STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315496	A. BUILDING _____ B. WING _____	04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL VINELAND	524 NORTH WEST BLVD VINELAND, NJ 08360

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F 000	INITIAL COMMENTS STANDARD SURVEY CENSUS: 237 SAMPLE SIZE: 35+2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, and other facility documentation, it was determined that the facility failed to maintain a medication error rate of less than 5%. This deficient practice was identified for 1 of 2 nurses observed administering medications to 2 of 6 residents (Resident #112 and #225) on 1 of 2 units, totaling 2 errors out of 33 medication opportunities that resulted in a medication error rate of [redacted] and was evidenced by the following: On 04/06/21 at 9:10 AM, the surveyor observed a Registered Nurse (RN #1) administering medications to Resident #112. Resident #112 had finished eating breakfast before the surveyor and the RN entered the room. The RN	F 759	F759 SS=D What corrective action (s) will be accomplished for those residents affected by the deficient practice? The Physician was notified of the Medication Errors for residents #112 and #225. The Physician ordered [redacted] for resident #112 and ordered Executive Order 26, 4.b. [redacted] for resident #225. Both residents did not suffer any ill effects. A Medication Error	5/3/21

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

Electronically Signed | 04/21/2021

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F 759	Continued From page 1 proceeded to administer Resident #112 all of their medications, including Executive Order 26, 4.b. [redacted] Resident #112 took all of the medications. The RN left the room and signed the Medication Administration Record (MAR) that the medication was given. The surveyor obtained and reviewed the April 2021 Physician's Order Summary (POS) for Resident #112, which included an order for Executive Order 26, 4.b. [redacted] The surveyor also obtained and reviewed the MAR, which additionally noted, "Caution: take 15 minutes before meals." The medication was scheduled for administration on the MAR at 7:30 AM. On 04/06/21 at 9:20 AM, the surveyor observed the RN administer medications to Resident #225. When the surveyor and RN entered the resident's room, the resident was eating breakfast and had completed 85% of his/her meal. The RN administered all medications to the resident, including Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. [redacted]); Resident #225 took all the medications together. The RN left the room and signed the MAR that the medications were given. The surveyor obtained and reviewed the April 2021 POS for Resident #225, which included an order for Executive Order 26, 4.b. [redacted] tablet administered orally one-half hour before meals and at the hour of sleep for Executive Order 26, 4.b. [redacted] The surveyor obtained and reviewed the MAR, which additionally noted, "Caution: Executive Order 26, 4.b. [redacted]. Avoid Executive Order 26, 4.b. [redacted]. Executive Order 26, 4.b. [redacted]	F 759	Incident Document was completed with actions noted as, restrict from medication administration until remediation completed and two (2) satisfactory med pass observations are conducted. RN#1 was restricted from medication pass and in-serviced post incident by staff development utilizing Nursing Services Policy #25-1 Medication/Treatment Administration. Also, as per protocol, RN#1 was observed on two (2) separate medication passes by the Pharmacy Consultant. Special emphasis during these observations was placed on adherence to administering medications at prescribed times and adhering to cautionary guidelines. RN#1 demonstrated competency and has resumed medication pass responsibilities. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All Residents receiving medications in the facility have the potential to be affected. Therefore, licensed nursing staff were in-serviced post incident on clinical standards of practice and Nursing Services Policy: #25-1 Medication and Treatment Administration. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur?	

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F 759	Continued From page 2 [redacted] During an interview with the RN on 04/06/21 at 9:34 AM, the surveyor inquired if the medication [redacted] was appropriately given to Resident #112. The RN replied, "It was given after breakfast, and it should be given before breakfast. It was not given properly." During the same interview, the surveyor also inquired about when the medication [redacted] for Resident #225 should be given. The RN stated, "It should be given before breakfast, but the meal was already here. It should be given at 7:30 AM." During an interview with the surveyor on 04/07/21 at 12:41 PM, the Director of Nursing Services stated if the RN gave the medications late or not as ordered, the RN should've notified the physician and obtained an order to either hold (the medication) or give it at another time. If the medication should be given on an empty stomach, it should be given on an empty stomach. The RN should've notified the physician for orders. A review of the facility's Medication/Treatment Administration policy with a revised date of January 2020 indicated "5. Medications must be given within one-hour before/after the time ordered. You MUST adhere to AC [before meals] and PC [after meals] times. If the time you are administering this medication is beyond the hour before or after, call the physician before administering for further orders." NJAC 8:39 - 29.2(d)	F 759	Licensed Nursing staff were in-serviced post incident by the Staff Development team and Nursing Administration on Nursing Services Policy: #25-1 Medication/Treatment Administration. Emphasis was also placed on adhering to cautionary guidelines on the MAR when administering the prescribed medications. The Pharmacy Consultant and Nursing Supervisors will conduct random medication pass observations of licensed nurses at least monthly on all nursing units. Significant findings will be forwarded to the DON for review and correction with a copy to the Quality Improvement Coordinator. Licensed Nursing staff will have one (1) medication pass observation conducted annually. Licensed Nursing Staff are remediated immediately by Nursing Administration upon on observation or report of medication errors. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change. The Nursing Administration and the Pharmacy Consultant conduct monthly medication pass observations and forward observation results to the DON for further	

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F 759	Continued From page 3	F 759	remedial and corrective actions as needed. The Quality Improvement Coordinator receives monthly medication pass results for trending. Negative trends are evaluated by the ACEO-Clinical and the Administrator to initiate systemic changes as well as individualized administrative actions when indicated. A Medication QAPI program has been established and will meet at least monthly to identify and implement process improvements to avoid errors of this nature in the future.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		5/6/21

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F 880	Continued From page 4 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 5 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to: a.) ensure that the urinary catheter drainage bag (drainage bag) was correctly stored to prevent the spread of infection for Resident #75, 1 of 4 resident's reviewed for the use of an indwelling urinary catheter; and, b.) follow proper hand hygiene practices during a tube feeding administration for Resident #187, 1 of 1 resident reviewed for tube feeding. This deficient practice was evidenced by the following: Reference: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, updated 5/17/2020 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet.	F 880	F880 SS=D What corrective action (s) will be accomplished for those residents affected by the deficient practice? 1. Resident #75 Executive Order 26, 4.b. was attached to the bed below the level of the resident□s bladder but was touching the floor. The Executive Order 26, 4.b. resident #75 was changed. A privacy cover was also provided for use by resident #75. CNA #1 was in-serviced according to Indwelling Catheter Care #27 -26 on proper incontinent care of a resident with a urinary drainage bag to prevent the spread of infection and Infection Control policy 19-19. The remediation emphasized residents with urinary catheter drainage bags are covered when possible to protect dignity when outside of their room, placement is below the resident□s bladder while ensuring that no tubing is on the floor or touching contaminated items, such as wheelchairs or the floor. 2. LPN #2 provided a tube feeding to resident #187 and was observed not washing her hands for the required 15	

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F 880	Continued From page 6 Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." 1. On 04/05/21 at 9:34 AM, the surveyor, observed Resident #75 lying in bed. The resident's Executive Order 26, 4.b. which was not contained in a Executive Order 26, 4.b., and Executive Order 26, 4.b. that faced the door. When interviewed at that time, Resident #75 did not respond to any of the surveyor's questions. On 04/06/21 at 9:01 AM, the surveyor observed Resident #75 lying in bed. The resident's Executive Order 26, 4.b. next to the side of the bed that faced the door. The surveyor made the same observations later on at 10:09 AM. According to the Resident Face Sheet, Resident #75 was admitted to the facility with medical diagnoses that Executive Order 26, 4.b. A review of the Quarterly Minimum Data Set (MDS), an assessment tool, Executive Order 26, 4.b., revealed Resident #75 was identified a Executive Order 26, 4.b. The MDS further revealed that Resident #75 had Executive Order 26, 4.b.	F 880	seconds. LPN #2 was remediated on Hand Hygiene using the Hand Hygiene Guidelines Policy #19-11 with emphasis on the section in the handwashing procedure which states, moisten the hands and wrists, apply a heavy lather of soap, use friction, rubbing one hand upon the other for 15 seconds. LPN #2 was assessed separately for Handwashing competency by the Staff Development Coordinator and was noted to be in compliance with the hand hygiene guidelines. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. Residents who have a urinary catheter drainage bags have the potential to be affected by the deficient practice. All Residents with urinary catheter drainage bags were identified. Their bags were inspected for the availability of privacy covers for use to provide dignity and privacy when outside of their room. No deficiencies were noted. Additionally, they were inspected for attachment to a bed or chair in such a manner to promote drainage below the level of the resident□s bladder and to ensure tubing was not touching the floor or other contaminated items. Upon investigation, it was determined that the drainage bag and tubing made contact with the floor due to the bed being placed in the lowest position due to the residents fall risk.	

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F 880	Continued From page 7 Executive Order 26, 4.b. During an interview with the surveyor on 04/07/21 at 9:28 AM, the Certified Nursing Assistant (CNA #1), responsible for caring for Resident #75, stated that she provided incontinent care to the resident and changed the Executive Order 26, 4.b. as needed. CNA #1 further stated that the resident's Executive Order 26, 4.b. and should not touch the floor for infection control. During an interview with the surveyor on 04/07/21 at 11:44 AM, the Licensed Practical Nurse (LPN #1) stated the CNA was responsible for emptying the drainage bag and recording the amount in the medical record. LPN #1 further stated that the resident's drainage bag should be kept below the bladder and off the floor at all times. During an interview with the surveyor on 04/07/21 at 12:39 PM, the Director of Nursing (DON) stated the resident's Executive Order 26, 4.b. Executive Order 26, 4.b. A review of the facility's "Indwelling Catheter Care" policy, dated February 2020, indicated positioning the drainage bag below the level of the bladder and off of the floor. The surveyor reviewed the facility's undated "Infection Control Guidelines for the Prevention of Indwelling Catheter-Associated Urinary Tract Infections" provided by the Chief Executive Officer (CEO). The policy reflected under the "Closed Sterile Drainage" section that the collection bag or tubing should not be allowed to touch the floor or other contaminated objects.	F 880	Nursing staff will be in-serviced on the correct protocols for providing care for a resident with a urinary drainage bag according to Indwelling Catheter Care #27 -26 which reflects that the collection bag and tubing should not touch the floor or other contaminated items, especially when placing the bed in the lowest position for a fall risk. Nursing staff were instructed to only lower the bed to a level that will ensure the foley bag does not touch the floor. 2. All residents are affected by staff adherence to Hand Hygiene to prevent the spread of infection. Staff interviewed, report lack of understanding and confusion regarding amount of time needed to ensure effective hand washing. Additionally, to address confusion the Hand Hygiene Guidelines Policy #19-11 was revised to incorporate the 20 second friction rub for both soap and water hand hygiene as well as when using waterless hand sanitizer for hand hygiene. Staff were in-serviced by Staff Development and Nursing Supervisors on Hand Hygiene according to the Hand Hygiene Guidelines Policy #19-11 with emphasis on the section concerning the handwashing procedure. In addition, the following was also conducted: All Topline staff and Infection Preventionist received training as follows: Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program	

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F 880	Continued From page 8 2. On 04/07/21 at 11:03 AM, the surveyor, observed LPN #2 administer a [redacted] Executive Order 26, 4.b. to Resident #187. The surveyor observed that the LPN gathered the tube feeding supplies and then washed her hands at the resident's sink for 12 seconds before putting on gloves. The surveyor further observed that after the LPN administered the tube feeding, she disposed of her gloves and washed her hands for seven seconds. During an interview with the surveyor on 04/07/21 at 11:16 AM, LPN #2 stated the process for handwashing included applying friction with soapy hands for 30 seconds. LPN #2 further stated that the importance of proper handwashing was to prevent infections. During an interview with the surveyor on 04/08/21 at 9:28 AM, the Registered Nurse (RN) Charge Nurse stated the handwashing process included lathering soapy hands together for 30 seconds. The RN Charge Nurse further noted that the importance of proper handwashing was to prevent the spread of germs between staff and residents. During an interview with the surveyor on 04/08/21 at 9:49 AM, the DON stated the handwashing process included scrubbing hands together with soap for no less than 15 seconds. The DON further noted the importance of proper handwashing was to prevent the spread of infection. During an interview with the surveyor on 04/08/2021 at 12:50 PM, the CEO stated that the LPN should have either washed her hands for 15	F 880	https://www.train.org/main/course/1081350/ Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ All Frontline staff received training as follows: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Sparkling Surfaces https://youtu.be/t7OH8ORr5Ig Clean Hands https://youtu.be/xmYMUly7qiE Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ ALL STAFF received training as follows:	

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F 880	Continued From page 9 seconds or used alcohol-based hand sanitizer. A review of the LPN's Infection Prevention Hand Washing Competency, dated 03/11/2020, included "Scrubs hands vigorously for at least 30 seconds," with an evaluation result of "YES." A review of the facility's Hand Hygiene Guidelines policy, with a reviewed date of February 2021, included under the Hand Washing Procedure section, "Moisten the hands and wrists, apply a heavy lather of soap" and "Use friction, rubbing one hand upon the other for 15 seconds." NJAC 8:39-19.4(a)(1)(5)	F 880	Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? 1. Charge nurses will monitor the residents on their nursing unit with urinary drainage bags for privacy covers when outside of their room, for proper attachment to a bed or chair in such a manner to promote drainage below the level of the resident□s bladder, and to ensure tubing is not touching the floor or other contaminated items, especially when the bed is lowered due to fall risk parameters. Nursing staff will be provided with additional educational sessions yearly on the correct protocols in providing care for a resident with a urinary drainage bag according to Indwelling Catheter Care #27 -26. 2. Hand Hygiene is covered on orientation and semi-annually along with Handwashing competency audits conducted to demonstrate adherence to facility protocol which emphasizes	

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F 880	Continued From page 10	F 880	moistening the hands and wrists, apply heavy lather of soap, use friction, rubbing one hand upon the other for no less than 20 seconds. The Infection Control Preventionist will perform random handwashing competencies on each nursing unit monthly utilizing the Hand Washing Quality Monitoring sheet. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change. 1. Nursing Supervisors will complete weekly audits of residents with urinary drainage bags to determine if privacy bags are being used, and if the urinary drainage bags are hanging below the level of the resident□s bladder along with no tubing on the floor, especially when the bed is lowered due to fall risk parameters. Upon completion they will be forwarded to Nursing Administration for review. Deficient practices or negative trends will be addressed as warranted. Results of audits will be forwarded monthly to QI for further trending and monitoring for four months. Urinary drainage bag competencies will be conducted by Staff Development upon orientation and annually thereafter or as needed when deficient practices are	

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F 880	Continued From page 11	F 880	identified. 2. Handwashing Inservice and Competencies for staff are conducted on orientation and semi-annually by Staff Development and the Infection Control Preventionist. Staff handwashing competencies are done randomly each month by the ICP and/or designee. Handwashing competencies will also be conducted during Employee Health visits at the time when the employee has their annual Tuberculin Screening Test (TST) screening. Results are forwarded to the DON and to QI for further trending to look at systemic causes resulting in more action plans. A monthly audit report will be completed by the Staff Development Coordinator and forwarded to the Administrator and Quality Improvement Coordinator. This audit will review all hand washing competencies completed to ensure every employee receives the mandatory bi-annual hand washing competencies as per DOH guidelines. Immediate corrective action will be initiated for any deficiencies noted in the monthly audit. This audit will be conducted for the next six months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315496		5/12/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JERSEY VETERANS MEMORIAL VINELAND	524 NORTH WEST BLVD VINELAND, NJ 08360

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0759 Reg. # 483.45(f)(1) LSC	Correction Completed 05/03/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 05/06/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/9/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			