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	11/10/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 392826 (187404)Based on observations, interviews, record review, and review of other pertinent facility provided documentation, the facility failed to ensure a.) the residents' current active care plan (CP) contained the interventions that were implemented after each resident's fall and were followed in order to prevent any additional falls for 3 of 3 residents (Residents #1, #2, and #3) reviewed for accidents and falls and b) fall investigations were thoroughly investigated and completed in accordance with the facility's practice and policy for 2 of 3 residents reviewed for falls (Residents #1 and #2). The deficient practice was evidenced by the following: 1.On 11/10/25 at 9:20 AM, Surveyor #1 (S #1) toured the Memory Unit and interviewed the Registered Nurse Supervisor (RNS), who informed S #1 that Resident #1 was at risk for falls due to cognitive impairment and had recent falls. On that same date at 9:25 AM, S #1 observed Resident #1 in the dining area, seated in a wheelchair (w/c) with other residents and able to feed self during breakfast. On 11/10/25 at 10:16 AM, S #1 asked the Executive Director (ED; also known as the Licensed Nursing Home Administrator) of Resident #1's last six months fall incident investigations and Physical Therapy (PT) notes. S #1 reviewed the medical records of Resident #1, and revealed: A review of the Resident Face Sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; unspecified dementia, unspecified severity, with psychotic disturbance, delusional disorders, and anxiety disorder unspecified. A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of 8/425, reflected a brief interview for mental status (BIMS) score of 5, which indicated that resident's cognition was severely impaired. A review of the Nursing Fall Risk assessment dated [DATE] revealed that the resident had history of falls 1-2x's (1 to 2 times) and total score was 15 (high risk). A review of the Nursing Post Fall Checklist revealed: (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/25, Resident #1 had a fall incident in the dining room while resident stood up from the w/c, and there was no injury noted. On 9/26/25, Resident #1 had a fall incident in the dining room, ambulating unassisted, found on the floor by the nurse in front of w/c, and there was no injury. On 9/30/25, Resident #1 attempted to stood up, fell from w/c to the floor in front of dining room. On 10/1/25, Resident #1 had a fall incident in the dining room and sustained reddish/blackish bump on forehead. A review of the provided accident investigation by the Director of Nursing (DON) revealed: On 9/15/25 at 12:45 PM, Resident #1 was witnessed by Licensed Practical Nurse #1 (LPN #1) fell backward from their w/c in the dining room, no injury. The measures to prevent recurrence was to continue to provide monitoring. On 9/26/25 at 8:20 AM, Resident #1 had an unwitnessed fall in the dining room with no injury. The corrective action taken, resident was assessed for injury and medical work up. The measures to prevent recurrence was close monitoring and assess for anti-roll back w/c. There were no statements from the staff. On 9/30/25 at 11:00 AM, Resident #1 attempted to get out of w/c in the dining room, fell, and no injury. The corrective action taken, recently on rehabilitation with medications (meds) change, psychotic meds were decreased. The measures to prevent recurrence was meds management and medical work up. LPN #2 statement included that while working in the hallway, a Certified Nurse Aide (CNA) called the LPN in the dining room, and found the resident on the floor in front of their w/c. There was no statement from the CNA and other staff. On 10/1/25 at 4:40 PM, Resident #1 had an unwitnessed fall in the dining room and the resident sustained bruising to right forehead. The measures to prevent recurrence was close monitoring. There was no statements included in the fall investigation. A review of the care plan (CP) revealed that the CP was not updated or revised to include the post fall interventions, measures to prevent recurrence of fall, that were, continue monitoring, close monitoring, and anti-roll back w/c. 2. On 11/10/25 at 9:20 AM, the RNS informed S #1 that Resident #2 was at risk for falls due to cognitive impairment and had recent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/10/25 at 9:38 AM, S #1 interviewed LPN #1, who informed S #1 that as per facility's standard of practice, when a resident had a fall incident, the nurse will initiate the investigation and utilize the incident report. He stated that there should be statements from staff who were assigned to the resident in order to determine what the resident was doing before the incident that could contributed to resident's fall. He further stated that the resident would be assessed at the time of incident, monitored every shift for three days, and all would be documented in the electronic medical records, the Resident's Representative (RR) and physician would be notified. LPN #1 added that it was the responsibility of the Nursing Supervisor to update or revise the CP of the new interventions post fall to prevent the recurrence of fall and further injury. On 11/10/25 at 9:50 AM, S #1 observed Resident #2 seated in their bed with one floormat on the right side of the bed floor and the resident was eating breakfast. There was no floormat on the left side of the bed. S #1 also observed that Resident #1 had discoloration around their right eye and dried wound on the right forehead. During the interview of S #1 with Resident #2, the resident was unable to state what happened to their right eye and forehead. The resident was unable to remember if they had fall incidents. Outside the resident's room was Certified Nursing Aide #1 (CNA #1) who informed S #1 that Resident #2 was cognitively impaired, and unable to state why the resident had right eye bruising and dried wound on right forehead, nor about fall incidents. On 11/10/25 at 9:55 AM, LPN #3 informed S #1 that she was the assigned nurse of Resident #2. LPN #3 stated that Resident #2 was cognitively impaired, was previously form subacute unit and had to moved in the memory care unit because the resident required more assistance and monitoring due to dementia. She confirmed that the resident's discoloration around the right eye and forehead was from a fall and that the resident was unable to remember what had happened. On that same date at 10:07 AM, CNA #2 informed S #1 that she was the assigned aide of Resident #2. She stated that the resident with periods of confusion, had a fall incident last weekend and sustained bruising to their right forehead and eye. She was unable to state as to why there was only one floor mat on the floor. S #1 reviewed the medical records of Resident #2, and revealed: A review of the Resident Face Sheet revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; other toxic encephalopathy (a neurological disorder caused by exposure to neurotoxic substances, leading to symptoms such as altered mental status, memory loss, and visual problems), difficulty in walking not elsewhere classified, and muscle weakness (generalized). A review of the most recent comprehensive MDS, with an ARD of 10/13/25, reflected a BIMS score of 4, which indicated that resident's cognition was severely impaired. A review of the Nursing Fall Risk assessment dated [DATE] revealed that the resident's total score was 14 (high risk). A review of the Nursing Post Fall Checklist revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/25, Resident #2 had an unwitnessed fall incident and sustained one centimeter long abrasion to right shin. On 11/5/25, Resident #2 had a fall incident in the dining room and sustained laceration and hematoma. A review of the provided accident investigation by the DON revealed: On 10/22/25 at 11:15 PM, Resident #2 had an unwitnessed fall, found sitting on the floor in front of their bed and sustained one cm (centimeter) long abrasion to right shin. The corrective actions taken was to place floor mattress to both side of the bed. The measures to prevent recurrence was to monitor hourly when in room. There were no statements from other staff except from the 11-7 shift nurse. On 11/2/25 at 10:40 AM, Resident #2 had an unwitnessed fall in the day room and sustained a small open area and ecchymosis area to right forehead. The corrective action taken, hip protectors in use, had resident in a supervised area at all times, and closely monitored. The measures to prevent recurrence was safety monitoring. There was no statements from staff. A review of the CP revealed that the CP was not updated or revised to include the post fall interventions, measures to prevent recurrence of fall, that were, floormats on the floor, monitor hourly when in room, supervised area at all times, and close monitoring. On 11/10/25 at 1:19 PM, the surveyors met with the ED, DON, and the Assistant Administrator in Training (AAIT), and the DON stated that it was an expectation that for the unwitnessed falls, there should be statements from staff in the accident reports. The DON further stated that the interventions in each fall incident should be in the CP. At that same time, S #1 asked the facility management what close monitoring different from continue monitoring and how the staff should follow the interventions post fall. The DON responded that the facility was unable to do 1:1 monitoring at the facility. S #1 notified the ED, DON, and AAIT of the above findings and concerns for Residents #1 and #2. A review of the CNA Documentation History Detail (CNA log) that was provided by the Registered Nurse MDS Coordinator (RNMDSC) revealed that there was no information about bilateral floor mats, hourly monitoring, and supervised at all times. On 11/10/25 at 2:13 PM, the surveyors met with the ED, DON, and AAIT, and there was no additional information provided by the ED. The DON confirmed that there were no other statements from staff for all identified fall investigations for Residents #1 and #2. 3. On 11/10/25 at 9:20 AM, Surveyor #2 (S #2) observed Resident #3 in bed eating breakfast independently. Resident #3 told S #2 that they had a stroke and had left-sided weakness. Resident #3 further stated that they had fallen a few times before the staff started using a mechanical lift for transfers. Resident #3 stated they had not fallen recently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #3's admission Record reflected the resident was admitted to the facility with diagnoses which included but were not limited to; hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body), bilateral osteoarthritis of the knees, and morbid obesity. A review of the most recent MDS, with an ARD of 6/24/25, reflected that Resident #3 had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Section GG assessed that the resident required the assistance of two staff members for transfers. A review of Resident #3's comprehensive CP dated 7/24/24 and reviewed 7/26/25, included a focus area that indicated that the resident was dependent on two staff members for transfers. A review of the facility's accident/ incident nurses note dated 6/11/25 at 10:10 PM, reflected that while the nurse was preparing meds in the hall, a CNA came out from Resident #3's room and informed the nurse that the resident slid down on one knee while the CNA was trying to transfer the resident from the toilet seat to the w/c. The nurse went to the room and observed Resident #3 on the bathroom floor on their knees, crying. Resident #3 complained of pain in their right knee. All responsible parties were notified. The Nurse Practitioner ordered an X-ray of the right knee and an order for the rehabilitation department to screen for treatment from the occupational and physical therapy department. Further review revealed that Resident #3 was transferred to the hospital Emergency Department due to complaints of knee pain. All testing proved negative for injury. The resident was readmitted to the facility on antibiotics for a urinary tract infection. On 11/10/25 at 12:15 PM, S #2 conducted a telephone interview with the assigned CNA (CNA #3) who transferred Resident #3 without the assistance of a second staff member. CNA #3 stated that she was not aware that the resident required two staff members for transfers and that she should have checked the resident's plan of care before transferring them. On 11/10/25 at 1:10 PM, during an interview with S #2, the RNMDSC confirmed that Resident #3 had been care-planned as dependent on two staff members for all transfers, effective from 1/18/24 to the present. On 11/10/25 at 1:20 PM, the survey team discussed the above observations and concerns with the ED, AAIT, and the DON. The DON confirmed that CNA #3 should have followed the resident's CP for a two-person transfer. A review of the facility's Accident/Incident Report Policy that was provided by the DON, with a reviewed date of 7/2025, revealed that it was the facility's policy to document and investigate all incidents that involve residents, whether or not injury occurs.Procedure:.3. The person completing the report will interview any witnesses to the event to determine what occurred. Any witness (es) to the accident & incident (A&I) will give a written, signed statement indicating any knowledge or information they have pertaining to the incident.6. All sections of the A&I Report are to be completed.These statements will be submitted to the Supervisor after entering the statement into electronic medical records. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Fall Policy and Procedure that was provided by the DON, with a reviewed date of 7/2025, revealed that it was the facility's policy to document and investigate all falls that involve residents, whether or not injury occurs.Procedure:.3. The person completing the report will interview any witnesses to the event to determine what occurred. Any witness (es) to the A&I will give a written, signed statement indicating any knowledge or information they have pertaining to the incident.6. All sections of the A&I Report are to be completed.These statements will be submitted to the Supervisor after entering the statement into electronic medical records. A review of the facility's Care Planning Policy that was provided by the DON with a revised date of 1/2025, revealed that there was no information about CP update and revision. No further information was provided by the ED. NJAC 8:39-27.1 (a); 33.1(d)