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 _____	01/07/2023

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 Survey Dates: 01/02/23 - 01/05/23 Survey Census: 201 Sample Size: 34 Supplemental Residents: 0 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		2/6/23

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

Electronically Signed | 01/28/2023

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

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F 657	Continued From page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure: 1. one resident (Residents (R) R82) and/or their representative out of a survey sample of 34 was invited to participate in their quarterly care plan meetings; and 2. the care plan policy included inviting residents/representatives to quarterly care plan meetings. This failure would affect all residents and/or representatives who are scheduled for quarterly care plan meetings. Findings include: Review of a document provided by the facility titled "Resident Face Sheet," indicated R82 was admitted to the facility on [redacted] with a diagnosis of [redacted] Review of R82's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] indicated a "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated R82 was [redacted] During an interview on 01/02/23 at 10:45 AM, R82 stated [redacted] did not get invited to quarterly care conferences. Review of a document provided by the facility titled "Department of Military and Veterans Affairs.	F 657	What corrective action (s) will be accomplished for those residents affected by the deficient practice? All residents and resident representatives if applicable will receive advance notice of care plan care conferences (initial, annual, quarterly and significant change) to enable resident/resident representative participation. A new form letter has been created that will be sent via email or USPS to the resident□s representative that will elicit participation in the care planning process. The resident/representative will also be informed that they may attend the conference. The Vineland Veterans Home values the input of residents and their representatives in the individualized care planning process. Additionally, the residents Registered Nurse Assessment Coordinator (RNAC) will meet with each resident prior to all care conferences to allow for participate in the care planning process and elicit any concerns or unmet needs the resident has prior to the care planning meeting. If the resident is unable or unwilling to attend the care planning conference the RNAC will meet with them following the meeting to review the care	

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F 657	Continued From page 2 . .New Jersey Veterans Memorial Home at Vineland," dated [NJ Exec Order 26.4b1] indicated R82's representative was invited to [NJ Exec] annual care conference which was scheduled on [NJ Exec Order 26.4b1]. Review of a document provided by the facility titled "Interoffice Memorandum," dated [NJ Exec Order 26.4b1] indicated R82 was invited to [NJ Exec] annual care conference scheduled on [NJ Exec Order 26.4b1]. During an interview on 01/04/23 at 8:47 AM, Social Services stated families and residents were only invited to the care conferences on an annual basis and not quarterly. During an interview on 01/04/23 at 9:11 AM, the [US FOIA (b)(6)] stated residents and representatives were invited during the annual or significant change care plan meetings and was not sure about being invited on a quarterly basis. During an interview on 01/04/23 at 9:41 AM, Medical Records confirmed she only sends out the invitations to residents and/or their representatives on an annual basis and has never sent out on a quarterly basis. During a subsequent interview on 01/04/23 at 10:31 AM, Medical Records brought in information regarding R82. Medical Records confirmed R82 was only invited to [NJ Exec] annual care conference scheduled for [NJ Exec Order 26.4b1]. She confirmed there were a total of four care conferences held for the resident in [NJ Ex Order] and the resident and/or [NJ Exec] representative were not invited to three of the four care conferences. Review of a document provided by the facility titled "Resident Care Planning," dated [NJ Exec Order 2]	F 657	plan to allow for resident participation in the process. Social Workers meet with residents throughout the assessment period and are kept abreast of issues or concerns the resident may be experiencing and will ensure these are discussed during the care planning conferences. These interactions are documented in the resident□s progress notes as well in the MDS Section Q □ Assessment and Goal setting Q0100 Participation in Assessment. 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 of the facility have the potential to be affected by the deficient practice. The process as described above will be initiated for all residents. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? The secretary for the care planning team will send the new letter to all resident/representatives, prior to the date of all (initial, annual, quarterly and significant change) care plan conferences. This letter will be sent via email or USPS	

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F 657	Continued From page 3 indicated ". . .To assure [sic] each resident/family member/guardian an opportunity to participate in the development of the resident's individualized care plan. . ." There was no information in the facility's policy which indicated the resident and/or the representative would be invited to the quarterly care plan conference. NJAC 8:39-13.2(a)	F 657	for those resident representatives who do not have an email address on file. Any responses will be forwarded to the Registered Nurse Assessment Coordinator (RNAC) for the resident to be included in the care planning process. 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. A monthly audit will be conducted for the next six (6) months. The audit will be conducted by the Supervisor of Care planning and MDS. The audit will review ten (10) care conference notifications conducted in the preceding month. The audit will review five (5) quarterly conferences and 5 other care conference types. The audit will review documentation that the resident representative and residents participation was elicited before the conferences were conducted. The results of the audits will be forwarded to the Administrator s office and Quality Improvement Coordinator within 5 days of the preceding month for trending and analysis. Any deficient practices noted will be addressed upon discovery. If audits reveal continued non-compliance, the Quality Assurance Performance Improvement (QAPI) Coordinator will initiate a Performance Improvement Plan	

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F 657	Continued From page 4	F 657	(PIP) team. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks until sustained compliance is achieved.	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interview with facility and [redacted] clinic staff and resident, and review of facility policies, the facility failed to ensure that one of two residents (Resident (R) 17) reviewed for [redacted] out of a total sample of 34 residents received proper treatment to maintain the use of [redacted]. This failure increased the risk of other residents [redacted] not being maintained and functional. Findings include: Review of the medical record revealed a diagnosis on the "Face Sheet" tab for (R 17 of [redacted]	F 685	What corrective action (s) will be accomplished for those residents affected by the deficient practice? Resident #17 [redacted] was assessed, and the screen on the device was cleaned. Resident #17 indicated [redacted] post cleaning of the screen. It was noted that additional screens were needed and therefore ordered and have been received. All nursing staff members will be provided with education that will consist of types of hearing aids and cleaning procedures for each. Additionally, the education will	2/6/23

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F 685	Continued From page 5 Review of undated NJ Exec Order 26.4b1 notes titled "Progress Notes" found in medical records storage indicated a NJ Exec Order 26.4b1 evaluation/assessment was performed. R17 completed NJ Exec Order 26.4b1 for Adults with a score of 32 indicating candidacy for NJ Exec Order 26.4b1 Review of the section of "Care Plan" revealed a quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of U.S. FOIA (b)(6) and an "MDS" with an ARD of U.S. FOIA (b)(6) revealed an admission date of NJ Exec Order 26.4b1 and that R17 had NJ Exec Order 26.4b1 that required the NJ Exec Order 26.4b1 and the use of a NJ Exec Order 26.4b1 Further review of this "MDS" revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1 indicating R17 was NJ Exec Order 26.4b1. Review of the medical record under the "Care Plan" tab revealed there was no care plan for the use of the NJ Exec Order 26.4b1 Review of the medical record under the "Orders" tab revealed physician orders initiated on NJ Exec Order 26.4b1 Change NJ Exec Order 26.4b1 one time per month on the NJ Exec Ord" Review of the medical record under the "Treatment Administration Record (TAR)" revealed the NJ Exec Order 26.4b1 had not been changed for the time periods of NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1 there is a notation of the (b) (1) (A)	F 685	contain reminders to discontinue physician□s orders should the order be unable to be completed based on the type of the hearing aide or compliance of the resident. 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 who wear hearing aids have the potential to be affected by this deficient practice. The residents who wear hearing aids will have their medical plan of care updated based on the type of hearing aid and the prescriber□s recommendations for cleaning. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? A new policy has been created to outline the process and procedure for hearing aid cleaning. The policy outlines the process that the facility staff will employ to ensure that storage and cleaning of hearing aids is initiated per prescriber□s direction and manufacturers recommendations. 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	

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F 685	Continued From page 6 Review of medical record under the "Progress Notes" tab revealed on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . Not applied. Resident stated they haven't been working and that NJ Exec has told NJ Exec Order 26.4b1 Interview with R17 on 01/03/23 at 9:14 AM indicated when questioned why NJ Exec was NJ Exec Order 26.4b NJ Exec stated NJ Exec was holding the NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 so NJ Exec Order 26.4b1 the surveyor speak. R17 stated if both NJ Exec Order 26.4b1 are in takes . R17 went on to indicate NJ Exec received the NJ Exec Order 26.4b1 for free about NJ Exec Order 26.4b1 ago. R17 stated NJ Exec because the NJ Exec Order 26.4b1 don't work. Interview with Licensed Practical Nurse (LPN) 1 on 01/04/23 at 9:40 AM revealed "NJ Exec Order 26.4b1 , if not, we send them out." LPN 1 went on to state that she often worked with R17 and was not familiar with NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 each month on the NJ Exec Orde Interview with the U.S. FOIA (b)(6) at the U.S. FOIA (b)(6) office on 01/05/23 at 10:30 AM who had fitted and assessed R17 for NJ Exec Order 26.4b1 , indicated that not replacing the screens on the NJ Exec Order 26.4b1 would affect the function of the NJ Exec Order 26.4b1 . Interview with the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) on 01/05/23 at 11:40 AM revealed there is no policy or procedure for the care and maintenance of NJ Exec Order 26.4b1 at the facility. NJAC 8:39-27.5(a)(b)	F 685	place to monitor the continued effectiveness of the systemic change. All new admissions with prescribed hearing aids and new orders for hearing aids for current residents will be audited by the Quality Improvement Team to ensure that the new policy is being followed for the next 4 months. This audit will be conducted monthly. Additionally, an audit will be conducted each month for the next four (4) months of 50% of the current residents who are prescribed hearing aids. This audit will evaluate the resident□s response to the hearing aid therapy, the cleaning schedule in place and if the proper storage of the hearing aid/s is in place. The results of the audits will be forwarded to the Administrator□s office and the Quality Improvement Coordinator within 5 days of the preceding month for trending and analysis. Any deficient practices noted will be rectified upon discovery. If audits reveal continued non-compliance, the Quality Assurance Performance Improvement (QAPI) Coordinator will initiate a Performance Improvement Plan (PIP) team. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks until sustained compliance is achieved.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		2/6/23

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F 803	Continued From page 7 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on resident council interview, staff interview, and record review, the facility failed to obtain food preferences and provide menus for meal selection for five residents (Resident (R)185, R113, R68, R8, and R101) out of nine residents reviewed for food preferences in a total sample of 34 residents. These deficient practices resulted in the residents who prefer to eat in their rooms instead of the dining room not having the	F 803	What corrective action (s) will be accomplished for those residents affected by the deficient practice? All residents have a baseline profile in our dietary menu program created upon admission and when any diet changes occur. This program identifies the residents likes and dislikes which chooses	

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F 803	Continued From page 8 opportunity to choose foods from the menu but instead received the main course. Findings include: On 01/03/23 at 10:43 AM, R185 stated [NJ Ex] has mentioned to the dietary department during food committee meetings that residents who prefer to eat in their rooms instead of the dining room do not choose other menu options. R185 stated no changes have been made to provide a way for the residents eating in their rooms to choose from the menu. Review of the "Menu Planning Committee Meeting," dated [NJ Exec Order 26.4(b)] revealed "[R185] stated the residents didn't have much a choice and it seemed to [NJ Exec O] that portions were smaller." During the Resident Council interview on 01/04/23 at 11:23 AM, R113, R68, R8, R101, and R185 stated how residents who prefer to eat in their rooms don't have many menu choices as they would if they ate in the dining room. The residents in the Resident Council interview agreed that during COVID it was nice when the staff would come by and provide menu options but since COVID restrictions have been lifted more menu options are given in the dining room. During an interview on 01/05/23 at 9:55 AM, the [US FOIA (b)(6)] stated the menus are posted on the units and the nursing staff has menus available for the residents. The residents can ask for the alternate entrée if they don't like what they are served. The residents can tell the nurses and then the nurses can call the kitchen. Some residents have the direct number to the dietary department. He also stated during COVID	F 803	the meal for the resident based on the expressed preferences. Additionally, if the resident does not want the provided meal, they are able to choose from the first choice, second choice, or daily specials such as; sandwich of the day, fruit and cottage cheese platter, grilled cheese, hot dog, wedge salad or pizza. This system is in place for all residents. During the survey, several residents indicated that they would like us to reinstitute the process that was in place during the height of the pandemic and take resident meal selections. During the pandemic, dining rooms were closed, and this process was put in place. The request has been to reinstitute this process for those residents who do not dine in the dining rooms. All residents who do not eat in the dining rooms will have a Life Enrichment representative meet with them weekly and allow them to choose their entrees for each day for the week. The menus for each resident will be personalized by their Nutritionist based on their prescribed diet, paying special attention to the prescribed diet consistency. The weekly menu selections for each resident will be provided to the Food Service department. 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 who dine in their rooms or in the solarium will have the opportunity to	

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F 803	Continued From page 9 life enrichment staff would go to the resident rooms and review the menu with the residents but once the residents were able to return to the dining room they proceeded to continue like they had before COVID. NJAC 8:39-17.1(c) NJAC 8:39-17.2(b) NJAC 8:39-17.4(a)	F 803	participate in the menu selection program. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? Upon admission, residents who do not dine in the dining room be enrolled or added to the menu selection process. Additionally, residents who have a significant change or diet change that affects their ability or desire to dine in the dining rooms will also be enrolled into the menu selection program. 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. Audits will be conducted weekly by the Clinical Nutritionists for the first two (2) months of 10 randomly selected residents who do not dine in the dining room. The audit will ensure that residents□ choices are being queried and prescribed diets are being followed. The same audits will be conducted biweekly for next two (2) months and monthly for the next two (2) months. As described above audits will be conducted for a total of six (6) months. The results of the audits will be forwarded to the Administrator□s office and Quality	

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F 803	Continued From page 10	F 803	Improvement Coordinator within 5 days of the preceding month for trending and analysis. Any deficient practices noted will be rectified upon discovery. If audits reveal continued non-compliance, the Quality Assurance Performance Improvement (QAPI) Coordinator will initiate a Performance Improvement Plan (PIP) team. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks until sustained compliance is achieved.	
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 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		2/6/23

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	315496	A. BUILDING _____ B. WING _____	01/07/2023

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 880	Continued From page 11 §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 transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 12 §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 record review, observations, staff and resident interviews, review of Centers for Disease Control and Prevention (CDC) guidance, and facility policy review, the facility failed to ensure infection control measures were appropriately implemented and maintained for: 1. one resident (Resident (R62), who had a diagnosis of NJ Exec Order 26.4b1 out of four residents reviewed for NJ Exec Order 26.4b1 and 2. one resident (R55) out of two residents reviewed for NJ Exec Order 26.4b1 care out of a total sample of 34 residents. Findings include: 1. Review of a document provided by the facility titled "Resident Face Sheet," indicated R62 was admitted to the facility on NJ Exec Order 26.4b1 Review of a document provided by the facility titled "Interdisciplinary Progress Notes (IDT)" for R62, dated NJ Exec Order 26.4b1, indicated the resident was sent to [redacted]. The IDT notes dated NJ Exec Order 26.4b1 revealed R62 was readmitted back to the facility. Review of hospital documents provided by the facility titled "Flowsheet Print Request," dated NJ Exec Order 26.4b, indicated R62 had a diagnosis of NJ Exec Order 26.4b1 Review of a document provided by the facility titled "Progress Notes Medical Provider Progress Note," dated NJ Exec Order 26.4b1 indicated R62 was NJ Exec Order 26.	F 880	What corrective action (s) will be accomplished for those residents affected by the deficient practice? 1. Resident R62 was NJ Exec Order 26.4b1 by the deficient practice of the US FOIA (b)(6) not donning eye wear that was required for the prescribed droplet precautions. The U.S. FOIA (b)(6) was immediately re-educated about proper PPE and adhering to transmission-based precautions in place. Additionally, the entire Rehabilitation Department was re-educated on proper PPE use and transmission-based precautions. 2. All nursing staff providing care to R55 were immediately re-educated on proper disposal of the suction catheter after each use. 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. Education for all staff on proper PPE use and transmission-based precautions is conducted frequently throughout the year for all employees. Re-education will be provided to all departments again with emphasis on required PPE based on the precautions in place.	

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F 880	Continued From page 13 for NJ Exec Order 26.4b1 Review of a document provided by the facility titled "Physician Telephone Order," dated NJ Exec Order 26.4b1, directed the facility staff to place R62 under NJ Exec Order 26.4b1. During an observation conducted on 01/03/23 at 1:50 PM, a NJ Exec Ord poster was on the outside of R62's door which indicated R62 was on NJ Exec Order 26 and directed staff to don (put on) eye protection and a face mask prior to entering into the resident's room. During an observation on 01/03/23 at 12:50 PM, the U.S. FOIA (b)(6) was observed in R62's room. The U.S. FOIA (b) was not wearing eye protection. She was observed wearing a gown, gloves, and a surgical mask. The U.S. FOIA came to R62's door and confirmed she was to don eye protection but had not and had overlooked it. During an interview on 01/05/23 at 10:21 AM, the U.S. FOIA (b)(6)) stated she met with the U.S. FOIA and notified the U.S. FOIA (b)(6) the need for an inservice concerning NJ Exec Or with the rehabilitation staff. 2. Review of a document provided by the facility titled "Resident Face Sheet," indicated R55 was admitted to the facility on NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 During an observation on 01/02/23 at 11:33 AM, R55's was sitting on NJ Exec Order 26.4b	F 880	2. All residents requiring bedside suctioning were identified. The suction machines and tubing of these residents were inspected to ensure all were adhering to policy and were disposed of after each use. Nursing staff providing care to these residents will receive re-education on policy Resident Care Services 27-6, Permanent Tracheostomy Care, suctioning and inner- cannula change. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? 1. Frequent daily rounding in the facility by administrative staff as well as auditing by the Quality Improvement Team will continue with emphasis on adhering to proper PPE use and transmission-based precautions for the protection of the employees and residents. 2. Nursing administration and the Infection Control Team will audit those residents requiring suctioning at bedside to ensure that the catheter is being properly disposed of after each use. Immediate remediation will be provided if deficient practices are observed. 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	

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F 880	Continued From page 14 side of [redacted] bed. Observed was an open package titled '[redacted] which then had [redacted] in the [redacted] package and the other end was connected to the [redacted] machine, [redacted]. During an observation on 01/03/23 at 9:59 AM, R55's [redacted] was sitting on [redacted] Observed was an open package titled [redacted] which then had [redacted] in the open package and the other end was connected to the [redacted] machine. An interview with R55's Family Member (FM)1 confirmed the [redacted] had been used to [redacted] from the [redacted] During an observation on 01/03/23 at 10:45 AM, R55's used [redacted] was still connected to the [redacted] machine and the other end was sitting in the same open package. During an interview on 01/03/23 at 1:48 PM, Licensed Practical Nurse (LPN) 2 stated he disposed of the [redacted] located in R55's room after FM1 asked him to throw it away. LPN 2 stated the [redacted] to the [redacted] machine was considered one time use. During an interview on 01/03/23 at 2:09 PM, the [redacted]) stated the used [redacted] connected to the [redacted] machine was considered a potential [redacted] control issue since the [redacted] was to be used one time and then thrown away. During an interview on 01/05/23 at 10:21 AM, the [redacted] stated all nurses were aware to dispose of the [redacted] machine [redacted] after one use.	F 880	place to monitor the continued effectiveness of the systemic change. 1. A weekly audit of 10 residents who have transmission-based precautions prescribed will be conducted by the Quality Improvement Team. The audit will observe employees moving in and out of the residents□ rooms to ensure proper PPE is being donned and doffed. The weekly audits will be conducted for two (2) months. The audits will then be conducted monthly for four (4) additional months. Deficient practices will be corrected immediately with additional remediation occurring with the employee. The completed audits will be maintained in the Quality Improvement Office and forwarded to the Administrators office for trending and analysis. 2. The Infection Control Team will conduct a weekly audit of all residents requiring bedside suctioning to ensure the catheter is being disposed of after each use. The weekly audits will be conducted for two (2) months. The audits will then be conducted monthly for four (4) additional months. Deficient practices will be corrected immediately with additional remediation occurring with the employee. The completed audits will be forwarded to the Administrators office and Quality Improvement Coordinator for trending and analysis.	

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F 880	Continued From page 15 Review of the Centers for Disease Control (CDC) dated 05/22 indicated ". . . Droplet transmission is, technically, a form of contact transmission, and some infectious agents transmitted by the droplet route also may be transmitted by the direct and indirect contact routes. However, in contrast to contact transmission, respiratory droplets carrying infectious pathogens transmit infection when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient, generally over short distances, necessitating facial protection. Respiratory droplets are generated when an infected person coughs, sneezes, or talks. . ." Review of a document provided by the facility titled "ISOLATION - CATEGORIES OF TRANSMISSION BASED PRECAUTIONS," dated 02/21, indicated ". . .Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection. . .In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets larger than 5 microns in size that can be generated by the individual coughing, sneezing, talking. . .Examples of infections requiring Droplet Precautions include. . .influenza. . ."	F 880		
F 883 SS=E	NJAC 8:39-19.4(a)(k) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		2/6/23

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F 883	Continued From page 16 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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F 883	Continued From page 17 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to offer one (Resident (R) 82) of five residents (and/or their representatives) reviewed for NJ Exec Order 26.4b1 in a total sample of 34 residents, the opportunity to be NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1) in accordance with nationally recognized standards. The facility failed to update their most current policies to reflect current standards on NJ Exec Order 26.4b1 . This practice had the potential to increase the risk for residents over 65 years of age and/or with NJ Exec Order 26.4b1 who had not been NJ Exec Order 26.4b1 per CDC guidelines to contract NJ Exec Order 26.4b1 . Findings include: Review of a document provided by the facility titled "Resident Face Sheet" indicated R82 was admitted to the facility on NJ Exec Order 26.4b1 . R82 was	F 883	What corrective action (s) will be accomplished for those residents affected by the deficient practice? One resident out of five (5) that were reviewed had received PCV13 and was not offered an additional vaccination of PPSV23 or PCV20 as per new CDC guidance. The one resident identified will receive the PPSV23. 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? The pneumococcal vaccination status of All residents in the facility will be reviewed to determine the need for an additional pneumococcal vaccine. An audit tool has been developed and will be utilized for the	

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F 883	Continued From page 18 65 years or older at the time of admission. Review of an untitled document provided by the facility (lists NJ Exec Order 26.4b1 received), indicated R82 received NJ Exec Order 26.4b1. There was no other information that the resident had received NJ Exec Order 26.4b or more recently NJ Exec Order 26.4 During an interview on 01/02/23 at 3:08 PM, the US FOIA (b)(6) stated she was unable to locate additional NJ Exec Order 26.4b1 information for R82. During an interview on 01/02/23 at 3:42 PM, the US FOIA stated she was unaware of CDC's newest recommendations for the NJ Exec Order 26.4b1 Review of Center of Disease Control (CDC) website titled NJ Exec Order 26.4b1 Summary of Who and When to NJ Exec Order 26.4b1 last reviewed 01/24/22, indicated ". . . CDC recommends [redacted] for all adults 65 years or older. The tables below provide detailed information . . . For adults 65 years or older who have not previously received any NJ Exec Order 26.4b1, CDC recommends you . . . Give NJ Exec Order 26.4b1 . . . If NJ Exec Order 26 is used, this should be followed by a dose of NJ Exec Order 26.4b at least one year later. The minimum interval is 8 weeks and can be considered in adults with an NJ Exec Order 26.4b1 [redacted] . . . If NJ Exec Order 26 is used, a NJ Exec Order 26.4b1 is NOT indicated . . . For adults 65 years or older who have only received a NJ Exec Order 26.4b1 CDC recommends you . . . May give 1 dose of NJ Exec Order 26.4b1. . . The NJ Exec Order 26.4b1 dose should be administered at least one year after the most	F 883	review. The vaccination policy of the Home has been updated to reflect new CDC guidance for additional protection against pneumococcal pneumonia. If the audit determines that based on the new policy guidance the resident should receive an additional vaccine, the resident and/or resident representative if applicable will be informed of the risks and benefits of the recommended additional vaccine and be asked to provide consent for the vaccine. The vaccine will then be administered to the resident. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? The facility will be providing education to all nurses and medical prescribers on the new Pneumococcal vaccination policy. The pneumococcal vaccination status of all residents will be reviewed, if the audit determines that based on the new policy guidance, the resident should receive an additional vaccine, the resident and/or resident representative if applicable will be informed of the risks and benefits of the recommended additional vaccine and be asked to provide consent for the vaccine. The vaccine will then be administered to the resident. Additionally, education on the new policy will be provided to the Admissions team, emphasizing the need to determine the	

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F 883	Continued From page 19 recent NJ Exec Order 26.4b1. Regardless of if NJ Exec Order 26.4b1 is given, an additional dose of NJ Exec Order 26.4b is not recommended since they already received it. For adults 65 years or older who have only received U.S. FOIA (b)(6) CDC recommends you . . . Give NJ Exec Order 26.4b1 as previously recommended. . . For adults who have received NJ Exec Order 26.4 but have not completed their recommended pneumococcal vaccine series with NJ Exec Order 26.4b1 one dose of NJ Exec Order 26.4 may be used if NJ Exec Order 26.4b is not available. If NJ Exec Order 26 is used, their NJ Exec Order 26.4b1 are complete . . . " The CDC guidelines went into effect on 10/21/21 per recommendations from the Advisory Committee on Immunization Practices (ACIP). Review of a document provided by the facility titled "Immunization" dated 02/21 indicated ". . .Consent for preventable vaccine administration which encompasses both consent and refusal of influenza, pneumococcal vaccines will be obtained at the time of admission from the resident, guardian or power of attorney for healthcare. . .The seasonal influenza vaccine will be offered to all residents to all residents of the facility between October 1 through March 31 of the current year. . .The pneumococcal vaccination shall be offered to all residents 65 years of age or older and residents with high risk factors. The written consent from the resident. guardian or power of attorney for healthcare competed [sic] at the time of admission that reflects both consent and refusal of annual vaccination will be reviewed. . ." There was no information on the facility's policy which would reflect current CDC recommendations on the pneumococcal vaccines.	F 883	pneumococcal vaccine status prior to admission to the facility. Based on the new policy, the team may recommend an additional pneumococcal vaccine be obtained before the applicant is admitted. If the applicant is unable to obtain the additional vaccination prior to admission, the vaccine will be provided upon admission to the facility. 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. Education on the new pneumococcal vaccine policy will be included in the new employee orientation and added to the annual education sessions for nurses. A 100% review of all resident□s pneumococcal status will be completed and followed by a monthly audit conducted by the Infection Control Preventionist. The audit will consist of review of pneumococcal vaccination status of all new admissions admitted in the previous month as well as five (5) randomly selected residents who were not recently admitted. The results of the audit will be forwarded to the Administrator□s office and Quality Improvement Coordinator within 5 days of the preceding month for trending and analysis. Any deficiencies noted during the audit will be addressed accordingly.	

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F 883	Continued From page 20 NJAC 8:39-19.4(i)	F 883	If audits reveal continued non-compliance, the Quality Assurance Performance Improvement (QAPI) Coordinator will initiate a Performance Improvement Plan (PIP) team. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks until sustained compliance is achieved.	

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident for five (5) of 14 day shifts as follows: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	What corrective action (s) will be accomplished for those residents affected by the deficient practice? The facility is actively recruiting CNAs, utilizing online recruitment platforms, social media and affiliations with CNA schools in the area. The goal is to always meet or exceed the mandated staffing ratios. 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?	2/6/23

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

Electronically Signed | 01/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050625	A. BUILDING: _____ B. WING _____	01/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 12/18/2022 through 12/24/2022 and 12/25/2022 through 12/31/2022, the staffing-to-resident ratio that did not meet the minimum requirement of one CNA to eight residents for the day shift is documented below: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -12/18/22 had 21 CNAs for 206 residents on the day shift, required 26 CNAs. -12/19/22 had 25 CNAs for 206 residents on the day shift, required 26 CNAs. -12/24/22 had 23 CNAs for 199 residents on the day shift, required 25 CNAs. -12/25/22 had 23 CNAs for 199 residents on the day shift, required 25 CNAs. -12/31/22 had 22 CNAs for 200 residents on the day shift, required 25 CNAs.	S 560	The staffing department contracts with three (3) staffing agencies that assist in providing additional CNAs as needed to meet mandated ratios. Our Human Resources Department conducts recruitment events weekly. We also have increased new employee orientation to twice a month. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? Admissions to the facility have been decreased to assist in meeting daily staffing ratios. The facility has applied for and received a grant from the federal Veterans Administration (VA) to be used for recruitment and retention of nursing staff. This is the second year the facility has participated in the VA grant opportunity. As the Home is state owned and operated, staff salaries are created and maintained by the Civil Service Commission (CSC) of New Jersey. Requests for increases in CNA salaries to improve recruitment has been sent to the CSC, and we are still awaiting the decision. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050625	A. BUILDING: _____ B. WING _____	01/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2	S 560	place to monitor the continued effectiveness of the systemic change. Administration will continue to review daily DOH staffing reports containing staffing ratios of CNAs for every shift for adherence to mandated ratios. If daily reviews reveal continued non-compliance, the Quality Assurance Performance Improvement (QAPI) Coordinator will initiate a Performance Improvement Plan (PIP) team. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks until sustained compliance is achieved.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315496 Y1	A. Building B. Wing Y2	3/8/2023 Y3

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 F0657	Correction	ID Prefix F0685	Correction	ID Prefix F0803	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.25(a)(1)(2)	Completed	Reg. # 483.60(c)(1)-(7)	Completed
LSC	02/06/2023	LSC	02/06/2023	LSC	02/06/2023
ID Prefix F0880	Correction	ID Prefix F0883	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed
LSC	02/06/2023	LSC	02/06/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/7/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 050625 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 3/8/2023 Y3

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/06/2023	ID Prefix Reg. # LSC	Correction Completed	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 1/7/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: FG2E12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315496	A. BUILDING **02** B. WING _____	**01/07/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/07/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/07/23 and was found to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The facility is three stories first occupied in 2006. The facility has concrete flooring, block bearing walls and metal protected stud roofing. The facility is noted to be a type II protected (222) with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has a 750 KW (kilowatt) diesel generator that is tested above 30% routinely each month.	K 000		

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

Electronically Signed | 01/25/2023

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.