

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Daughters of Israel Pleasant Valley Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>19106</p> <p>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.</p> <p>The deficient practice was evidenced by the following.</p> <p>The surveyor conducted a group meeting on 10/16/24 at 11:00 AM with 6 alert and oriented residents chosen by the facility.</p> <p>Six of 6 residents stated they did not know where to find the State inspection results.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>The surveyor showed the binders to the Director of Nursing (DON) on 10/17/24 at 9:15 AM while in the HP day room. The DON confirmed the most recent inspection results of 8/10/23 were not posted in the books. She stated she would update the binders.</p> <p>The DON returned to the surveyor on 10/17/24 at 9:30 AM. She stated the Administrator 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.</p> <p>NJAC 8:39-9.4(b)(c)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419</p> <p>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 side rails for 1 of 21 residents, (Resident #56) and b.) ensure staff follow the physician's order according to the 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.</p> <p>This deficient practice was evidenced by the following:</p> <p>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.</p> <p>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.</p> <p>1. On 10/10/24 at 10:45 AM, the surveyor observed Resident #56 in bed with his/her eyes open with two full padded side rails in use. The resident did not respond to the surveyor and the surveyor was unable to interview the resident.</p> <p>On 10/18/24 at 10:35 AM, the surveyor observed Resident #56 in bed with their eyes closed. The surveyor observed two full padded side rails in use.</p> <p>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 dementia and depression.</p> <p>The surveyor reviewed the Minimum Data Set (MDS), an assessment tool dated 5/26/24 which assessed Resident #56 had a brief interview for mental status score of 2 out of 15 which indicated a severe cognitive impairment. Further review of the MDS revealed Resident #56 was dependent on staff for activities of daily living (ADLs) and transfers from the bed to the chair.</p> <p>A review of Resident #56's care plan (CP) reflected a focus area for ADL function and mobility effective date 5/28/24 that included an intervention that the resident will be provided one side rail up in bed for positioning.</p> <p>A review of the current physician's orders (PO) reflected a PO for 1 side rail up when in bed for positioning. The CP had an original order date of 1/17/20 and a renewal date of 10/8/24.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Side Rail assessment dated [DATE] indicated .Side rails are indicated and serve as an enabler to promote independence in bed mobility .side rails are not considered a restraint device .provide one side rail up in bed for positioning .</p> <p>A review of Resident #56's Side Rail assessment dated [DATE] indicated .Side rails are indicated and serve as an enabler to promote independence in bed mobility .side rails are not considered a restraint device . provide one side rail up in bed for positioning .</p> <p>A review of Resident #56's Consent form for the use of 1 side rail was signed by the resident's daughter and facility social worker and dated 12/1/21.</p> <p>On 10/17/24 at 11:42 AM, the surveyor interviewed the Director of Building Services who stated that the facility ordered the side rails from the original manufacturer of the bed frame. He further stated that he ordered standard size siderails.</p> <p>On 10/18/24 at 10:36 AM, the Director of Nursing (DON) accompanied the surveyor to resident #56's room and the DON and surveyor together observed Resident #56 was in bed with 2 full padded side rails up. The DON confirmed that the PO was for 1 side rail, a Side Rail Assessment should have been completed quarterly and a PO should have been obtained prior to the use of 2 side rails.</p> <p>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.</p> <p>2.) On 10/16/24 at 9:47 AM, the surveyor observed the LPN prepare medications for Resident #252 that included a physician order (PO) for losartan 25 milligram (mg) tablet, give 1 tablet by oral route once daily at 9:00 AM, for hypertension with Parameters to hold for systolic blood pressure (SBP) less than 110 and a PO for metoprolol succinate ER 25mg give 1 tablet by oral route once daily, give with meals every day at 9:00 AM, with parameters to hold for SBP less than 100 and to hold for pulse less than 56 beats per minute. The LPN stated that he had already taken Resident #252's vital signs earlier that morning. The surveyor asked the LPN what time he had taken them. The LPN replied, about an hour ago, and proceeded to administer the two blood pressure medications.</p> <p>On 10/16/24 at 1:06 PM, the surveyor interviewed the LPN in the presence of another surveyor who acknowledged that he should have taken Resident #252's vital signs within 15 minutes of administering the blood pressure medications per facility policy.</p> <p>On 10/16/24 at 1:34 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to discuss the above observations and concerns. The DON stated that the LPN should have retaken the vital signs prior to administering the medications.</p> <p>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.</p> <p>No further information was provided by the facility.</p> <p>(continued on next page)</p>		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-27.1(a), 29.2(d)		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>36419</p> <p>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 Activities of Daily Living (ADL) received personal hygiene care in accordance with the facility policy.</p> <p>This deficient practice was identified for 1 of 1 resident (Resident #22,) reviewed for ADL care and was evidenced by the following:</p> <p>On 10/10/24 at 10:49 AM, the surveyor observed Resident #22 in bed with the Certified Nursing Assistant (CNA) assigned to their care in their room. The surveyor observed the resident's fingernails to be long, jagged and soiled with a brown substance underneath. Resident #22 stated that he/she would like to go to the salon to have their nails cleaned and manicured. The CNA told the resident she would see if the resident was on the list to go to the salon.</p> <p>On 10/16/24 at 12:00 PM, the surveyor observed Resident #22 in the HP front dining room seated in a wheel chair. The surveyor observed the resident's fingernails to be long, jagged and soiled with a brown substance underneath.</p> <p>On 10/17/24 at 9:53 AM, the surveyor observed Resident #22 in bed. The surveyor observed the resident's fingernails to be long, jagged and soiled with a brown substance underneath.</p> <p>On 10/17/24 at 10:15AM, the surveyor, in the presence of another surveyor, interviewed the CNA. The CNA stated that CNAs were only responsible for cleaning the residents nails, but the activity staff were responsible for clipping and filing their nails. The surveyor showed the CNA Resident #22's nails. The CNA acknowledged that they were long, jagged and soiled with a brown substance underneath. The surveyor asked the CNA why she hadn't cleaned Resident #22's fingernails. The CNA did not respond to the surveyor's question.</p> <p>On 10/17/24 at 10:22 AM, the surveyor, in the presence of another surveyor, interviewed the Licensed Practical Nurse (LPN) assigned to Resident #22's care. The LPN stated that the CNAs were responsible for cleaning, clipping and filing resident's nails.</p> <p>A review of the Admission Record revealed Resident #22 had been admitted with diagnoses which included but were not limited to; dementia, end-stage heart failure, and chronic respiratory failure with hypoxia (a medical condition that occurs when there is not enough oxygen in the body's tissues.)</p> <p>A review of the most recent Annual Minimum Data Set (MDS) an assessment tool, dated 3/22/24, included but was not limited to; a brief interview of mental status (BIMS) score of 0 of 15 which indicated the resident had a severe cognitive impairment. Section GG documented that Resident #22 required moderate assistance with personal hygiene.</p> <p>A review of the Care Plan documented a focus area date effective 3/25/24, the resident required assistance with ADL care and mobility. Interventions included but were not limited to . encourage resident to participate in ADL care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/17/24 at 3:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns.</p> <p>On 10/18/24 at 8:44 AM, the DON provided the surveyor with a copy of the Salon List dated 10/10/24. A review of the list reflected that Resident #22 would go to the Salon, as requested. It further document that their last visit was 9/12/24.</p> <p>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).</p> <p>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.</p> <p>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 care. Activities may apply polish only .</p> <p>NJAC 8:39-27.1(a), 27.2(g)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>36419</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer oxygen therapy according to the physician's order and failed to ensure respiratory nasal cannula tubing was stored in accordance with infection control measures for 1 of 1 resident reviewed for Respiratory therapy, Resident #22.</p> <p>This deficient practice was evidenced by the following:</p> <p>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, 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.</p> <p>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.</p> <p>On 10/10/24 at 10:49 AM, the surveyor observed Resident #22 lying in bed with Oxygen (O2) delivered via a nasal cannula (NC) tubing attached to the O2 concentrator at 2 liters per minute (LPM)). The surveyor observed that there was an additional NC tubing dated 10/4/24 attached to a portable O2 tank that was on the back of Resident #22's wheelchair. The NC tubing was hung over the portable tank and it was not contained in a bag.</p> <p>On 10/17/24 at 9:53 AM, the surveyor observed Resident #22 lying in bed with O2 delivered at 2.5L via a NC tubing attached to the O2 concentrator. The surveyor observed that additional NC tubing dated 10/12/24, was attached to a portable O2 tank on the back of the wheelchair. The NC tubing was hung over the portable tank and it was not contained in a bag.</p> <p>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; dementia, end-stage heart failure, and chronic respiratory failure with hypoxia (a medical condition that occurs when there is not enough oxygen in the body's tissues.)</p> <p>A review of Resident #22's most recent Annual Minimum Data Set (MDS), an assessment tool, dated 3/22/24 included; a Brief Interview for Mental Status (BIMS) score of 0 of 15 which indicated the resident had a severe cognitive impairment. Section GG documented that Resident #22 required moderate assistance with personal hygiene and Section O documented that the resident was receiving respiratory treatment which included O2 therapy.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Care Plan documented a focus area effective 3/25/24 which included: Resident has a Respiratory Disorder: dyspnea (shortness of breath) related to end-stage congestive heart failure (CHF). Interventions included but were not limited to: Oxygen therapy as per physician order and to provide treatments per physician order.</p> <p>A review of the October 2024 Physician's Orders revealed an active physician order (PO) with an order date of 2/13/22 and renewed of 10/8/24 for: O2 at 2LPM (liters per minute) per NC every shift.</p> <p>On 10/17/24 at 10:15 AM, the surveyor, in the presence of another surveyor, interviewed the CNA who stated that the night shift was responsible for ensuring that the NC tubing was stored properly in a plastic bag. The surveyor asked the CNA if she should have discarded the tubing and obtained a new one since they both observed the tubing was not stored properly in a bag. The CNA confirmed that she should have discarded the contaminated tubing and obtained a new clean tubing.</p> <p>On 10/17/24 at 10:22 AM, the surveyor, in the presence of another surveyor, interviewed the Licensed Practical Nurse (LPN) assigned to the care of Resident #22. The surveyor showed the LPN the O2; the LPN confirmed that the O2 was infusing at 2.5 LPM and that the PO was for 2LPM. The LPN acknowledged that during his morning rounds, he should have checked that the Oxygen was infusing per the physician order and should have checked to see that the NC tubing was stored properly in a bag.</p> <p>On 10/17/24 at 3:03 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The DON stated the facility policy was that the O2 tubing should be stored in a bag when not in use.</p> <p>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 .</p> <p>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 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 .</p> <p>On 10/18/24 at 11:30 AM, the survey team met with the LNHA and DON. No additional information was provided by the facility.</p> <p>N.J.A.C. 8:39- 19.4(a); 27.1(a)</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>45449</p> <p>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.</p> <p>This deficient practice was evidenced by the following:</p> <p>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.</p> <p>On 10/16/24 at 11:24 AM, during an interview with the surveyor, the Human Resources Director (HRD) stated that the Director of Nursing (DON) was in-charge of education, competencies (lecture, training, pre and posttests) and performance reviews for the nursing staff.</p> <p>On 10/17/24 at 11:57 AM, during an interview with the surveyor, the DON 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 DON 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 DON also stated that the performance reviews for all nursing staff were based on the result of the competencies.</p> <p>On 10/17/24 at 1:02 PM, the surveyor requested from the DON and the Licensed Nursing Home Administrator, for the policy and procedure for the competencies and performance reviews of the nursing staff.</p> <p>On 10/18/24 at 9:00 AM, in the presence of two surveyors and the DON, 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.</p> <p>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 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.</p> <p>No additional information was provided.</p> <p>N.J.A.C. 8:39-43.17 (b)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45449</p> <p>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 controlled dangerous substance (narcotic medications, with high potential for abuse and are tracked with detail) to Resident #19, and discrepancies were identified, for the narcotic stored in the medication cart located on the high side of the LP unit, and b.) reconciliation of Controlled Drug Inventory Record (CDIR; shift to shift log, a count/signature of two (2) nurses for narcotic accountability) were consistently signed/completed for the medication cart located on the B-side of the HP unit.</p> <p>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:</p> <p>1.) On 10/17/24 at 9:16 AM, the two (2) surveyors and the Registered Nurse (RN) began the inspection of the narcotic medication cart inspection, which was stored in a mounted, double locked portion of the medication cart (narcotic box) located on the high side of the LP unit. In the presence, of a surveyor, and the RN, the surveyor observed that the CDIR was not signed by two (2) nurses for that day.</p> <p>At that time, the RN 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 Controlled Drug Record (IPDCR; declining inventory sheet used to track removal of a controlled drug from inventory) for Tramadol 50 mg (a narcotic medication, indicated for pain) that was administered on 10/16/24 [the night before].</p> <p>At that time, the RN 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 count for accountability on 10/16/24, did not identify the discrepancy prior to her shift. The RN informed the surveyors that she had notified the Nursing Supervisor and would let the Director of Nursing know of the shift-to-shift count discrepancy.</p> <p>On 10/17/24 at 9:24 AM, in the presence of a surveyor and the RN, the surveyor observed Resident #19's bingo card (blister packet which contains the medication) with a pharmacy label for Tramadol 50mg contained 10 tablets.</p> <p>At that time, the surveyor compared the bingo card against the IPCDR for Resident #19's Tramadol. The IPCDR log reflected a documented quantity of 11 remaining.</p> <p>At that time, the RN informed both surveyors that the discrepancy was that the 3:00 PM to 11:00 PM nurse had not signed the removal of the Tramadol from inventory (IPCDR log) however the nurse had signed the Medication Administration Record for 10/16/24, an attestation of administration .</p> <p>The surveyor reviewed the medical record for Resident #19.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Daughters of Israel Pleasant Valley Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1155 Pleasant Valley Way West Orange, NJ 07052	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 low back pain. Further review of the qMDS reflected Resident #19 received scheduled and as needed (PRN) pain medications. The resident reported moderate level of pain intensity.</p> <p>Review of the quarterly Minimum Data Set (qMDS), an assessment tool dated 8/20/24, reflected a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated that the resident was cognitively impaired.</p> <p>Review of the electronic Medication Administration Record (eMAR) for October 2024, included a physician order for Tramadol 50 milligram (mg) by oral route every 12 hours as needed (PRN) for pain. The physician order start date was 2/12/24. The surveyor compared the eMAR against the IPCDR which reflected that the Tramadol was not signed on the IPCDR as removed from the inventory but was signed administered on eMAR on 10/16/24.</p> <p>Review of the eMAR for September 2024, included a physician order for Tramadol 50 milligram (mg) by oral route every 12 hours as needed for pain. The physician order start date was 2/12/24. The surveyor compared the eMAR against the IPCDR which revealed the following:</p> <ul style="list-style-type: none"> -on 9/13/24 at 2:00 PM, the IPCDR was signed as removed from inventory but was not signed on the eMAR as administered. -on 9/23/24 at 8:57 PM, the IPCDR was signed as removed from inventory but was not signed on the eMAR as administered. <p>On 10/17/24 at 1:08 PM, during an interview with two (2) surveyors, Resident #19 stated she was not in pain and confirmed receiving Tramadol last night but could not recall the other dates.</p> <p>On 10/17/24 at 3:07 PM, in the presence of the survey team, the Licensed Nursing Home Administrator and the DON, the surveyor discussed the concern regarding the missing accountability, reconciliation and discrepancy of the IPCDR log against Resident #19's eMAR.</p> <p>On 10/18/24 at 9:13 AM, the DON stated that she had investigated the discrepancy between the IPCDR and the eMAR. The DON stated that there were two (2) different nurses involved who both stated that the PRN medication was in fact removed from inventory but was refused by the resident. Both nurses neglected to document the refusal, and the disposal of the narcotic medications. Both nurses were given education on medication administration and narcotic protocols. The DON acknowledged the concern.</p> <p>2.) On 10/17/24 at 10:17 AM, the surveyor, in the presence of another surveyor and the RN/Nursing Supervisor (RN/NS) began the narcotic medication cart inspection, located in the B-side of the HP unit.</p> <p>At that time, the surveyor reviewed the shift-shift log for October 2024 which reflected the following:</p> <ul style="list-style-type: none"> -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. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-10/7/24 at 11:00 PM, the nurse going off duty was blank.</p> <p>-10/9/24 at 7:00 AM, the nurse going on duty was blank.</p> <p>-10/10/24 at 7:00 AM, the nurse going on duty was blank.</p> <p>-10/10/24 at 3:00 PM, the nurse going off duty was blank.</p> <p>-10/12/24 at 11:00 PM, the nurse going off duty was blank.</p> <p>On 10/17/24 at 3:07 PM, in the presence of the survey team, the Licensed Nursing Home Administrator and the DON, the surveyor discussed the concern regarding the shift-to-shift reconciliation of controlled dangerous substance were not consistently signed/completed.</p> <p>On 10/17/24 at 10:50 AM, in the presence of the two (2) surveyors, the RN/SP confirmed the missing signatures on the CDIR, and acknowledged that the shift to shift log should have been signed by two (2) nurses. The RN/NS stated that he would ensure education be provided to the nursing staff and would inform the DON of the discrepancy.</p> <p>On 10/18/24 at 9:58 AM, the DON stated that she had investigated the concern for the missing shift to shift signature for reconciliation of the narcotic medications. The DON stated that two (2) nurses were involved and were given education regarding the importance of the shift-to-shift reconciliation. The DON acknowledged the errors.</p> <p>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.</p> <p>NJAC 8:39- 27.1(a), 29.2 (a) (d), 29.4 (i)(k), 29.7(c)</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>34421</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>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.</p> <p>This deficient practice was evidenced by the following:</p> <p>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 Infection Control Preventionist (IP) had not been in attendance for the three meetings.</p> <p>On 10/15/24 at 11:40 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the IP was not able to attend the QAPI meetings since that staff member works the evening shift (3-11) and is also the nursing supervisor. The DON stated that they do received reports from the IP, who meets with the DON often.</p> <p>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.</p> <p>N.J.A.C. 8:39-33.1 (b)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36419</p> <p>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:</p> <p>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.</p> <p>On 10/10/24 at 12:20 PM, the surveyor observed the Certified Nursing Assistant (CNA) assisted the residents with their hand hygiene. The surveyor observed the CNA 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 CNA. The CNA discarded the 4 wipes into the trash and without performing hand hygiene applied clothing protectors to the four residents.</p> <p>On 10/11/24 at 11:50 AM, the surveyor observed dining services in the HP front dining room.</p> <p>On 10/11/24 at 11:55 AM, the surveyor observed the activity coordinator (AC) 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 AC, 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.</p> <p>On 10/11/24 at 12:05 PM, the Activity Director (AD) entered the HP front dining room, and the surveyor observed the AD remove the plastic trash bag from the resident's wheelchair. At that same time, the surveyor asked the AD if the AC should have tied the trash bag to the back of a resident's wheelchair. The AD replied that she would not have done that, but everyone is different. The surveyor asked the AD if it was an Infection Control/dignity concern. The AD did not respond to the surveyor's inquiry.</p> <p>On 10/11/24 at 12:08 PM, the surveyor interviewed the AC 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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/11/24 at 12:54 PM, the surveyor interviewed the CNA 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 gloves, and put on a new pair of gloves to clean another resident's hands. The surveyor asked the CNA if she was in serviced to perform hand hygiene between gloves changes. The CNA replied, no. The surveyor asked the CNA why she did not follow her regular process for cleaning resident's hands yesterday as the surveyor had observed the CNA had not used gloves, nor had she sanitized her hands between residents. The CNA replied she had not practiced appropriate hand hygiene because she was nervous. The CNA acknowledged that she should have performed hand hygiene between residents.</p> <p>On 10/16/24 at 1:22 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The LNHA stated that the AC had been educated on proper infection control practices.</p> <p>On 10/17/24 at 3:03 PM, the survey team met with the LNHA and DON who confirmed that the staff should sanitize their hands between residents.</p> <p>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 .</p> <p>NJAC 8:39 - 19.4(a)(m)(n); 27.1 (a)</p>		