| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315029 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Daughters of Israel Pleasant Valley Home | 1155 Pleasant Valley Way<br>West Orange, NJ 07052 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to sanitize and air dry steam table pans in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 3/9/26 at 11:07 AM, in the presence of the General Manager (GM) and the Executive Chef (EC), the surveyor observed the following:On the dairy side of the kitchen, on a shelf in the food preparation area, the surveyor also observed 6 spice containers with their tops opened. The GM stated these lids should be closed. On the dairy side of the dish washing area, the surveyor observed 2 large shallow steam table pans, stacked and wet nested with water between them, the surveyor also observed 3- 2/3rd sized steam table pans, stacked and wet nested with water between them. The GM stated that the steam table pans should not be stacked when wet and should have been air dried first.A review of the Labeling and Dating policy, dated 5/2023, revealed all foods are labeled, dated, and securely covered.A review of 3 Compartment sink policy, dated 5/2023 revealed dishes should be air dried and do not stack wet dishes. NJAC 8:39-17.2(g) |

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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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) that the physician's orders were followed according to the standard of clinical practice for 4 of 4 residents, (Resident #8, 72, 108 and 114), reviewed for respiratory care, and b.) failed to provide a humidifier according to the facility's policy and procedure for one (1) of 4 residents, (Resident #108) reviewed for respiratory care.This deficient practice was evidenced by the following:1.On 3/6/26 at 10:35 AM, the surveyor observed Resident #8 in bed in their room, receiving oxygen via a nasal cannula (NC, a plastic prong attached to a tube, inserted into the nostrils through which O2 flows) from a concentrator and the surveyor observed the oxygen flow meter was set at 3.5 liters per minute (lpm).<br><br>A review of Resident #8's electronic health record (EHR) reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to: Dysphagia (a difficulty swallowing), Cerebral infarction (a stroke) and left hemiplegia and hemiparesis (weakness and/or paralysis of left side of the body).<br><br>A review of Resident #8's Annual Minimum Data Set (MDS), an assessment tool dated 2/24/26 revealed Resident #8 has severe cognition impairment and is dependent with all activities of daily living and transfers.<br><br>A review of Resident # 8's physician orders revealed an order with a start date of 12/4/25 and the details of the order prescribed resident to receive oxygen via nasal canula continuously at a flow rate of 2 lpm.<br><br>On 3/6/225 at 12:50 PM, the surveyor made a second observation of Resident #8 in bed in their room, receiving Oxygen via nasal canula from a concentrator and the surveyor confirmed the oxygen flow meter was set at 3.5 lpm.<br><br>On 3/6/26 at 12:55 PM, the surveyor interviewed the (Licensed Practical Nurse (LPN #1) assigned to Resident #8's care. The LPN #1 confirmed that Resident #8's oxygen orders in the resident's electronic health record (EHR) indicated that oxygen was ordered for a flow rate of 2 lpm continuously.<br><br>On 3/6/26 12:58 at PM, the LPN accompanied the surveyor to Resident #8's room, and the LPN #1 confirmed the resident's oxygen was flowing at 3.5 liters per minute according to flow meter on the concentrator. She readjusted the flow to the prescribed rate of 2 lpm. The surveyor asked the LPN #1 about oxygen administration for Resident #8 and the LPN #1 stated that only nurses set or adjust concentrator flow rates for oxygen and that oxygen should always be administered as ordered by physician.<br><br>2. On 3/6/26 at 10:25 AM, the surveyor observed Resident #72 awake, lying in bed with a NC on both nostrils attached to a concentrator (a device that supplies O2) running at 4 lpm.<br><br>On 3/9/26 at 10:37 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #72, which revealed the following:<br><br>A review of the admission Record (AR, an admission summary) reflected that Resident #72 was<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | admitted with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD, lung disease that makes it difficult to breathe).<br><br>A review of the admission MDS, (an assessment tool used to facilitate the management of care) dated 1/29/26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the residents had severely impaired cognition. Further review of the A/MDS, as reflected in section O-Special Treatments, Procedure and Program, revealed that Resident #72 was using O2 while a resident in the facility.<br><br>A review of the Physician Order (PO) with the start date of 2/9/26, O2 continuously at 2 lpm via NC.<br><br>A review of the care plan (CP) activity report initiated on 1/23/26 focused on the residents at risk for respiratory distress due to the diagnosis of COPD. Intervention included, but was not limited to, O2 therapy as per the physician's order.<br><br>3. On 3/6/26 at 10:52 AM and on 3/9/26 at 10:12 AM, the surveyor observed Resident #108 awake, lying on the bed, receiving oxygen at 3.5 lpm via NC attached to a concentrator. The surveyor did not observe an oxygen humidifier attached to the concentrator.<br><br>On 3/11/26 at 10:32 AM, the surveyor observed Resident #108 O2 is at 4.5 lpm via nasal cannula attached to the concentrator. The surveyor interviewed the Licensed Practical Nurse (LPN#1), who is in the room with the surveyor. LPN#1 checked the O2 parameter of the resident and confirmed that it was at 4.5 lpm. LPN #1 stated that during his rounds at 7:00 AM, the O2 was at 3 lpm, and he did not know what happened next.<br><br>On 3/6/26 at 1:21 PM, the surveyor reviewed the hybrid medical record of Resident #108, which revealed the following:<br><br>A review of the AR reflected that Resident #108 was admitted with diagnoses that included but were not limited to congestive heart failure (CHF, the heart cannot pump blood efficiently to meet the body's needs).<br><br>A review of the A/MDS dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 0 out of 15, which indicated that the residents had severely impaired cognition. Further review of the A/MDS, as reflected in section O-Special Treatments, Procedure and Program, revealed that Resident #108 was using oxygen while a resident in the facility.<br><br>A review of the PO with the start date of 2/9/26, oxygen at 3 lpm via NC continuously every shift for SOB (shortness of breath).<br><br>A review of the CP activity report initiated on 3/13/26 focused on the residents at risk of having complaints of dyspnea (difficulty breathing) related to the diagnosis of CHF. Intervention included, but was not limited to, O2 therapy as per the physician's order.<br><br>On 3/9/26 at 12:53 PM, the surveyor interviewed LPN #2, who stated that he does not put a humidifier in Resident #108's room because there is no order.<br><br>4. On 3/6/26 at 10:41 AM, the surveyor observed Resident #114 was awake and was using O2 at 3 lpm via NC attached to the concentrator.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/9/26 at 10:26 AM, the surveyor observed Resident #114 in bed awake on O2 at 3.5 lpm via NC. The LPN#2 confirmed that the resident was receiving 3.5 lpm of O2 therapy and did not provide further information.<br><br>A review of the AR reflected that Resident #114 was admitted with diagnoses that included but were not limited to unspecified dementia (a loss of memory), unspecified severity with psychotic disturbance.<br><br>There was no recent MDS assessment available for Resident #114 in the hybrid medical record.<br><br>A review of the CP activity report initiated on 3/4/26 focused on the residents at risk of having complaints of dyspnea. Intervention included, but was not limited to, O2 therapy as per the physician's order.<br><br>A review of the PO with the start date of 3/3/26, oxygen at 2 lpm via NC as needed for O2 saturation less than 92%, SOB, or respiratory distress.<br><br>A review of the Resident Treatment Administration Record for Resident #114 revealed that there is no record for 3/6/26 and 3/9/26 that the resident received an O2 treatment.<br><br>On 3/11/26 1:54 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA), Assistant LNHA, and the Director of Nursing regarding the above concern, but did not provide further information.<br><br>A review of the facility policy title Oxygen Therapy, revised date of June 2025, revealed under Procedures: 1. Check the order in the resident's chart for the amount of oxygen and frequency of administration, or follow standard of practice to maintain saturation level. and 2. If oxygen is more than 3L (liters), use a humidifier bottle with sterile water to the indicated level. Date the humidifier and change it daily.<br><br>NJAC 8:39-25.2(c)3 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices to prevent and control the spread of infection. Specifically the facility failed to: a) post required signage at the rooms for 9 of 9 residents reviewed for Enhanced Barrier Precautions (Resident #'s 1, 2, 4, 8, 12, 67, 108, 113, 114), b) failed to handle medications in a sanitary manner during medication administration observation and medication storage review by 1 of 3 nurses observed during medication administration and 1 of three nurses observed during medication storage review, and c) a failure to cleanse blood glucometer between uses by 1 of 3 nurses observed during medication administration. This deficient practice was evidenced by the following:1.On 3/6/25 at 10:35, the surveyor conducted initial tour of the HP nursing care unit and observed no enhanced barrier precaution (EBP) signage on door, doorway or entrance to room #HP-334, a private room of Resident #8.<br><br>A review of Resident #8's electronic health record (EHR) reflected the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to: Dysphagia (a difficulty swallowing), Cerebral infarction (a stroke) and left hemiplegia and hemiparesis (weakness and/or paralysis of left side of the body).<br><br>A review of Resident #8's Annual Minimum Data Set (MDS), an assessment tool dated 2/24/26 revealed Resident #8 has severe cognition impairment and is dependent for all activities of daily living and transfers.<br><br>A review of Resident # 8's physician orders reflected that the resident is ordered to receive no nutrition and hydration orally but received nutrition and hydration through a gastrostomy tube inserted directly through the abdominal wall into the stomach.<br><br>On 3/6/26 at 1:00PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) assigned to care for Resident #8. The LPN # 1 accompanied the surveyor to room HP-334 and the surveyor asked the LPN #1 how a staff member would know a resident was on EBP and what activities and personal protective equipment (PPE) would be required to care for the resident, the LPN # 1 stated there is a bin of PPE in the doorway. The surveyor asked the LPN #1 about appropriate signage to indicate enhanced barrier precautions. The LPN # 1 stated there was no signage in use on this resident's door or doorway and she acknowledged Resident #8 was placed on EBP due to her gastrostomy tube.<br><br>2. On 3/6/26 at 10:38 AM, during a tour on a unit, the surveyor observed a clear storage bin outside of Resident #4's room. There was an orange round magnetic dot on the door frame. The bin stored personal protective equipment (PPE) gowns and other supplies. There was no signage at the door or on the bin to indicate usage of PPE.<br><br>The surveyor reviewed the electronic medical record of Resident #4.<br><br>A physician order dated 5/27/25 indicated EBP every shift.<br><br>A review of a care plan for Resident #4 with a focus of EBP related to the presence of a wound revealed an intervention which indicated clear signage must be posted on the door or wall outside of the resident room indicating the type of precautions and required PPE. The intervention and care plan was dated 5/2/25.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. On 3/9/26 at 10:20 AM, during a tour on a unit, the surveyor observed a clear storage bin outside of Resident #113's room. The bin stored PPE gowns and other supplies. There was an orange round magnetic dot on the door frame. There was no signage at the door or on the bin to indicate the use of PPE.<br><br>The surveyor reviewed the electronic medical record of Resident #113.<br><br>A physician order dated 2/13/26, indicated EBP isolation.<br><br>A review of a care plan for Resident #113 with a focus of EBP related to the presence of a wound and enteral feeding tube revealed an intervention which indicated clear signage must be posted on the door or wall outside of the resident room indicating the type of precautions and required PPE. The intervention and care plan was dated 2/13/26.<br><br>On 3/9/26 at 10:23 AM, the surveyor interviewed LPN # 2 assigned to the residents about the bins at the resident's door. The LPN # 2 stated the bins stored PPE supplies used by staff when providing care to residents with wounds, enteral feedings, and urinary catheters. The LPN # 2 was not sure of the name for the type of isolation precaution. The surveyor asked the LPN # 2 how staff and visitors would know what protocols to follow for the isolation precaution. The LPN # 2 replied that the PPE in bin were for staff and not visitors as they provided high contact care to residents. LPN #2 further explained that a resident with an active infection that required another type of isolation precaution there would be a sign on the door to see the nurse prior to entering the room. The surveyor asked the LPN # 2 about the orange magnetic dot on the door. The LPN # 2 replied to the surveyor they were not sure what it was for.<br><br>4. On 3/6/26 at 10:52 AM and on 3/9/26 at 10:12 AM, the surveyor observed Resident #108 awake, lying on the bed, with an indwelling catheter with a privacy bag attached to the lower side of the bed.<br><br>On 3/6/26 at 1:21 PM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #108, which revealed the following:<br><br>A review of the admission Record (AR, an admission summary) reflected that Resident #108 was admitted with diagnoses that included, but were not limited to, urinary retention.<br><br>A review of the admission MDS, (an assessment tool used to facilitate the management of care) dated 2/12/26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the residents had severely impaired cognition.<br><br>A review of the physician order with the start date of 2/6/26, check for indwelling catheter placement every shift.<br><br>A review of the care plan (CP) activity report initiated on 2/8/26 focused on the residents who had an indwelling catheter due to urinary retention.<br><br>5. On 3/6/26 at 10:41 AM, the surveyor observed that Resident 114 was lying in bed awake.<br><br>A review of the AR reflected that Resident #114 was admitted with diagnoses that included but were not limited to unspecified dementia (a loss of memory), unspecified severity with psychotic<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | disturbance.<br><br>There is no recent MDS assessment available for Resident #114 in the hybrid medical record.<br><br>A review of the physician order to clean the sacral wound with wound cleanser, apply medihoney cover with calcium alginate daily with a start order of 3/3/26 and an EBP with an order date on 3/4/26.<br><br>A review of the CP activity report initiated on 3/4/26 focused on the residents, skin breakdown located in the sacrum. intervention included, but was not limited to, monitoring for signs and symptoms of infection. There is no intervention for the EBP order.<br><br>On 3/9/26 at 10:14 AM, the surveyor interviewed the LPN # 3 assigned to the HP unit regarding the EBP. She stated that the orange dot is the EBP signage, but did not provide further information regarding the orange dot.<br><br>On 3/9/26 at 12:50 PM, the surveyor interviewed CNA #1 and CNA#2 from the HP unit, who stated that they do not know what the orange dot in the outside room of the resident is.<br><br>6. On 3/9/26 at 8:32 AM, the surveyor observed medication administration. The surveyor observed that the LPN # 4 did not clean or disinfect the glucometer after using it on Resident #58.<br><br>On 3/9/26 at 9:15 AM, the surveyor interviewed LPN #4 who stated that they did not clean the glucometer after use because the wipes were not at their cart. However, LPN #4 stated that they cleaned the glucometer before use when they wiped down all the items on their medication cart before beginning medication administration earlier that day. The surveyor asked LPN #4 if the glucometers are shared among residents, and LPN#4 stated that each resident has their own glucometer. The surveyor observed that there was no resident label on the glucometer. There was a capital letter A written in permanent marker on the glucometer. When the surveyor asked LPN #4 how they knew this glucometer belonged to Resident #58, LPN #4 stated that this was what their supervisor told them. They did not know what the letter A meant and stated that they thought it was the resident's initial. LPN #4 acknowledged that the nurses are supposed to wipe down the glucometer before and after using them.<br><br>On 3/9/26 at 1:01 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Assistant LNHA. The LNHA stated that the glucometers are shared among residents. They clarified that the letter A written on the glucometer referred to Cart A and did not refer to a resident.<br><br>A review of the facility's procedure for Blood Glucose Monitoring, revised 7/2025, revealed next to number 18, Disinfect glucometer prior to storing in cart.-Dispatch wipes.<br><br>On 3/9/26 at 8:40 AM, the surveyor observed that LPN #4 placed the Humalog U-100 Insulin Pen in their pocket after they administered the insulin to Resident #58. LPN #4 also dropped the insulin pen on the floor as they exited the resident's room. Then, LPN #4 placed the insulin pen back inside the plastic bag in the medication cart without cleaning or sanitizing the insulin pen.<br><br>On 3/10/26 at 12:34 PM, in the presence of the survey team, the surveyor interviewed the Infection Preventionist Nurse, who acknowledged that it is not the correct practice to store medication in a pocket of clothing. The Infection Preventionist Nurse stated that LPN #4 should have cleaned and<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | disinfected the insulin pen after they dropped it on the floor.<br><br>7. On 3/11/26 at 11:38 AM, the surveyor inspected Medication Cart B on Unit LP in the presence of the LPN #5. The surveyor observed that the Systane eye drops box labeled for Resident #32 was open, and the bottle was missing. The surveyor asked LPN #5 where the bottle was located, and LPN #5 removed the bottle from their shirt pocket.<br><br>On 3/11/26 at 1:21 PM, the surveyor interviewed LPN #5 who acknowledged that it is not the correct practice to store medication in a pocket of clothing. LPN #5 stated that medications should be stored in the medication cart.<br><br>On 3/11/26 at 1:33 PM, the surveyor interviewed the Registered Nurse Supervisor who stated that it is not the correct practice to store medication in a pocket of clothing.<br><br>A review of the facility's Administration of Medications Procedure, revised 5/2025, revealed, Return all medications to the cart.<br><br>A review of the facility's Policy, Medication Storage, revised 11/2025, revealed, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier.<br><br>A review of the facility's Comprehensive Infection Control Policy revealed, It is the policy that this facility's Infection Prevention and Control Program (ICPC) is based upon information from the Facility assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. Section 1c of the policy revealed, Standard and transmission-based precautions to be followed to prevent the spread of infections.<br><br>8. On 3/6/26 at 10:13 AM, the surveyor observed that EBP signage was lacking on the door of the room for Resident #67. The surveyor observed that the resident had an indwelling catheter.<br><br>A review of the electronic health record of Resident #67 revealed an order for Enhanced Barrier Precaution, originally ordered on 09/19/2025, with a schedule of Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00 pm-7:00 am. Moreover, the care plan of Resident #67, effective 07/28/2025, revealed, Resident #67 requires enhanced barrier precautions related to (r/t) presence of wound and foley. Interventions included, but were not limited to, Clear signage must be posted on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g. gown and gloves).<br><br>9. On 3/6/26 at 10:53 AM, the surveyor observed that EBP signage was lacking on the door of the room for Resident #12.<br><br>A review of the electronic health record of Resident #67 revealed an order for Enhanced Barrier Precaution, originally ordered on 03/04/2026.<br><br>On 3/6/26 at 11:11 AM, the surveyor interviewed the Registered Nurse #1 (RN #1). RN #1 stated that the way staff would know a resident is on EBP is by the box with the blue gowns outside the door. RN #1 was not aware of signage for EBP.<br><br>On 3/10/26 at 12:34 PM, in the presence of the survey team, the surveyor interviewed the Registered (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Nurse Infection Preventionist (RNIP) who stated that the facility puts a bin outside the door and an orange tag on the doorpost to indicate EBP. The RNIP stated they were aware of the need for EBP signage.<br><br>The facility's policy, Enhanced Barrier Precautions, revised 1/2026, did not address signage for EBP.<br><br>10.On 3/6/26 at 11:22 AM, the surveyor observed Resident #1 seated in a wheelchair in the unit day room watching television. At the same time, the surveyor observed the resident's room. There was a plastic 3 drawer bin at the entrance to the room containing disposable gowns, masks and gloves. No signage for isolation instructions was visible at the entrance to the room.<br><br>A review of the resident's electronic medical record revealed the following information.<br><br>The 12/31/25 admission MDS assessment tool indicated the resident was cognitively intact as evidenced by a BIMS score of 12 out of a possible 15 (Section C). The resident was admitted with 2 unstageable pressure injuries (Section M).<br><br>The 1/8/26 wound consultant documented that the resident had pressure injuries to the left ankle and the right heel and skin tears to the left forearm and left lateral lower leg.<br><br>The Physician's Orders report contained a 2/4/26 treatment order for a medicated topical paste to the right lateral lower leg covered with a medicated gauze and topped with a thick cover gauze pad.<br><br>The Physician's Orders report did not include an order for EBP, a type of isolation used for close contact with residents who have open wounds and indwelling medical devices. The Centers for Disease Control updated its EBP recommendations in July 2022, which included requirements for signage at the entrance to resident rooms with instructions for caregivers as to what tasks are considered close contact. Close contact tasks would require the caregiver to wear a gown and gloves.<br><br>11.On 3/6/26 at 11:34 AM, the surveyor observed Resident #2 in bed with eyes closed. The surveyor observed an indwelling urinary catheter in place in a blue privacy bag.<br><br>Signage for EBP instructions was not visible at the entrance to the resident room. A 3 drawer plastic bin containing personal protective equipment was located at the entrance to the room.<br><br>A review of the electronic medical record included the following information.<br><br>The 2/13/26 admission MDS assessment tool indicated the resident was cognitively intact as evidenced by a BIMS score of 12 out of a possible 15 (Section C) and utilized an indwelling urinary catheter (Section H).<br><br>The Physician's Orders report included a 3/2/26 order for Enhanced Barrier Precautions.<br><br>On 3/6/26 at 10:40 am, the surveyor interviewed the RN #2. RN#2 stated residents with indwelling urinary catheters and those with pressure injuries should be on EBP. RN#1 was unaware of the requirement for signage for EBP.<br><br>On 3/9/26 at 8:31am, the surveyor interviewed CNA#3 who was unaware of the use of EBP for indwelling medical devices and open wounds.<br>(continued on next page) |

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| | 315029 | A. Building<br>B. Wing | 03/12/2026 |

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| Daughters of Israel Pleasant Valley Home | 1155 Pleasant Valley Way<br>West Orange, NJ 07052 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/10/26 at 12:46pm, the surveyor interviewed the Registered Nurse Infection Preventionist (RNIP). The RNIP is responsible for oversight of the facility's Infection Control Program. The RNIP confirmed residents with open wounds or indwelling medical devices required EBP. She was unaware of the CDC requirement for signage alerting caregivers of the type of isolation and instructions for close contact with those residents.<br><br>On 3/10/26 at 1:30 pm, the surveyor discussed the infection control concerns with the LNHA.<br><br>The surveyor reviewed the facility policy titled Enhanced Barrier Precautions, initiated 3/2024 and last reviewed 3/2025. The policy failed to include the necessity for signage outside of resident rooms with EBP.<br><br>The surveyor reviewed the facility document titled Infection Control and Prevention, updated 10/2025. It included instructions to place appropriate isolation signage outside of the resident's room and designated units (Step 9).<br><br>NJAC 8:39-19.4(a); 27.1(a) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 4 of the 22 residents (Resident #19, 61, 108, and #114) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: 1. On 3/6/26 at 10:33 AM, the surveyor observed Resident #19 in bed awake, alert, and able to make needs known. The surveyor observed that the resident's call device was hanging on the bed, and the resident was leaning to the opposite side of the bed, where the call bell was out of reach. Resident #19 was asking where the call device was, and they stated they cannot reach it. On the same day at 12:09 PM, the surveyor observed that the resident's call device was out of the resident's reach. On 3/6/26 at 12:54 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #19, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #19 was admitted with diagnoses that included but were not limited to an unspecified dementia (loss of memory), unspecified severity, without behavior, psychotic, mood, and anxiety (excessive worry). A review of the significant change Minimum Data Set (SC/MDS), (an assessment tool used to facilitate the management of care) dated 2/3/26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had severe cognitive impairment. Further review of the SC/MDS, as reflected in section GG, revealed that Resident #19 was dependent on staff for activities of daily living (ADL). A review of the Care Plan (CP) activity report initiated on 2/12/26 focused on the residents' resistance to care, refusal of showers, refusal of repositioning, and getting out of bed. Interventions included, but were not limited to, keeping the call bell within easy reach when the resident is in bed. 2. On 3/6/26 at 10:35 AM, the surveyor observed Resident#61 asleep in bed. The call device is located hanging on top of the resident's headboard. It was clipped to the wall itself, four inches from the outlet. On the same day at 12:11 PM, the surveyor observed that the resident's call device was still hanging on top of the resident's headboard, out of the resident's reach. On 3/6/26 at 1:04 PM, the surveyor reviewed the hybrid medical record of Resident #61, which revealed the following: A review of the AR reflected that Resident #61 was admitted with diagnoses that included but were not limited to Alzheimer's disease (a disorder that affects memory, thinking, and behavior). A review of the quarterly MDS (Q/MDS) dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 3 out of 15, which indicated that the resident had severe cognitive impairment. Further review of the Q/MDS, as reflected in section GG, revealed that Resident #61 was dependent on staff for ADL. A review of the CP activity report indicates that there are no interventions that include the call light, which should be within easy reach of the resident for assistance. 3. On 3/6/26 at 10:52 AM, the surveyor observed that Resident #108's call device was located on the floor under the bed. Resident #108 stated that they cannot find the call device because they wanted the television to be turned on. On the same day at 12:13 PM, the surveyor checked the call device of Resident #108. It was observed that the call device was still located on the floor under the resident's bed. On 3/6/26 at 1:21 PM, the surveyor reviewed the hybrid medical record of Resident #108, which revealed the following: A review of the AR reflected that Resident # 108 was admitted with diagnoses that included but were not limited to hemiplegia (a muscle weakness that affects one side of the body) following cerebral infarction (a blood clot forms in an artery in the brain) affecting the left non-dominant side. A review of the admission MDS (A/MDS) dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 0 out of 15, which indicated that the residents had severely impaired cognition. Further review of the A/MDS, as reflected in section GG, revealed that Resident #108 requires staff assistance for ADLs. A review of the CP activity report initiated on 2/8/26 focused on the residents, showing a decline in ADL activities secondary to multiple<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | comorbidities. Intervention included, but was not limited to, keeping the call bell within reach when in the room. 4. On 3/6/26 at 10:41 AM, the surveyor observed that the Resident #114 call device was tied to the right-side rails and was hanging off the bed out of the resident's reach. It was observed that the resident was unable to reach out for the call device due to the limitation of movement in the right hand. On 3/6/26 at 1:51 PM, the surveyor reviewed the hybrid medical record of Resident #114, which revealed the following: A review of the AR reflected that Resident #114 was admitted with diagnoses that included but were not limited to unspecified dementia (a loss of memory), unspecified severity with psychotic disturbance. There is no recent MDS assessment available for Resident #114 in the hybrid medical record. A review of the CP activity report initiated on 3/4/26 focused on the residents, showing a decline in ADL activities secondary to renal cancer and progressing dementia. Intervention included, but was not limited to, keeping the call bell within reach when in the room. On 3/9/26 at 10:23 AM, the surveyor interviewed the Certified Nurse Assistant (CNA) who stated that the call device should be placed on the right side of the resident, since the left hand is contracted or weak, and the right hand is okay to reach the call bell. The CNA added that the call device should be within the resident's reach. On 3/9/26 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the resident should have a call device and should be placed within their easy reach, even if the BIMS is 0, because the first cry for help is to use the call bell. On 3/11/26 at 1:54 PM, the team met with the Licensed Nursing Home Administration (LNHA), Asst. LNHA and the Director of Nursing regarding the concern above, but did not provide further information. A review of the facility policy title Call Bell Monitoring & Responsibility, revised date of August 2025, revealed under Policy: 6. Call bells are to be left within reach at all times. NJAC 8:39-31.8(c)9 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for one resident's room (Resident # 3's room [ROOM NUMBER]) and in the hallway of the HP unit.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 3/6/26 at 12:32 PM, in Resident # 3's room (room [ROOM NUMBER]), the surveyor observed that approximately 10 inches of the wall paper was peeling off the wall near the bottom of the window sill. The surveyor also observed an approximately 2 inch break in the plastic corner protector on the wall in the resident's room.<br><br>2. On 03/6/26 at 11:00 AM, during the initial tour of the facility the surveyor observed the following in the hallway and common area of the HP nursing care unit:<br><br>In the hallway, near the smoke doors in the area of room [ROOM NUMBER], there was an approximately 24 inch wide by 4-foot-tall area of missing wallpaper with hanging ragged edges. In the same area of the hall as the first observation, the surveyor observed a second an approximately 8 inch wide 4 foot tall area of torn missing wallpaper. On the ceiling, in the same area of the hallway, the surveyor observed several large brown colored stains on 3 ceiling tiles.<br><br>In the common room marked living room for the HP nursing care unit, the surveyor observed an approximately 6 foot wide area of torn missing wallpaper above the heating baseboard unit, under the window. The exposed area of wall above the heating baseboard unit, had dried brown stains, and the baseboard heater had a crusty brown substance and dents on it.<br><br>On 3/11/26 at 1:15 PM, the surveyor interviewed the Director of Building Services (DBS) regarding findings on the HP nursing care unit. The DBS reviewed photos of the surveyor's findings and discussed responsibility for repairs. The DBS acknowledged the areas of disrepair and stated his department was responsible for repairs of the facility. He stated the areas should be repaired and acknowledged the appearance of these areas in their current state detracted from the facility's homelike environment<br><br>On 03/11/26 at 1:55 PM, the surveyor discussed the above concerns with Administrator, Director of Nursing (DON), and the Assistant Administrator and Administrator acknowledged the missing wall paper and stained ceiling tiles in HP hallways detracted from the facility's homelike environment. All agreed these issues should be repaired.<br><br>On 3/12/26 at 11:36 AM, the surveyor discussed the above concerns for room [ROOM NUMBER] with the Administrator, Director of Nursing, and the Assistant Administrator, who also agreed these issues should be repaired.<br><br>NJAC 8:39-4.1(a)11. 31.4 (a), (b), (c), (f) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on interviews and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool used to facilitate the management of care), in accordance with federal guidelines, for 1 (one) of 22 residents (Resident #108), who were reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: On 3/6/26 at 10:52 AM and on 3/9/26 at 10:12 AM, the surveyor observed Resident #108 awake, lying on the bed, with an indwelling catheter with a privacy bag attached to the lower side of the bed. On 3/6/26 at 1:21 PM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #108, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #108 was admitted with diagnoses that included, but were not limited to, a pressure ulcer of the sacral region, unstageable. A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated 2/12/26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the residents had severely impaired cognition. Further review of the A/MDS, as reflected in section H-Bowel and Bladder, revealed that the indwelling catheter was not coded for appliances. A review of the Physician Order (PO) with the start date of 2/6/26, check for indwelling catheter placement every shift. A review of the care plan (CP) activity report initiated on 2/8/26 focused on the residents who had an indwelling catheter due to urinary retention. On 3/10/26 at 11:00 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC), who stated that she should code the Resident #108's indwelling catheter. On 3/11/26 1:54 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA), Asst. LNHA and the Director of Nursing regarding the above concern, but did not provide further information. NJAC 8:39-33.2 (c)5 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure care and services were provided in accordance with professional standards of practice for 2 of 22 residents reviewed (Residents #1 and #11). Specifically, the facility failed to clarify a physician order resulting in duplicative treatment orders, accurately document completion of a treatment order for Resident # 1, and provide comprehensive insulin management for Resident # 11.The findings are as follows: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 casefinding, 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.<br><br>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 casefinding; 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.<br><br>1.On 3/6/26 at 11:22 AM, the surveyor observed Resident #1 seated in a wheelchair in the unit day room watching television.<br><br>A review of the electronic medical record revealed the following information.<br><br>The 12/31/25 admission Minimum Data Set (MDS) assessment tool indicated the resident had no cognitive deficits as evidenced by a Brief Interview for Mental Status score of 12 of a possible 15 (Section C) and was admitted with 2 unstageable pressure injuries and skin tears (Section M).<br><br>The 3/2026 Physician's Orders (PO) report included a 2/4/26 treatment order for the right lateral lower leg for application of a medicated topical paste covered by a medicated gauze and covered with a thick gauze pad.<br><br>Also included in the 3/2026 PO was a 3/4/26 treatment order for the right lateral lower leg for application of a lanolin and petrolatum topical ointment and wound was to be left open to air (no covering).<br><br>The 3/2026 electronic Treatment Administration Record (eTAR) contained nursing documentation that both treatments were done to the same site on 3/5, 3/6, 3,7, 3/8 and 3/9.<br><br>On 3/10/26 at 10 AM, the surveyor reviewed wound consultation reports. The most recent report in the electronic medical record was dated 2/24/26. The wound consultant wrote a treatment recommendation to continue applying the medicated paste, medicated gauze, and cover with a thick pad.<br><br>The wound consultant documented this treatment will be done daily until discontinued.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/10/26 at 11:30 AM, the surveyor observed the facility Registered Nurse (RN #1) perform a wound treatment to the resident's right lateral lower leg.<br><br>RN #1 applied a lanolin and petrolatum topical ointment to the right lateral lower leg and left the wound open to air. Resident #1 questioned RN #1 why he was not applying a cover dressing. RN #1 stated the resident was confusing the order with an older previous order.<br><br>RN #1 completed the order and logged into the eTAR to document completion of the wound treatment. The surveyor observed in the eTAR that the treatment had been documented as having been done hours earlier. RN #1 stated I documented it as done when it was not done. I should have waited until I completed the treatment to document its' completion.<br><br>On 3/10/26 at 1:44 PM, the surveyor discussed the duplicate treatment order and the nurse signed as done when the treatment was not completed with the Licensed Nursing Home Administrator (LNHA).<br><br>On 3/11/26 at 10:07 AM, the LNHA responded there was a 3/3/26 wound care consultation that was not uploaded into the electronic medical record until 3/9/26. The LNHA provided a PO indicating on 3/9/26 at 4:20 PM the order for a medicated topical paste and cover dressing was discontinued.<br><br>2. A review of resident #11's Electronic Health Record reflects the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to type 2 diabetes, Chronic obstructive pulmonary disease and congestive heart failure.<br><br>A review of Resident #11's Minimum Data Set (MDS), an assessment tool dated 1/20/26 reflected that the resident had a brief interview for mental status (BIMS) score 14 out of 15, which indicated minimal to no cognitive impairment.<br><br>A review of the resident Plan of Care effective date of 2/23/26 reflects no focuses, interventions or goals are included to outline care for resident's type 2 diabetes.<br><br>A review of resident 11's physician orders reflects the resident had an order dated 1/9/2026 prescribing Humalog U-10 insulin 100U/ml subcutaneous solution, inject by subcutaneous route before meals and at bedtime per sliding scale coverage after testing blood glucose level. Scheule every day at 8:15 am, 12:30pm, 5:15 pm and 9:00 pm. Protocol: insulin sliding scale if blood glucose equals 200-249: 2 units of Humalog insulin, 250-299: 4 units Humalog insulin, 300-349: 6 units of Humalog insulin, 350-399: 8 units of Humalog insulin, 400-449: 10 units of Humalog insulin, Above 450: 12 units of Humalog insulin and notify Physician or Nurse Practitioner.<br><br>A review of Resident #11's record of blood glucose readings reveals the resident's blood glucose result documented on 2/13/26 at 9:43 pm was 473. The resident's medication administration record (MAR) reflected documentation that 12 units of Humalog were administered as ordered but no documentation was evident in the MAR or the remainder of EHR indicates the physician or Nurse Practitioner were notified of these results as required by the physician's order.<br><br>On 3/12/26 at 10:40 AM the surveyor interviewed RN assigned to the care of Resident #11. The surveyor asked the RN about care plans for residents with specific disease processes, The RN agreed residents with type 2 diabetes should have care plans with focuses and interventions to manage diabetes. The RN acknowledged after consulting the EHR that Resident#11 did not have a care plan with focuses or interventions for type 2 diabetes. The RN confirmed that Resident#11 has order since<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/9/26, including directions that if the resident had a blood glucose test result over 450, the resident was to be administered 12 units Humalog insulin and that physician or nurse practitioner were to be notified of the result and the notification would be charted in the resident's EHR.<br><br>On 3/12/26 at 11:03 AM, the survey met with the Director of Nursing (DON) and discussed that residents EHR does not reflect a care plan for diabetes and does not include documentation of Physician notification of a 473 blood glucose test result on 3/13/26. The DON stated she would review Resident #11's EHR and respond.<br><br>On 3/12/26 at 11:45 AM, the surveyor and team met with the DON, LNHA and ALNHA, and discussed the concerns with Resident #11. The DON confirmed that the resident's EHR does not reflect documentation that physician notification occurred for the blood glucose results on 2/13/26 as ordered. The DON confirmed that no focuses or intervention were documented or included in the plan of care for Resident # 11 and that the care plan should include measures for type 2 diabetes.<br><br>NJAC 8:39-27.1 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to address the recommendations made by the Consultant Pharmacist (CP) which was identified for 1 of 5 residents (Resident #113) reviewed for unnecessary medications. This deficient practice was evidenced by the following:On 3/9/2026 at 10:20 AM, the surveyor observed Resident #113 lying in their bed, alert, and verbally responsive. Resident #113 was receiving an enteral feeding (a way of delivering nutrition directly to the stomach or small intestine) via a feeding pump. The resident had a urinary drainage bag covered with a urinary privacy bag, hanging from the bottom of the bed frame.On 3/9/2026 at 10:45 AM, the surveyor reviewed the facility provided admission Medication Review (aMRR) for Resident #113 dated 2/13/26 completed by the Consultant Pharmacist (CP). The aMRR included a recommendation to clarify the resident's Flomax capsule order with the physician as the medication should be swallowed whole, not opened, crushed, or chewed; and the resident received medication via g-tube. The recommendations were unsigned to indicate the recommendations were followed up.The surveyor reviewed the electronic medical record (EMR) of Resident #113.The Resident Face Sheet (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, left leg above knee amputation.A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated 2/19/26, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #113 scored a 3, which indicated the resident had severe cognitive impairment. In Section K (Swallowing/Nutritional Status), Resident #56 was coded as receiving nutrition through a feeding tube while a resident.A physician's order dated 2/13/26 documented tamsulosin (Flomax) 0.4 milligram (mg) capsule, give one capsule by gastrostomy tube (G-tube; a soft tube inserted through the abdomen into the stomach to provide long term nutrition, hydration, and medication) once daily.On 3/9/26 at 11:29 AM, the surveyor interviewed the Registered Nurse (RN) Supervisor, about CP recommendations who stated the Director of Nursing (DON) was responsible for reviewing and following up on CP recommendations. The RN Supervisor further explained that when the DON was absent the RN supervisor would be responsible. The surveyor asked the RN supervisor after receiving CP recommendation reports how soon it would be expected for the recommendations to be followed up. The RN supervisor replied that they would be completed within the same week and for high priority recommendations would be followed up with physician right away. The RN supervisor further explained the report would have written notations and be signed to indicate completion.The surveyor discussed Resident #113's CP recommendations and review of the EMR revealed no documentation of follow up. Additionally, the report was unsigned. The RN supervisor stated that it would have been reviewed by the DON and would follow up to provide any additional information.On 3/10/2026 at 11:03 AM, the RN supervisor informed the surveyor that they followed up with the physician regarding the CP's recommendation for Flomax yesterday and clarified the order. The RN supervisor acknowledged the recommendation was not followed up prior to surveyor inquiry. On 3/10/26 at 12:30 PM, Additional review of the aMRR revealed lidocaine 5% (Lidoderm) topical patch recommendations to time patch administration at 9am and removal at 9pm as the medication was effective for 12 hours.A review of the physician's orders and March 2026 Medication Administration Record (MAR) revealed an order dated 2/14/26 for Lidocaine 5% topical patch, apply one patch topically once daily to lower back (for low back pain); remove at bedtime. The lidocaine patch was timed for 7 AM to 3 PM and 3 PM to 11PM. On 3/10/26 at 1:56 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Assistant LNHA of the above concerns that not all CP recommendations from 2/13/26 were followed up by the facility and the report was unsigned to indicate review by the nursing staff and physician. The LNHA stated she would discuss with the RN supervisor to provide additional information. On 3/11/26 at 10:03 AM, the (continued on next page) |

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|---|---|---|---|
| | 315029 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Daughters of Israel Pleasant Valley Home | 1155 Pleasant Valley Way<br>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.

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LNHA, Asst LNHA, and the DON met with the survey team. The DON stated as of that morning all recommendations were followed up. The DON stated she could not speak to why the CP recommendations were not addressed prior to surveyor inquiry. The surveyor received the facility policy for aMRR. The surveyor requested any other facility policies related to CP recommendations.On 3/12/26 at 12:00 PM, the DON stated there was no additional policy related to CP recommendations. No additional information was provided by the facility.A review of the undated facility policy titled admission MEDICATION RECONCILIATION PROTOCOL AND CONTACTING OUTSIDE PCP [Primary Care Provider] which revealed under Policy: All admitted residents will have their transfer orders reviewed and reconciled The R.N. Supervisor or designate and Medical Director or designee will coordinate clarification orders.Under the policy's Procedure revealed: .2. All new admission physician orders will be faxed to pharmacy consultant for review and reconciliation.3. The R.N. Supervisor or designee will review and reconcile the discharge orders of all newly admitted admissions to [facility] within 24 hours of admission. Medication requiring clarification will be discussed with the attending physician.The policy did not further address the procedure for follow up of CP recommendation reports. NJAC 8:39-27.1 (a); 29.3 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility failed to: (a) properly store, and date medications in 1 of 4 medication carts and 1 of 2 medication storage rooms inspected; and (b) ensure controlled medications were stored in a separately locked, permanently affixed compartment in 1 of 3 medication carts inspected for medication storage. This deficient practice was evidenced by the following:<br><br>1. On [DATE] at 11:08 AM, the surveyor inspected the medication storage room on the HP unit in the presence of Licensed Practical Nurse (LPN) # 1 assigned to the unit. There were 2- 0.45% Normal Saline, one Liter intravenous bags which both had a manufacturer's expiration date of [DATE] stored in a cabinet. LPN #1 confirmed the IV bags were expired and removed them to be disposed.<br><br>The LPN stated she was unsure of when the eye drops were opened or if it was used. The pharmacy label read refrigerate before opening.<br><br>There was a Novolin R flexpen for a resident observed with a written open date of 9/1 on the plastic bag it was stored in and written on the flexpen itself. The pharmacy label on the flexpen appeared to have a written date of 9/11. The LPN #1 stated the date opened was 9/11 and not 9/1.<br><br>2. On [DATE] at 11:21 AM, the surveyor inspected medication cart A on the HP unit in the presence of LPN #2. Upon opening a drawer of the cart, the surveyor observed an opened Ipratropium Bromide 0.5 mg/Albuterol Sulfate 3.0 mg (Duoneb) foil packet containing nebulizer inhalation vials. The foil packet had a written date of [DATE] and had no resident name written on it. LPN #2 stated the date indicated when the packet was opened. The LPN #2 could not say which resident it belonged to and acknowledged it should have been stored in the resident's duoneb manufacturer box which had a label with the resident's name on it. The LPN #2 believed the duoneb medication's expiration after opening the foil packet was two weeks but was not sure. LPN #2 stated he would ask their nurse supervisor.<br><br>In the same drawer the surveyor observed Resident #104's duoneb manufacturer box which had a pharmacy label with an order date of [DATE] and indicated the duoneb order was for a ten day duration. Inside the box there was an opened foil packaging containing duoneb vials with no date on it; and underneath the packaging were four attached duoneb vials not stored in a foil packaging with no date on them.<br><br>In the same drawer, the surveyor observed Resident #33's duoneb manufacturer box which contained inside a single foil packet which had a written date of [DATE]. The LPN #2 removed identified items from the medication cart and stated he would follow up with the nurse supervisor.<br><br>On [DATE] at 1:28 PM, the surveyor informed the Registered Nurse (RN) Supervisor of the above medication storage concerns. The RN supervisor acknowledged the IV bags in the medication should have been disposed as it expired in [DATE]. The RN supervisor was not sure of the medication's expiration after opening the foil packaging. The RN supervisor acknowledged items should be stored in a resident specific medication box and not kept loose in the drawer. The RN supervisor stated she would follow up with the Director of Nursing (DON) and the pharmacy.<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. On [DATE] at 11:38 AM, the surveyor inspected Medication Cart B on Unit LP in the presence of the LPN #3. The surveyor observed that the compartment for storage of controlled drugs was not permanently affixed to the medication cart. The surveyor was able to lift and fully remove the compartment from the medication cart. When the surveyor lifted the compartment, they observed that the compartment had no bottom, and the controlled medications were visible and accessible.<br><br>On [DATE] at 11:49 AM, the surveyor interviewed LPN #3 who acknowledged that the compartment for storage of controlled drugs should be affixed and will notify their supervisor.<br><br>On [DATE] at 1:33 PM, the surveyor interviewed the RN Supervisor who stated that they will follow up to provide a response regarding the above concern.<br><br>On [DATE] at 1:52 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Assistant LNHA, and the DON of the above medication storage concerns.<br><br>On [DATE] at 9:15 AM, the DON provided the surveyor a document, dated [DATE] titled Medications which need to be dated upon opening from their pharmacy consultant which listed medications and expiration after opening. The list included Duoneb, 6 pack foil packet which indicated expiration 7 days after opening; and Duoneb, 30 pack foil packet which indicated expiration 14 days after opening.<br><br>On [DATE] at 11:45 AM, the DON stated to the surveyor all identified IV and nebulizer medications were disposed. There was no additional information provided by the facility.<br><br>A review of the facility's policy and procedure titled, Medication Storage, with a revised date of [DATE] under Policy revealed: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier.<br><br>The facility's Administration of Medications Procedure, Medication Administration Policy, and Medication Storage Policy and Procedure did not address the requirement of the facility to provide permanently affixed compartments for storage of controlled drugs.<br><br>NJAC 8:39-29.4 |