to the surveyor's question. On 10/17/24 at 10:22 AM, the surveyor, in the presence of another surveyor, interviewed the US FOIA (b)(6) assigned to Resident #22's care. The US FOIA (b) stated that the CNAs were responsible for NJ Ex Order 26.4(b)(1) and NJ Ex Orde resident's NJ Ex Order A review of the Admission Record revealed Resident #22 had been admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) A review of the most recent Annual Minimum Data Set (MDS) an assessment tool, dated NJ Ex Order 26.4(, included but was not limited to; a brief	F 677	QAPI meetings monthly for three months and then quarterly thereafter.	

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F 677	Continued From page 9	F 677		

interview of mental status (BIMS) score of "[redacted] of 15" which indicated the resident had [redacted]. Section [redacted] documented that Resident #22 required [redacted] assistance with NJ Ex Order 26.4(b)(1).

A review of the Care Plan documented a focus area date effective [redacted], the resident required assistance with [redacted] and [redacted] Interventions included but were not limited to... encourage resident to participate in [redacted]

On 10/17/24 at 3:03 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]) to discuss the above observations and concerns.

On 10/18/24 at 8:44 AM, the [redacted] provided the surveyor with a copy of the [redacted] List dated [redacted]. A review of the list reflected that Resident #22 would go to the [redacted] "as requested". It further document that their last visit was [redacted]

A review of the facility provided, "Certified Nurse Aide Job Description" undated, included but was not limited to; Assists resident with or performs Activities of Daily Living (ADL).

A review of the facility provided, "ADL" policy & procedure revised 8/24, included but was not limited to; Purpose ... to ensure that the residents are receiving the assistance they need from staff according to their personal preference.

A review of the facility provided "Resident care and infection control" undated, included ...nails should be cleaned and trimmed/filed when needed, this is part of day-to- day standard of

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F 677	Continued From page 10 care. Activities may apply polish only ...	F 677		
F 695 SS=D	NJAC 8:39-27.1(a), 27.2(g) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer NJ Exec Order 26.4b1 according to the physician's order and failed to ensure NJ Ex Order 26.4(b)(1) was stored in accordance with infection control measures for 1 of 1 resident reviewed for NJ Ex Order 26.4(b)(1), Resident #22. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching,	F 695	POC F695 Criteria 1: The facility failed to administer NJ Ex Order 26.4(b)(1) according to the physician□s order and failed to ensure the NJ Ex Order 26.4(b)(1) was stored in accordance with infection control measures. NJ Ex Order 26.4(b)(1) was discarded and replaced and was set at proper per physician orders. Criteria 2: All residents are at risk for this deficient practice Criteria 3: Policies and procedures were reviewed and revised when necessary. Nursing staff was provided with education on how to follow respiratory care management orders and storage of respiratory devices.	12/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING _____ B. WING _____	C 10/18/2024

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

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F 695	Continued From page 11 health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 10/10/24 at 10:49 AM, the surveyor observed Resident #22 lying in bed with NJ Ex Order 26.4(b)(1) via NJ Ex Order 26.4(b)(1) attaached to the NJ Ex Order 26.4(b)(1) . The surveyor observed that there was an additional NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b) attached to a NJ Ex Order 26.4(b)(1) that was on the NJ Ex Orde of Resident #22's NJ Ex Order 26.4(b)(1) The NJ Ex O was NJ Ex Order 26.4(b)(1) the NJ Ex Order 26.4(b)(1) and it was not contained in NJ Ex Order 26 On 10/17/24 at 9:53 AM, the surveyor observed Resident #22 lying in bed with NJ Ex Order 26.4(b)(1) via NJ Ex Order 26.4(b)(1) attached to the NJ Ex O The surveyor observed that additional NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1 , was attached to a NJ Ex Order 26.4(b)(1) on the back of the wheelchair. The NJ Ex Order 26.4(b)(1) was hung over the NJ Ex Order 26.4(b)(1) and it was not contained in NJ Ex Order 26	F 695	Criteria 4: The DON or designee will conduct weekly audits to ensure that respiratory care orders are being followed and infection control storage guidelines are being met with results reviewed during the facility□s QAPI meetings monthly for three months and then quarterly thereafter.	

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F 695	Continued From page 12	F 695		

A review of Resident #22's Admission Record indicated that the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted], and [redacted].)

A review of Resident #22's most recent Annual Minimum Data Set (MDS), an assessment tool, dated [redacted] included; a Brief Interview for Mental Status (BIMS) score of "[redacted] of 15" which indicated the resident had [redacted] Section [redacted] documented that Resident #22 required [redacted] assistance with [redacted] and Section [redacted] documented that the resident was receiving [redacted] treatment which included [redacted]

A review of the Care Plan documented a focus area effective [redacted] which included: Resident has a [redacted]: [redacted] ([redacted]) related to [redacted]). Interventions included but were not limited to: [redacted] as per physician order and to provide treatments per physician order.

A review of the [redacted] Physician's Orders revealed an active physician order (PO) with an order date of [redacted] and renewed of [redacted] for: [redacted] every shift.

On 10/17/24 at 10:15 AM, the surveyor, in the presence of another surveyor, interviewed the [redacted] who stated that the night shift was responsible for ensuring that the [redacted] was stored properly in [redacted] The surveyor asked the [redacted] if she should have discarded the

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F 695	Continued From page 13	F 695		

[redacted] and obtained a new one since they both observed the [redacted] was not stored properly in a [redacted] The [redacted] confirmed that she should have discarded the NJ Ex Order 26.4(b)(1) and obtained a new [redacted].

On 10/17/24 at 10:22 AM, the surveyor, in the presence of another surveyor, interviewed the US FOIA (b)(6) assigned to the care of Resident #22. The surveyor showed the [redacted] the [redacted] the [redacted] confirmed that the [redacted] was NJ Ex Order 26.4(b)(1) and that the PO was for [redacted]. The [redacted] acknowledged that during his morning rounds, he should have checked that the [redacted] was [redacted] per the physician order and should have checked to see that the [redacted] was stored properly in [redacted].

On 10/17/24 at 3:03 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6)) to discuss the above observations and concerns. The [redacted] stated the facility policy was that the [redacted] should be stored in [redacted] when not in use.

A review of the facility provided,"RN/LPN Job Description" undated, included but was not limited to ...the nurses will provide safe and effective nursing care in accordance with the nursing practices and policies of the facility, NJ DOH and CMS guidelines ...practices infection control according to established facility and department policies ...

A review of the facility provided, "Oxygen Therapy" policy and procedure dated/revised 6/12/24, included the following: A licensed professional nurse will administer oxygen via

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F 695	Continued From page 14 cannula or mask as prescribed by physician ...check the order in the resident's chart for amount of oxygen and frequency of administration ...change oxygen tubing and bag weekly; keep tubing in bag when not in use ... On 10/18/24 at 11:30 AM, the survey team met with the U.S. FOIA (b) (and U.S. FOIA (b) No additional information was provided by the facility.	F 695		
F 730 SS=F	N.J.A.C. 8:39- 19.4(a); 27.1(a) Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation, it was determined that the facility failed to ensure that the Certified Nursing Aide (CNA) received a performance review for five (5) of five (5) CNA files reviewed. This deficient practice was evidenced by the following: A review of the facility provided, Licensed annual education, competencies, and performance reviews, dated January 2023 to October 2024, did not reveal performance reviews for the five (5) randomly selected CNAs.	F 730	POC F730 Criteria 1: The facility failed to ensure that 5/5 Certified Nursing Aides received an annual performance review per the requirements of 483.95(g) Annual performance reviews were completed on the 5 CNA□s Criteria 2: All residents are at risk for this deficient practice Criteria 3: Policies and procedures were reviewed and revised when necessary. DON, nursing supervisors and HR	12/15/24

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F 730	Continued From page 15 On 10/16/24 at 11:24 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) stated that the U.S. FOIA (b) (6)) was in-charge of education, competencies (lecture, training, pre and posttests) and performance reviews for the nursing staff. On 10/17/24 at 11:57 AM, during an interview with the surveyor, the U.S. FOIA (b) stated that the performance reviews were conducted based on the results of the competencies. When a nursing staff's competencies resulted with a concern, then a performance review was conducted. The U.S. FOIA (b) stated that the 5 randomly selected CNAs did not have concerns with their competencies and confirmed that the CNAs had no performance reviews on file. The U.S. FOIA (b) also stated that the performance reviews for all nursing staff were based on the result of the competencies. On 10/17/24 at 1:02 PM, the surveyor requested from the U.S. FOIA (b) and the U.S. FOIA (b) (6) , for the policy and procedure for the competencies and performance reviews of the nursing staff. On 10/18/24 at 9:00 AM, in the presence of two surveyors and the U.S. FOIA (b) the surveyor discussed the concern with the CNAs performance reviews that was not conducted at least every 12 months, and the education provided was not based on the performance review. A review of the facility policy provided, Employee Training and Performance Management, dated 2/6/23, included that staff were required to work competently, effectively, and safely to care for its	F 730	Director were provided with education for annual review requirements Criteria 4: The DON or designee will conduct monthly audits to ensure that annual performance reviews are provided and guidelines are being met with results reviewed during the facility□s QAPI meetings monthly for three months and then quarterly thereafter.	

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F 730	Continued From page 16 residents. To ensure that all staff meet this requirement the following policy ensured that employees were consistently monitored and trained/educated as needed to ensure they completed their job/task successfully. No additional information was provided.	F 730		
F 755 SS=D	N.J.A.C. 8:39-43.17 (b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		12/15/24

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F 755	Continued From page 17 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to consistently provide pharmaceutical services in accordance with professional standards to ensure a.) reconciliation and accountability of dispensed and administered NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted]) to Resident #19, and discrepancies were identified, for the NJ Ex Order 26.4(b [redacted] stored in the medication cart located on the high side of the NJ Ex [redacted] unit, and b.) reconciliation of NJ Ex Order 26.4(b)(1) Inventory Record (NJ Ex Order 26.4(b)(1) [redacted] were consistently signed/completed for the medication cart located on the B-side of the NJ Ex [redacted] unit. The deficient practice was identified for one (1) of two (2) medication carts reviewed during the medication storage and labeling task and was evidence by the following: 1.) On 10/17/24 at 9:16 AM, the two (2) surveyors and the U.S. FOIA (b) (6) [redacted]) began the inspection of the NJ Ex Order 26.4(b [redacted] medication cart inspection, which was stored in a mounted, double locked portion of the medication cart (NJ Ex Order 26.4(b)(1) [redacted]) located on the high side of the NJ Ex [redacted] unit. In the presence, of a surveyor, and the U.S. FOIA	F 755	POC F755 Criteria 1: The facility failed to consistently provide pharmaceutical services in accordance with professional standards to ensure reconciliation and accountability of dispensed and administered NJ Ex Order 26.4(b)(1) [redacted]. Declining sheets/ records in question were completed, 1:1 education was provided to staff involved and remaining nursing staff received education on reconciliation and accountability. Criteria 2: All residents are at risk for this deficient practice Criteria 3: Policies and procedures were reviewed and revised when necessary. Nursing staff were inserviced on shift-to-shift counts, resident narcotic declining sheets and narcotic management. Criteria 4: The DON or designee will conduct weekly audits to ensure that all necessary narcotic reconciliation and accountability records are completed, and guidelines are being met with results	

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F 755	Continued From page 18 the surveyor observed that the [NJ Ex Order 2] was not signed by two (2) nurses for that day. At that time, the [U.S. FO] stated that she did not sign the shift-to-shift log with the 11:00 PM, to 7:00 AM shift nurse that morning, because she had noticed that the 3:00 to 11:00 PM nurse had not signed Resident #19's Individual Patient [NJ Ex Order 26.4(b)(1)] Record ([NJ Ex Order 26.4(b)(1)]) for [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)]) that was administered on [NJ Ex Order 26.4(b)(1] [the night before]. At that time, the [U.S. FO] could not explain how the two (2) nurses from the 3:00 PM to 11:00 PM shift nurse and the 11:00 PM to 7:00 AM shift nurse who conducted the shift-to-shift [NJ Ex Order 2] for accountability on [NJ Ex Order 26.4(b)(1], did not identify the discrepancy prior to her shift. The [U.S. FO] informed the surveyors that she had notified the [U.S. FOIA (b) (6)] would let the U.S. FOIA (b) (6) know of the shift-to-shift [NJ Ex Order 2] discrepancy. On 10/17/24 at 9:24 AM, in the presence of a surveyor and the [U.S. FOI] the surveyor observed Resident #19's bingo card (blister packet which contains the medication) with a pharmacy label for [NJ Ex Order 26.4(b)(1)] contained 10 tablets. At that time, the surveyor compared the bingo card against the [NJ Ex Order 26.4] for Resident #19's [NJ Ex Order 26.4(b)(1)] The [NJ Ex Order 26.4] log reflected a documented quantity of 11 remaining. At that time, the [U.S. FO] informed both surveyors that the discrepancy was that the 3:00 PM to 11:00 PM nurse had not signed the removal of the [NJ Ex Order 26.4(b)(1)] from inventory ([NJ Ex Order 26.4] log) however	F 755	reviewed during the facility□s QAPI meetings monthly for three months and then quarterly thereafter.	

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the nurse had signed the Medication Administration Record for [NJ Ex Order 26.4(b)(1)] an attestation of administration .

The surveyor reviewed the medical record for Resident #19.

According to the Resident Face Sheet (an admission summary) Resident #19 was admitted to the facility with diagnosis that included but was not limited to NJ Ex Order 26.4(b)(1). Further review of the qMDS reflected Resident #19 received scheduled and as needed (PRN) [NJ Ex Ord] medications. The resident reported NJ Exec Order 26.4b1 of [NJ Ex Ord] [NJ Exec Order 26.4b1] Review of the quarterly Minimum Data Set (qMDS), an assessment tool dated [NJ Ex Order 26.4(b)(1] reflected a Brief Interview for Mental Status (BIMS) score of [NJ] out of 15, which indicated that the resident was NJ Ex Order 26.4(b)(1).

Review of the electronic Medication Administration Record (eMAR) for NJ Ex Order 26.4(b)(1) included a physician order for NJ Ex Order 26.4(b)(1) [redacted] by oral route every 12 hours as needed (PRN) for [NJ Ex Orde] The physician order start date was [NJ Ex Order 26.4(b] . The surveyor compared the eMAR against the [NJ Ex Order 26.4] which reflected that the [NJ Ex Order 26.4(b)(1)] was not signed on the [NJ Ex Order 26.4] as removed from the inventory but was signed administered on eMAR on [NJ Ex Order 26.4(b)(1].

Review of the eMAR for NJ Ex Order 26.4(b)(1), included a physician order for NJ Ex Order 26.4(b)(1) [redacted] by oral route every 12 hours as needed for [NJ Ex Order] The physician order start date was [NJ Ex Order 26.4(b)] The surveyor compared the eMAR against the [NJ Ex Order 26.4] which revealed the following:

-on [NJ Ex Order 26.4(b)] at 2:00 PM, the [NJ Ex Order 26.4] was signed

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as removed from inventory but was not signed on the eMAR as administered.
-on [NJ Ex Order 26.4(] at 8:57 PM, the [NJ Ex Order 26.4] was signed as removed from inventory but was not signed on the eMAR as administered.

On 10/17/24 at 1:08 PM, during an interview with two (2) surveyors, Resident #19 stated [NJ Exec O] was not [NJ Ex Order 26.] and confirmed receiving [NJ Ex Order 26.4(b)(1)] last night but [NJ Exec Order 26.4b1] the other dates.

On 10/17/24 at 3:07 PM, in the presence of the survey team, the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b)] the surveyor discussed the concern regarding the missing accountability, reconciliation and discrepancy of the [NJ Ex Order 26.4] log against Resident #19's eMAR.

On 10/18/24 at 9:13 AM, the [U.S. FOIA (b] stated that she had investigated the discrepancy between the [NJ Ex Order 26.4] and the eMAR. The [U.S. FOIA (b] stated that there were two (2) different nurses involved who both stated that the PRN medication was in fact removed from inventory but was [NJ Exec Order 26.] by the resident. Both nurses neglected to document the refusal, and the disposal of the [NJ Ex Order 26.4(b] medications. Both nurses were given education on medication administration and [NJ Exec Order 26.4b] protocols. The [U.S. FOIA (b] acknowledged the concern.

2.) On 10/17/24 at 10:17 AM, the surveyor, in the presence of another surveyor and the [U.S. FOIA (b) (6)]) began the [NJ Ex Order 26.4(b] medication cart inspection, located in the B-side of the [NJ Ex O] unit.

At that time, the surveyor reviewed the shift-shift log for [NJ Ex Order 26.4(b)(1)] which reflected the

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following:
-10/7/24 at 7:00 AM, the nurse going on duty was blank (two (2) nurses' signature was not found).
-10/7/24 at 3:00 PM, the nurses going on and off duty were blank.
-10/7/24 at 11:00 PM, the nurse going off duty was blank.
-10/9/24 at 7:00 AM, the nurse going on duty was blank.
-10/10/24 at 7:00 AM, the nurse going on duty was blank.
-10/10/24 at 3:00 PM, the nurse going off duty was blank.
-10/12/24 at 11:00 PM, the nurse going off duty was blank.

On 10/17/24 at 3:07 PM, in the presence of the survey team, the U.S. FOIA (b) (6) and the U.S. FOIA (b) the surveyor discussed the concern regarding the shift-to-shift reconciliation of NJ Ex Order 26.4(b)(1) were not consistently signed/completed.

On 10/17/24 at 10:50 AM, in the presence of the two (2) surveyors, the U.S. FOIA (b) (6) confirmed the missing signatures on the NJ Ex Order 26 and acknowledged that the shift to shift log should have been signed by two (2) nurses. The U.S. FOIA (b) (6) stated that he would ensure education be provided to the nursing staff and would inform the U.S. FOIA (b) of the discrepancy.

On 10/18/24 at 9:58 AM, the U.S. FOIA (b) stated that she had investigated the concern for the missing shift to shift signature for reconciliation of the NJ Ex Order 26.4(b) medications. The U.S. FOIA (b) stated that two (2) nurses were involved and were given education regarding the importance of the shift-to-shift reconciliation. The U.S. FOIA (b) acknowledged the

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	315029	A. BUILDING _____ B. WING _____	C 10/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 22 errors. Review of the undated, facility provided policy, Nursing Medication Administration included the following: Narcotics must be counted shift- to-shift and discrepancies should be reported to the Supervisor/ DON when noted. Narcotics need to be signed off on declining sheet at the time they are taken out of the bingo card then signed on the eMAR after resident has taken the medication. If the resident declines Med once removed it, then needs to be cosigned as wasted and a note written in progress notes. NJAC 8:39- 27.1(a), 29.2 (a) (d), 29.4 (i)(k), 29.7(c)	F 755		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 868		12/15/24

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F 868	Continued From page 23 program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to assure that the required staff attended the quarterly Quality Assurance (QA) meetings. This was identified for 3 of 3 quarterly QA meetings reviewed. This deficient practice was evidenced by the following: The surveyor requested to review the QA meeting sign in sheets for the last 3 quarters dated September 5, 2024, July 16, 2024 and May 23, 2024, upon entrance. A review of the QA meetings sign in sheets revealed that the U.S. FOIA (b) (6) had not been in attendance for the three meetings. On 10/15/24 at 11:40 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that the U.S. was not able to attend the QAPI	F 868	POC F868 Criteria 1: The facility failed to ensure that the required staff attend the quarterly QAPI meetings. QAPI meeting times have been readjusted to include RNIP Criteria 2: All residents are at risk for this deficient practice Criteria 3: Policies and procedures were reviewed and revised when necessary. QAPI meeting time was adjusted and Administration were inserviced on QAPI policy and required attendees. Criteria 4: The DON or designee will conduct monthly audits to ensure that all required staff members are in attendance	

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F 868	Continued From page 24 meetings since that staff member works the evening shift (3-11) and is also the nursing supervisor. The [redacted] stated that they do received reports from the [redacted] who meets with the [redacted] often. A review of the Quality Assurance Performance Improvement (QAPI) Program, dated July 2024, revealed that the "members of the QAPI shall include but not be limited to: Medical Director, Director of Nursing, Director of Social Services, Director of Admissions, Director of Rehabilitation, Director of Activities, Director of Admissions, and Director of Building Services." The QAPI Plan did not indicate that the IP should be in attendance. N.J.A.C. 8:39-33.1 (b)	F 868	at meetings and guidelines are being met with results reviewed during the facility□s QAPI meetings monthly for three months and then quarterly thereafter.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		12/15/24

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F 880	Continued From page 25 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 26 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 observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure that infection control practices were followed by ensuring proper hand hygiene was performed prior to dining services and hand wipes were used and discarded appropriately . This deficient practice was identified on 1 of 3 nursing units (HP) and evidenced by the following: On 10/10/24 at 12:00 PM, the surveyor observed twenty residents seated in the HP front dining room preparing for their lunch meal. On 10/10/24 at 12:20 PM, the surveyor observed the U.S. FOIA (b) (6)) assisted the residents with their hand hygiene. The surveyor observed the U.S. FOIA cleaned a resident's hands with hand wipes, applied a clothing protector and without performing hand hygiene, cleaned another resident's hands with a hand wipe, applied a clothing protector and without performing hand hygiene reached back into the container of hand wipes, removed 4 wipes and handed them to four different residents. The four unsampled residents cleaned their hands and handed the soiled wipes back to the U.S. FOIA (b) The U.S. FOIA discarded the 4 wipes into the trash and without performing hand hygiene applied clothing protectors to the four residents.	F 880	POC F880 Criteria 1: The facility failed to ensure that infection control practices were followed by ensuring proper hand hygiene wash performed prior to dining services and that hand wipes were used and discarded properly. The staff identified were educated at the time of the infraction and remaining staff were educated on hand hygiene protocols. Criteria 2: All residents are at risk for this deficient practice Criteria 3: Policies and procedures were reviewed and revised when necessary. Education was provided to activity and nursing staff on proper infection control protocols on hand hygiene practices. Criteria 4: The DON or designee will conduct weekly audits to ensure that all required staff members are in attendance at meetings and guidelines are being met with results reviewed during the facility□s QAPI meetings monthly for three months and then quarterly thereafter.	

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F 880	Continued From page 27 On 10/11/24 at 11:50 AM, the surveyor observed dining services in the HP front dining room. On 10/11/24 at 11:55 AM, the surveyor observed the U.S. FOIA (b) (6)) donned a pair of gloves, used a hand wipe to clean a resident's hands then tied the plastic trash bag to the back of the resident's wheelchair and discarded the gloves and wipe into the bag. The U.S. FOI without sanitizing her hands, donned a new pair of gloves, cleansed a resident's hands, and discarded the wipe and gloves in the trash bag that was tied to the back of the resident's wheelchair. On 10/11/24 at 12:05 PM, the U.S. FOIA (b) (6) entered the HP front dining room, and the surveyor observed the U.S. FC remove the plastic trash bag from the resident's wheelchair. At that same time, the surveyor asked the U.S. FC if the U.S. FC should have tied the trash bag to the back of a resident's wheelchair. The U.S. FC replied that she would not have done that, "but everyone is different." The surveyor asked the U.S. FC if it was an Infection Control/dignity concern. The U.S. FC did not respond to the surveyor's inquiry. On 10/11/24 at 12:08 PM, the surveyor interviewed the U.S. FC who acknowledged that she should have sanitized her hands between residents and confirmed she should not have tied a trash bag to the back of a resident's wheelchair. On 10/11/24 at 12:54 PM, the surveyor interviewed the US FOIA (b) who stated that her process during dining services was to put on gloves, use a hand wipe to clean a resident's hands, discard the wipe in the trash, remove and discard the	F 880		

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F 880	Continued From page 28 gloves, and put on a new pair of gloves to clean another resident's hands. The surveyor asked the U.S. FOIA (if she was in serviced to perform hand hygiene between gloves changes. The U.S. FOIA (replied, "no." The surveyor asked the U.S. FOIA (why she did not follow her regular process for cleaning resident's hands yesterday as the surveyor had observed the U.S. FOIA (had not used gloves, nor had she sanitized her hands between residents. The U.S. FOIA (replied she had not practiced appropriate hand hygiene because she was "nervous." The U.S. FOIA (acknowledged that she should have performed hand hygiene between residents. On 10/16/24 at 1:22 PM, the survey team met with the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) to discuss the above observations and concerns. The U.S. FOIA (b) (stated that the U.S. FC had been educated on proper infection control practices. On 10/17/24 at 3:03 PM, the survey team met with the U.S. FOIA (b) (and U.S. FOIA (who confirmed that the staff should sanitize their hands between residents. A review of the facility's policy entitled, "Hand Hygiene" reviewed 6/24 included ...Hand hygiene is considered the most important procedure for preventing the spread of infection ...hand hygiene must be performed after all resident care/contact ...after removing gloves and any other personal protective equipment ... NJAC 8:39 - 19.4(a)(m)(n); 27.1 (a)	F 880		

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	030703	A. BUILDING: _____ B. WING _____	C 10/18/2024

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

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	POC S560 Criteria 1: The facility failed to maintain minimum direct care staff ratios. No residents were directly affected by this deficient practice. Staffing schedules were reviewed by the DON for compliance. Appropriate number of staff will be scheduled according to census and matrix acuity	12/15/24

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

Electronically Signed | 10/31/24

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S 560	Continued From page 1 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 Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 09/22/2024 to 10/05/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -09/22/24 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/27/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. On 10/16/24 at 11:24 AM, during an interview with the surveyor, the Human Resources Director (HRD) stated that she completed the monthly	S 560	Criteria 2: All residents have the potential to be affected by this deficient practice Criteria 3: All nursing staff administration will be educated regarding maintaining staffing levels to ensure that staffing mandate requirements are being met. Criteria 4: Staffing ratios will be reviewed daily by the DON or HR Director on a daily basis. Results will be presented at the facility□s QAPI meetings monthly for three months and then quarterly thereafter for 1	

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S 560	Continued From page 2 master schedule (the schedule of Certified Nursing Assistants and nurses for 2 pay periods, to equal 1 month). The HRD informed the surveyor that the schedule was computer generated. At that time, the HRD and the Director of Nursing (DON) worked actively together to cover call outs for the uncovered day time shift, and the nursing supervisors were in charge with the task of covering call outs for the evening, overnight, and weekend shift coverage. In the event, the nursing supervisors were unsuccessful in finding a person to cover the shift then they either called the HRD and the DON to help cover the shift. At that time, the HRD stated she was aware of the staffing ratios, which were: 1 CNA to 8 residents for the day shift 1 CNA to 10 residents for the evening shift 1 CNA to 14 residents for the overnight shift At that time, the HRD stated that they usually scheduled more than required staff for the facility because the scheduled staff was dependent on the resident's needs. The DON guided her with the number of staff to schedule, but when a nursing staff called out, and they were unable to find a nursing staff to cover the shift, then they may not have met the required coverage for that one (1) specific shift. The HRD also stated that incentives were offered to encourage shift coverage for the nursing that called out. No further information was provided.	S 560		

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S 720	Continued From page 3	S 720		
S 720	8:39-7.3(d) Mandatory Resident Activities Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to post the scheduled two evening activity programs per week in the dementia unit and provide a diversified program for the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) residents to maintain the resident's NJ Ex Order 26.4(b)(1) and self-respect. This deficient practice was identified for two (1) of two (2) activities calendar (NJ Ex Order 26.4(b)(1) Unit) reviewed for October 2024. On 10/10/24 at 11:02 AM, during the initial tour of the locked HP (NJ Ex Order 26.4(b)(1) unit, the surveyor observed the October 2024 activities calendar, had one (1) scheduled nighttime activity scheduled on Sundays at 6:00 PM. On 10/17/24 at 11:11 PM, during a tour with the two (2) surveyors, the Registered Nurse/ Nurse Supervisor (RN/NS) confirmed the October 2024 activities calendar, posted on the bulletin board of the LP unit was the correct. The calendar reflected two (2) nighttime activities scheduled on Sunday and Wednesday at 6:00 PM On 10/17/24 at 11:25 AM, during an interview with	S 720	POC S720 Criteria 1: The facility failed to post the scheduled two evening activity programs per week in the dementia unit. Calendars were updated to include two scheduled evening activities per week. Criteria 2: All residents on the dementia unit have the potential to be affected by this deficient practice Criteria 3: Policies and procedures were reviewed and revised, when necessary, Activity staff were educated to provide two evening activities per week. Criteria 4: Calendars will be reviewed monthly by the Executive Director and Activities Director to ensure that guidelines are being met and results will be presented at the facility□s QAPI meetings monthly for three months and then quarterly thereafter for 1 year.	12/15/24

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S 720	Continued From page 4 two (2) surveyors, the Director of Recreation (DoR) stated that she was responsible for planning the activities on the calendars. The DoR informed the surveyors that the calendars were posted in the resident's rooms, bulletin boards, and dining area; flyers were also distributed. This was accomplished by her and her recreation staff. On 10/17/24 at 11:35 AM, in the presence of the two (2) surveyors, the DoR walked to the bulletin board of the NJ Ex Order 26.4(b)(1) unit where the DoR confirmed that the October 2024 activities calendar posted, was accurate. The DoR also confirmed that a 6:00 PM activity was only posted for Sundays and not for Wednesday 10/9/24, Wednesday 10/16/24, Wednesday 10/23/24, and Wednesday 10/30/24. At that time, the DoR stated that the focus was on the LP unit residents who were awake for the nighttime activities. The DoR, also stated that the recreation staff rounded on the NJ Ex Order 26.4(b)(1) unit, invited the residents, to see who wanted to join the evening activity at the LP unit. The DoR further stated that the activities on the NJ Ex Order 26.4(b)(1) unit, were not as structured in comparison to the LP unit because of their NJ Ex Order 26.4(b)(1) [redacted] At that time, the concerns regarding the one (1) nighttime activity posted for the NJ Ex Order 26.4(b)(1) unit, and the concern for the other nighttime activity that was verbally offered, lacked diversity for the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) HP (NJ Ex Order 26.4(b)(1) unit residents. On 10/17/24 at 11:57 AM, in the presence of a surveyor and the Director of Nursing, the surveyor discussed the concerns regarding the one (1) nighttime activity posted for the NJ Ex Order 26.4(b)(1) unit,	S 720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030703	A. BUILDING: _____ B. WING _____	C 10/18/2024

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

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S 720	Continued From page 5 and the concern for the other nighttime activity that was verbally offered, that lacked diversity for the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) HP (NJ Ex Order 26.4(b)(1) unit residents. A review of the undated, facility policy Activities Policy and Procedure, included the following: It is the policy of [facility name redacted] to provide structured and unstructured activities for our residents. Activities are determined by resident preference, ability/functional level, cognition physical, spiritual, emotional, and social. No policy did not include two (2) evening activities would be provided. NJAC 8:39-7.3(a)(6)(d)	S 720		
S1350	8:39-19.4(d) Mandatory Infection Control and Sanitation The infection control coordinator shall provide continuous collection and analysis of data, including determination of nosocomial infections, epidemics, clusters of infections, infections due to unusual pathogens or multiple antibiotic resistant bacteria, and any occurrence of nosocomial infection that exceeds the usual baseline levels. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to adhere to the Executive Directive No. 20-0261 issued by the New Jersey Commissioner in response to the NJ Ex Order 26.4(b)(1)	S1350	POC S1350 Criteria 1: The facility failed to adhere to the Executive Directive No. 20-0261 issued by the NJ Commissioner in	12/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030703	A. BUILDING: _____ B. WING _____	C 10/18/2024

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S1350	Continued From page 6 [NJ Ex Order 26.4(b)(1)] by failing to hire a full-time Infection Control Preventionist for the facility. This deficient practice is as follows: On 10/15/24 at 11:20 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the Registered Nurse Infection Preventionist (RNIP) who fulfills the role of Infection Preventionist (IP), also fulfills the role of Nursing Supervisor on the evening shift (3pm-11pm). The LNHA stated she is aware that the facility needs to have a full time IP based on the licensed beds of 303 but has a low census of 104 so the facility utilized the IP as a nursing supervisor as well. On 10/15/24 at 11:40 AM, the surveyor interviewed the Director of Nursing, who provided the RNIP's Job Description, stated that the RNIP does in fact work as a nursing supervisor and as an addendum job, she work as an IP on evening shift (3pm-11pm). The surveyor reviewed RNIP's job description, which revealed that the RNIP's title is Nursing Supervisor. The surveyor also reviewed the Infection Control Preventionist and Wound Care Addendum Job Description, signed by the RNIP on [NJ Ex Order 26.4(b)] which revealed that the RN also is working in that role as well and it does not indicate whether the role is full or part time. The addendum job description revealed "This job description addendum is intended to outline the additional responsibilities and requirements of your position as it relates to Infection Control and Wound Care. It is meant as an adjunct to your regular job description and does not replace it." A review of the last two weeks of nursing	S1350	response to the COVID-19 Pandemic by not hiring a full-time IP for the facility. The IP job description was modified to include only infection control duties. Criteria 2: All residents have the potential to be affected by this deficient practice Criteria 3: RNIP title, duties and schedule were revised to be full time and compliant with Executive Directive No. 20-0261 Criteria 4: DON and HR Director will meet with RNIP weekly to monitor that IP plan(s) are being followed and will report data to QAPI monthly for three months, then quarterly thereafter for twelve months	

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S1350	Continued From page 7 schedules revealed that the RNIP worked as a Nursing Supervisor for evening (3pm-11pm) shift on the following days: 10/11/24, 10/10, 10/8, 10/7, 10/6, 10/4, and 10/1. No further information was provided.	S1350		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315029 Y1	A. Building B. Wing Y2	12/30/2024 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0577	Correction	ID Prefix F0658	Correction	ID Prefix F0677	Correction
Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	12/15/2024	LSC	12/15/2024	LSC	12/15/2024
ID Prefix F0695	Correction	ID Prefix F0730	Correction	ID Prefix F0755	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.35(d)(7)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	12/15/2024	LSC	12/15/2024	LSC	12/15/2024
ID Prefix F0868	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	12/15/2024	LSC	12/15/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON 10/18/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030703 Y1	A. Building B. Wing Y2	12/30/2024 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S0720	Correction	ID Prefix S1350	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-7.3(d)	Completed	Reg. # 8:39-19.4(d)	Completed
LSC	12/15/2024	LSC	12/15/2024	LSC	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/18/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	**10/18/2024**

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 10/10/2024 thru 10/16/2024. Daughters of Israel was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/10/24 thru 10/16/2024 and Daughters of Israel was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Daughters of Israel Pleasant Valley Home is a two-story building with a partial basement that was built in 1961 with an addition that was built in 1980. It is composed of Type II protected construction. The facility is divided into 24 - smoke zones. RHP (first floor), has 41 rooms and has been closed for approximately 4 years. WLP (second floor), located above the sub-acute unit has 56 beds and has been closed approximately 2 years. BP (basement), located above the LP unit has 47 beds and has been closed for approximately 7 years. The facility has 3 diesel powered emergency	K 000		

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

Electronically Signed | 10/31/2024

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

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K 000	Continued From page 1 backup generators: 1. [NJ Ex Order 26.] 400KW generator provides power to the RHP, LP, HP, and BP units. 2. [NJ Ex Order 26.] 150 KW generator provides power to the Admin and OT/PT areas. 3. [NJ Ex Order 26.] 150KW generator provides power to the SP and WLP units.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is	K 222		12/15/24

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K 222	Continued From page 2 constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/11/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that doors in a required means of egress were not equipped with a latch or lock. This deficient practice had the potential to affect all residents and was evidenced by the	K 222	K222 Egress Doors Criteria #1 The thumb latch identified on the main door was removed.	

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K 222	Continued From page 3 following: An observation at 10:04 AM, revealed that both sets of automatic sliding doors at the main entrance were equipped with a thumb turn latch. In an interview at the time, the [redacted] confirmed the observation, latched the doors shut and unsuccessfully attempted to exit the building. The facility's[redacted] was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM	K 222	Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly audits of all identified exit door will be to ensure that they do not contain a thumb latch lock. Criteria #4 The Director of Building Services will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 271 SS=F	N.J.A.C 8:39-31:2(e) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/10/2024 and 10/11/2024 in the presence of the [redacted]), it was determined that the facility failed to ensure that exit discharge was provided with a hard packed all-weather and level surface in accordance with NFPA 101:2012 Edition, Section 7.7, 7.1.6, 7.1.7 and 19.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 271	K271 Discharge from Exits Criteria #1 The two inch change in elevation on the sidewalk outside of HP 341, outside by the employee dining room was repaired. The concrete missing outside of the rehab gym door was repaired.	12/25/24

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K 271	Continued From page 4 An observation at 12:14 PM, revealed that there was a 2-inch change in elevation from the separation of the concrete at the end of the ramp in the exit discharge in the HP unit near room 341. An observation at 12:41 PM, revealed that there was a 1-inch and 2-inch change in elevation from a sunken section of the exit discharge sidewalk near the employee dining room. An observation on 10/11/2024 at 9:50 AM, revealed that there was an 18-inch x 24-inch section of concrete missing in the exit discharge from the rehab area. In interviews at the time, the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM.	K 271	Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly audits of all exit discharge surfaces to ensure they are free of obstruction and are a hard packed surface. Criteria #4 The Director of Building Services will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 281 SS=F	N.J.A.C 8:39-31.2(e) Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on	K 281	K281	12/15/24

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K 281	Continued From page 5 10/16/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to provide illumination of the means of egress that was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all residents and was evidence by the following: An observation at 9:59 AM revealed that all the lights in the corridor and the exit sign of the unoccupied BP unit were controlled by a light switch on the wall and were turned off. In an interview at the time, the U.S. FOIA (b) (6) confirmed the observation. The U.S. FOIA (b) (6) then flipped the switch on the wall which turned on all the corridor and exit sign lights. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM.	K 281	Illumination of Means of Egress Criteria #1 The exit sign in the unoccupied BP hallway that was found to be controlled by a wall switch was repaired to ensure continuous illumination. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly audits of all exit signs to ensure they have continuous illumination. Criteria #4 The Director of Building Services will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 293 SS=F	N.J.A.C 8:39-31:2(e) Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced	K 293		12/15/24

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	315029	A. BUILDING **01** B. WING _____	**10/18/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 6 by: Based on observations and interviews on 10/10/2024 and 10/11/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that exits were marked by an approved sign that was readily visible and failed to identify any door that was likely to be mistaken for an exit with a sign that reads "NO EXIT" in accordance with NFPA 101:2012 Edition, Sections 7.10.1.2.1, 7.10.8.3.1 and 7.10.8.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 10/10/2024 at 11:35 AM and 12:30 PM revealed, that exit from the enclosed courtyards was not marked by an approved sign that was readily visible on the LP and HP units. Additionally, the doors that led into the enclosed courtyards from the dining rooms could be mistaken for an exit and were not provided with signs that read "NO EXIT". An observation on 10/11/2024 at 9:39 AM revealed that the exit from the enclosed courtyard on the SP unit was not marked by an approved sign that was readily visible and the doors that led into the enclosed courtyard could be mistaken for an exit and were not provided with a signs that read "NO EXIT". In interviews at the time, the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM.	K 293	K293 Exit Signage Criteria #1 The exit doors that lead to the enclosed courtyards on the LP and HP units were provided with signs that read no exit. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly audits of all doors to enclosed patios to ensure they have the proper signage. Criteria #4 The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	**10/18/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 7 N.J.A.C 8:39-31:2(e)	K 293		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/10/2024 and 10/11/2024 in the presence of the U.S. FOIA (b) (6)), it was	K 321	K321 Hazardous Areas/Enclosure	12/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	**10/18/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 8 determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7, 8.4 and NFPA 13. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 10/10/2024 between 10:56 AM and 11:47 AM revealed that the soiled utility rooms near rooms 34, 54 and 61 on the LP unit did not close and latch when tested by the U.S. FOIA (b) (6) An observation on 10/11/2024 at 9:57 AM revealed that Club Room #1 and the Employee Lounge near the employee entrance were being used as storage rooms for PPE. The size of the room and the amount of combustible items being stored would make the rooms hazardous areas. The doors to the storage rooms were not self-closing or automatic closing. An observation on at 10:20 AM revealed that both sets of double swinging doors to the laundry room did not close and latch when tested by the U.S. FOIA (b) (6) In interview at the time, the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM. N.J.A.C 8:39-31:2(e) NFPA 13	K 321	Criteria #1 The identified soiled utility room door on the LP unit that did not latch was repaired. Doors to the Club Room and employee lounge were provided with self-closing devices The set of double doors leading to the laundry room that did not latch were repaired. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly audits of all fire rated doors to ensure they close and latch. Criteria #4 The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation	K 341		12/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	**10/18/2024**

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

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K 341	Continued From page 9 A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/10/2024 and 10/11/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to provide fire alarm notification by audible and visible signals in the enclosed courtyard of the LP, HP and SP units in accordance with NFPA 101:2012 LSC Edition, Sections 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72:2010 Edition, Sections 18.5, 18.5.2.4,and 24.4.2.20.9. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 10/10/2024 at 11:35 AM and 12:30 PM revealed that the enclosed courtyards on the LP and HP units were not provided with means of audible and visual notification of the fire alarm system. An observation on 10/11/2024 at 9:39 AM	K 341	K341 Fire Alarm System-Installation Criteria #1 The enclosed patios identified on HP, LP and SP were provided with visual and audible notification of the fire alarm Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly audits of the enclosed patios to ensure they are provided with visual and audible notifications of the fire alarm system. Criteria #4	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 341	Continued From page 10 revealed that the enclosed courtyard on the SP unit was not provided with means of audible and visual notification of the fire alarm system. In interviews at the time, the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM. N.J.A.C 8:39-31:2(e) NFPA 72	K 341	The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on	K 351	K 351	12/15/24

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	315029	A. BUILDING 01 B. WING _____	10/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 11 10/11/2024 and 10/16/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that it was protected throughout by an approved automatic sprinkler system in accordance with NFPA 101:2012 Edition, Sections 19.3.5.1, 9.7 and NFPA 13, Standard for the installation of Sprinkler Systems. This deficient practice had the potential to affect all residents and is evidenced by the following: An observation on 10/11/2024 at 9:32 AM revealed, that room 228 on the SP unit had two closet spaces that contained HVAC units. Neither closeted space contained sprinklers. An observation on 10/16/2024 at 9:20 AM revealed, that rooms 232 and 227 on the WLP unit had closet spaces that contained HVAC units. The closeted spaces did not contain sprinklers. In interviews at the time, the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM. N.J.A.C 8:39-31:2(e) NFPA 13	K 351	Sprinkler System Installation Criteria #1 Return plenum spaces identified on the SP unit room 128 and WLP unit rooms 232 and 227 had sprinklers installed. Criteria #2 All residents have the potential to be affected by this deficient practice. Criteria #3 Director of Building Services will conduct monthly sprinkler audits. Criteria #4 Director of Building Services will report the results of these audits to the facilitiy□s QAPI committee monthly for three months and then quarterly thereafter.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		12/15/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 355	Continued From page 12 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/10/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that portable fire extinguishers were installed so that the top of the fire extinguisher was not more than 5-feet above the floor in accordance with NFPA 101: 2012 Edition, Section 9.7.5 and NFPA 10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:50 AM, revealed that the fire extinguisher near the dining room on the LP unit was installed at 68-inches above the ground. In an interview at the time, the U.S. FOIA (b) (6 confirmed the observation and stated that all the fire extinguishers in the LP hallway were installed at the same height. An observation at 11:52 PM revealed that the fire extinguishers near 301 and 331 on the HP unit were installed at 69-inches above the ground. In an interview at the time the U.S. FOIA (b) (6 stated that just like the LP unit, all the fire extinguishers in the HP unit were installed at the same height. N.J.A.C 8:39-31:2(e) NFPA 10	K 355	K355 Portable Fire Extinguishers Criteria #1 The identified fire extinguishers on the HP and LP units that were found to be hung at a height where the top was greater than 5 feet were rehung at the appropriate height. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly fire extinguisher audits to ensure they are hung at the proper height. Criteria #4 The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 374		12/15/24

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K 374	Continued From page 13 Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/10/2024 and 10/11/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that smoke barrier doors closed into their frames and were kept clear of anything that could interfere with the free operation of the door in accordance with NFPA 101:2012 Edition, Sections 19.3.7.6, 19.3.7.8, 19.3.7.9, NFPA 105 sections 5.2.2.1 and 5.2.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 10/10/2024 at 11:05 AM, revealed that a smoke barrier door to the back section of the LP unit was prevented from closing by a door stop that was not properly attached to the ground. An observation at 11:13 AM, revealed that the back dining room door on the LP unit did not latch closed when tested by the U.S. FOIA (b) (6)	K 374	K374 Smoke Barrier Doors Criteria #1 The identified fire doors on the LP unit that was prevented from closing due to a door stop was repaired. The back dining room door and by room 62 on LP that did not latch was repaired. The door by the dietitian office that did not properly close was repaired. The paper wedged in the staff dining room door was removed. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly smoke barrier door audits to ensure they properly close and latch.	

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K 374	Continued From page 14 An observation at 11:40 AM, revealed that the dining room door near room 62 on the LP unit did not latch closed when tested by the U.S. FOIA (b) (6) An observation at 11:47 AM, revealed that the smoke barrier doors near the dietitian office did not close into its frame when tested by the U.S. FOIA (b) (6) An observation at 12:46 PM, revealed that the employee dining room door near the HP unit was being held open by wedged pieces of paper towel. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM. N.J.A.C 8:39-31:2(e) NFPA 105	K 374	Criteria #4 The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/10/2024 and 10/11/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that	K 521	K521 HVAC Criteria #1	12/15/24

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K 521	Continued From page 15 resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 10/10/2024 between 10:28 AM and 12:10 PM, revealed that the bathroom ventilation in room 50 on the LP unit and rooms 305 and 333 on the HP unit were not functioning when tested the U.S. FOIA (b) (6) An Observation on 10/11/2024 at 9:21 AM, revealed that the bathroom ventilation in room 115 on the SP unit was not functioning when tested by the US FOIA (b)(6) In interviews at the time the U.S. FOIA (b) (6) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 1:00 PM. N.J.A.C 8:39-31.2(e) NFPA 90A.	K 521	The ventilation in the bathrooms in room 50 on the LP unit, and rooms 305 and 333 on the HP unit were repaired. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly bathroom ventilation audits. Criteria #4 The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record.	K 531		12/15/24

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 16 Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 10/16/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that elevators were inspected and tested in accordance with NFPA 101:2012 Edition, Sections 19.5.3, 9.4.2,9.4.3 and ASME A 17.1, and A 17.3. This deficient practice had the potential to affect all residents and is evidenced by the following: A documentation review revealed that the last annual elevator inspection certificate that was on file was issued on 02/11/2022. The certificate that was provided for device P2-02 was a temporary certificate of occupancy/compliance and stated, "the following conditions must be met no later than 02/09/2023 or the owner will be subject to fine or order to vacate: as stated in the attached inspection report, all violations should be corrected." The inspection report that indicated the violations and or the remedy of the violations could not be provided.	K 531	K 531 Elevators Criteria #1 Documentation for the 2024 elevator inspection was received. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly elevator inspection audits to ensure that all elevators are inspected on a timely basis. Criteria #4 The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315029	A. BUILDING **01** B. WING _____	**10/18/2024**

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

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K 531	Continued From page 17 Annual elevator certificates of occupancy/compliance for 2023 or 2024 were not provided for any of the three elevators. In an interview at the time, the U.S. FOIA (b) (6 confirmed that inspections were not done in 2023 and stated that the elevator inspections for 2024 were done on 06/27/2024, and they were just waiting on the certificates to arrive. Documentation for an annual safety test of ELV 1 was provided. No Further documentation regarding the elevators was provided. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM. N.J.A.C 8:39-31:2(e) ASME A 17.1, A 17.3	K 531		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761		12/15/24

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	315029	A. BUILDING **01** B. WING _____	**10/18/2024**

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K 761	Continued From page 18 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review, observations, and interviews on 10/16/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review revealed that monthly inspections only inspected for the closing and latching of fire doors. Annual inspections in accordance with NFPA 80 5.2.4.2 were not provided and the list did not include the fire doors to stairway enclosures. An observation at 10:20 AM, revealed that the door to the stairway enclosure near the conference room contained a fire rated door assembly. In an interview at the time, the U.S. FOIA (b) (6 confirmed the observation and stated that doors that are usually kept in the closed position are not part of his fire door inspections. An observation at 10:22 AM, revealed that the 2-cent plain coffee shop contained 2 rolling fire doors. In an interview at the time, the U.S. FOIA (b) (6 confirmed the observation stated that since the rolling fire doors are kept in the closed position and the coffee shop is closed, the rolling fire doors are no longer drop tested annually.	K 761	K 761 Maintenance, Inspection and Testing Doors Criteria #1 Documentation for the 2024 elevator inspection was received. Criteria #2 All residents are found to be at risk due to this deficient practice Criteria #3 The Director of Building Services or designee will conduct monthly elevator inspection audits to ensure that all elevators are inspected on a timely basis. Criteria #4 The Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	

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K 761	Continued From page 19 The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference at 1:00 PM N.J.A.C 8:39-31.2(e) NFPA 80	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		12/15/24

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K 918	Continued From page 20 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review, observations, and interview between 10/10/2024 and 10/16/2024, it was determined that the facility failed to ensure that emergency generators were provided and maintained in accordance with NFPA 99:2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 10/11/2024 between 10:35 AM and 1:30 PM revealed: 1) The [NJ Ex Order 26] 150 KW emergency generator did not have an annunciator panel in a continuously occupied area, did not have a functioning backup battery emergency light and the generator was not provided with a remote manual stop station. 2) The 150 KW generator located in the blue room had not functioned in two years and a rental 150 KW generator was being utilized in its place. The emergency generator did not have an annunciator panel in a continuously occupied area, did not have a functioning backup battery emergency light and the generator was not provided with a remote manual stop station. 3) The [NJ Ex Order 26] 400 KW emergency generator did not have an annunciator panel in a continuously occupied area, was not provided with a backup battery emergency light and the generator was	K 918	K918 Electrical Systems-Essential Electric Criteria #1 Battery backup lights were repaired in each area by the [NJ Ex Order 26] generator, the generator in the blue room and the [NJ Ex Order 26.4(b)] generator. Consultations with generator companies will take place to discuss installation of an annunciator panel and remote manual stop station on each of the generators and/or replacement of the generators. Criteria #2 All residents have the potential to be affected by this. Criteria #3 Director of Building Services will conduct monthly audits of the emergency back up lighting. Director of Building Services will conduct monthly audits of the generator. Criteria #4 Director of Building Services or designee will report the results of these audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	

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K 918	Continued From page 21 not provided with a remote manual stop station. In interviews at the times, The [U.S. FOIA (b) (6)] confirmed the observations and stated that they believed they were grandfathered into not needing to comply with the regulations for the annunciator panel or remote stop, and that a rental generator is being used in place of the blue room generator because they are waiting to see what is going to happen with the planned renovations/constructions. A documentation review on 10/15/2024, revealed that the [NJ Ex Order 26] 400 KW generator shut down 20 minutes into the monthly load test on 7/16/2024 and would not restart. It was not load tested for the month of August and was not tested again until it was repaired on 9/4/24. Over 7 weeks later. In an interview on 10/16/2024, when asked why the generator was not tested for the month of August, the [U.S. FOIA (b) (6)] stated that they were waiting on parts to repair the generator. The [U.S. FOIA (b) (6)] confirmed that while the facility was waiting for the generator repairs, they did not have emergency power/lighting on the RHP, LP, HP, or BP units for over 7 weeks and stated that as part of their contract with the generator company they would be provided with a generator of the same capacity within 2 hours in case of an emergency. A documentation review on 10/15/2024, revealed the 150 KW [NJ Ex Order 26] generator did not pass the load bank test that was conducted on 9/8/2023. On the generator load test report that was provided, the generator service company stated "Unit failed load bank test. Unit shut down due to high engine temperature. Unit will need to be	K 918		

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K 918	Continued From page 22 repaired or replaced." In an interview on 10/16/2024, the [redacted] stated "The repairs were not made because the [redacted] 150 KW generator is a non-resident area generator, should it no longer work we would take it offline. Since it works fine with the load connected to it, we continue to operate it as per P3 generator". The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM N.J.A.C 8:39-31:2(e) NFPA 99	K 918		
K 928 SS=F	Gas Equipment - Labeling Equipment and Cylind CFR(s): NFPA 101 Gas Equipment - Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL." Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	K 928		12/15/24

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K 928	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/10/2024 and 10/11/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that when empty and full oxygen cylinders were stored in the same enclosure, empty cylinders were marked to avoid confusion and delay in accordance with NFPA 99: 2010 Edition, Sections 11.6.5.2 and 11.6.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 10/10/2024 at 12:24 PM, revealed that the oxygen storage room on the HP unit contained both full and empty oxygen cylinders, (16) total. There was no signage or markings indicating which cylinders were filled or empty. An observation on 10/11/2024 at 9:01 AM, revealed that the oxygen storage room on the SP unit contained both full and empty oxygen cylinders (18) total. There was signage posted that read "Please place empty tanks in rack". The rack contained two empty and 10 filled oxygen cylinders. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 10/16/2024 at 1:00 PM. N.J.A.C 8:39-31:2(e) NFPA 99	K 928	F928 Gas Equipment-Labeling Equipment and Cylinders Criteria #1 The identified oxygen storage tanks in the oxygen storage rooms on both HP and SP that contained both full and empty tanks were separated. Separate oxygen racks were placed in the oxygen rooms on HP and SP. One rack will be for full tanks and the other will be for empty. Criteria #2 All residents are found to be at risk for this deficient practice. Criteria #3 Oxygen room audits will be conducted by the Director of Nursing or designee on a daily basis. Criteria #4 The Director of Nursing or designee will report the results of the oxygen storage audits to the facility□s QAPI committee monthly for three months and quarterly thereafter.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315029 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/30/2024 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	12/15/2024	LSC K0271	12/25/2024	LSC K0281	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	12/15/2024	LSC K0321	12/15/2024	LSC K0341	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	12/15/2024	LSC K0355	12/15/2024	LSC K0374	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	12/15/2024	LSC K0531	12/15/2024	LSC K0761	12/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	12/15/2024	LSC K0928	12/15/2024	LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO