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 ______	C 08/30/2024

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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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS STANDARD SURVEY: CENSUS: 225 SAMPLE: 35 C/O # NJ 162596, 170203, 170875, 172481, 173373, 173665, 174541, 174816, 174817, 175551 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		10/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/17/2024

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 656	Continued From page 1 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #: NJ174817 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to develop a comprehensive, person-centered care plan to	F 656	What corrective action (s) will be accomplished for those residents affected by the deficient practice? Resident #186 had already been treated for the NJ Exec Order and NJ Exec Order 26.4 administration	

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F 656	Continued From page 2	F 656		

include physician prescribed interventions for a NJ Ex Order 26 treatment and NJ Exec Order 26.4b1 administration that were implemented after a NJ Exec Order 26.4b1 This deficient practice was identified for 1 of 12 residents (Resident #186) reviewed for NJ Exec Order 2

This deficient practice was evidenced by the following:

During the initial tour of the facility on 08/19/2024 at 11:52 AM, the surveyor observed Resident #186 in their room, who was being fed by a US FOIA (b)(6) at the bedside. The resident closed their eyes and NJ Exec Order to the surveyor when spoken to

A review of Resident #186's Face Sheet revealed that the resident had diagnosis which included but were not limited to: NJ Exec Order 26.4b1

A review of Resident #186's Quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, indicated that the resident's Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, revealed that the resident was NJ Exec Order 26.4

A review of the Interdisciplinary Progress Notes (IPN) revealed an entry dated NJ Exec Order 26.4 at 4:45 AM, indicated that " ...At approximately 03:26 AM heard commotion on couch in day room. This nurse and US FOIA (b)(6) went to resident and NJ Exec Order 26.4b1 him/her from NJ Exec Order 26 Upon NJ Exec Order 26.4b1 in his/her room noted NJ Exec Order 26.4b to NJ Exec Order 26.4b1 measuring NJ Exec Order 2 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1

had been completed. The date of the NJ Exec Order was NJ Exec Order 26.4b1, with treatment, including NJ Exec Order 26.4b1 and NJ Exec Order 26.4b to the NJ Exec Order completed on NJ Exec Ord The NJ Exec Order was noted to be completely NJ Exec Order on NJ Exec Order 26.4b1. The resident made a NJ Exec Order 26.4b1 from this NJ Exec Order 2

The intervention added to the care plan was as follows: If resident becomes NJ Exec Order 26 staff to assist NJ Exec to NJ Exe room to NJ Exe bed instead of the couch to avoid any future incidents of this kind.

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 have wounds and/or are receiving antibiotics have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes made to ensure that
the deficient practice will not recur?

Registered Nurse Assessment Coordinators (RNACs) will receive education on expectations of prompt revisions or additions to care plans based on changes in resident conditions, i.e. wounds, antibiotics starts, falls, etc.&The education sessions to include RNACs, Nurses and SONS are scheduled for

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F 656	Continued From page 3 with NJ Exec Order 26.4b1 ..." A further review of Resident # 186's IPN revealed an entry dated NJ Exec Order 26.4b at 5:17 AM, "Resident and another resident were NJ Exec Order 26.4b1 on couch appeared both residents NJ Exec Order 26.4b . Upon reviewing footage with supervisor and security both residents NJ Exec Order 26.4b1 and other resident NJ Exec Order . On NJ Exec Order 26.4b at 2:42 PM, " ...Resident with a NJ Exec Or on NJ Exec Order 26.4b1 with NJ Exec Order 26 ... NJ Exec Order 26.4b1 and NJ Ex . NJ Exec Order 26.4b1 associated with incident with NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 cleaned, NJ Exec O applied and NJ Exec Order 26.4b1 applied and NJ Exec Order 26.4b1. New order for [sic.] days of NJ Exec Order 26.4 ordered ... A review of Resident # 186's Physician's Orders revealed an order dated NJ Exec Order 26.4b at 4:58 AM, for Tx (treatment) to: NJ Exec Order 26.4b1 with NJ Exec O apply NJ Exec Order 26.4b1 cover up with NJ Exec Order 26.4b1 times 7 (seven) days Treatment once daily. A second order was reviewed dated NJ Exec Order 26.4b at 5:15 PM, for NJ Exec Order 26.4b1 tablet 1 (one) tab oral for 7 (seven) days twice daily for NJ Exec Order 26.4b1 for NJ Exec Order 26.4 . The medication was scheduled for administration at 9:00 AM and 9:00 PM. A review of Resident # 186's Medication Record revealed that NJ Exec Order 26.4b1 tablet 1 (one) tablet oral for 7 (seven) days twice daily for NJ Exec Order 26.4b1 for NJ Exec Order 26.4 was documented that the medication	F 656	September 26, October 1, and October 9, 2024. All Unit Charge Nurses will also receive the same education as noted above. To facilitate prompt identification of resident condition changes all RNACs will receive the 24-hour Nursing SONS report for each shift. 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 daily clinical services morning meeting which includes the MDS Coordinator will review care plans to ensure appropriate and prompt interventions are in place based on resident condition, changes identified on rounds and the previous week□s 24-hour reports. This audit will be conducted weekly. Deficient practices will be corrected immediately. The results of the audit findings will be reviewed by the Administrator and Quality Assurance Specialist to identify trends to assess the need for a QAPI PIP and the need for additional educational opportunities. The audits will be conducted weekly for two (2) months. Care Plan audits will be conducted by the	

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F 656	Continued From page 4	F 656		

was administered to the resident as ordered from NJ Exec Order 26.4b through the completion date of NJ Exec Order 26.4b .A review of the resident's Treatment Record revealed that the entry for Tx to NJ Exec Order 26.4b NJ Exec Order 26 with NJ Exec O apply NJ Exec Order 26.4b1 cover up with NJ Exec Order 26.4b1 times 7 (seven) days treatment once daily was administered to the resident as ordered from NJ Exec Order 26.4b through the completion date of NJ Exec Order 26.4 .

A review of Resident #186's Care Plan revealed that there was no documented evidence that the facility initiated a resident centered care plan that identified that the resident sustained a NJ Exec Order 26.4 to their NJ Exec Order 26.4b because of a NJ Exec Order 26.4b1 which resulted in the need for the resident to receive a physician NJ Exec Order 26.4b1 and NJ Exec Order treatment.

A review of the "Supervisory Nursing Services Twenty-Four Hour Report" dated NJ Exec Order 26.4b, revealed that Resident #186 was involved in a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b during the 11-7 shift. It detailed that the resident was asleep on the couch in the day room, NJ Exec Order 26 and NJ Exec Order 26.4b1 and resident NJ Exec Order 26 and NJ Exec Order 26.4b1. The resident sustained NJ Exe on NJ Exec Order 26.4b1 NJ Exec O protocol in place ...

A review of the "Nursing Services Twenty-Four Hour Report" dated NJ Exec Order 26.4b revealed that Resident #186 was involved in a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b (11-7) NJ Exec Order 26.4b1 ...

On 08/22/2024 at 9:13 AM, the surveyor interviewed the US FOIA (b)(6) who stated that if any interventions were

Quality Assurance Department monthly using a sample size of five (5) randomly selected residents per Nursing Unit. This audit is already in place and will continue indefinitely. This audit reviews six aspects of appropriate care planning and identifies deficiencies with corrections occurring immediately.

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.

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F 656	Continued From page 5 placed, or a new treatment was ordered as a result of a NJ Exec Order 26.4b1 , it should be reflected on the Care Plan by the US FOIA (b)(6) The US FOIA (b)(6) further stated that a nurse or a supervisor could type into the care plan and notify the US FOIA (b)(6) that they made some adjustments to the Care Plan. On 08/22/2024 at 9:43 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that when a NJ Exec Order 26.4b1 occurred, if a NJ Exec Order treatment was required due to an NJ Exec Order it should get carried over into the interdisciplinary progress notes and the US FOIA (b)(6) then transcribed the occurrence into the Care Plan and included an NJ Exec Order 26.4b or treatment if they were ordered. On 08/22/2024 at 11:43 AM, the surveyor interviewed the US FOIA (b)(6) who stated that if she were present in the facility, the nursing staff called her to alert her of a need to update the Care Plan. The US FOIA (b)(6) stated she also reviewed the resident's Interdisciplinary Progress Notes to determine if there were changes. The US FOIA (b)(6) reviewed Resident #186's Care Plan in the presence of the surveyor and stated that the only update that she saw in response to the resident's involvement in a NJ Exec Order 26.4b1 was on NJ Exec Order 26.4b , when the NJ Exec Order 26.4b1 Plan was updated to include, "If resident becomes NJ Exec Order 2 return him/her to his/her room." The US FOIA (b)(6) stated that was a mistake and should have instead been included in the resident's NJ Exec Order 26.4b1 care plan. The US FOIA (b)(6) stated that she was aware that the resident NJ Exec Order 26.4b1 and was getting an NJ Exec Order 26.4b The US FOIA (b)(6) stated that she would have thought that they would have added the NJ Exec Order 26.4b	F 656		

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F 656	Continued From page 6	F 656		

and treatment for the NJ Exec to the resident's Care Plan, but she just could not find it on there. The US FOIA (b)(6) further stated, "Honestly, we were never told that we had to put NJ Exec Order 26.4b1 or NJ Exec Order treatments on the Care Plan."

On 08/22/2024 at 1:03 PM, the surveyor interviewed the US FOIA (b)(6)) who stated that her expectation was for the Care Plan to be updated with new interventions or revisions soon after an occurrence. The US FOIA (b) stated that in morning meeting we look at all new NJ Exec Order 26.4b starts, and make sure that it was care planned for. The US FOIA (b) clarified that the process to include NJ Exec Order treatments and NJ Exec Order 26.4b1 on the Care Plan had only been in place for approximately three months or so and should have been reflected on the resident's Care Plan.

On 08/27/2024 at 10:53 AM, the surveyor interviewed Licensed Practical Nurse (LPN #3) who stated that the Care Plan was updated by the US FOIA (b)(6). LPN #3 stated that when she served as US FOIA (b)(6), she reported any changes in resident status to the US FOIA (b)(6) r, and then passed on the information on the 24-Hour Report, and at shift change. LPN #3 further stated that the US FOIA (b)(6) reported a change in resident status to the US FOIA (b)(6) who was responsible to update the Care Plan.

On 08/27/2024 at 1:06 PM, the surveyor interviewed the US FOIA (b) regarding Resident #186's Care Plan that was not updated to include both a physician prescribed NJ Exec Order 26.4b and NJ Exec Order treatment. The US FOIA (b) stated that there was a lack of communication that did not occur. The US FOIA (b) stated that any Registered Nurse could update

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F 656	Continued From page 7 the Care Plan. The US FOIA (b) further stated that the portion of the "Incident Case Report" that prompted a conversation to be had between the US FOIA (b)(6) and the US FOIA (b)(6) to update the care plan was missed. A review of the facility policy, "Resident Care Planning-RAI (Resident Assessment Instrument) 27-37.3 (Revised September 2023) revealed the following: The care plan must describe the services that are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The effectiveness of the care plan must be evaluated from its initiation and modified quarterly and as necessary; communication regarding care plan changes is ongoing among interdisciplinary team members. A review of the facility policy, "Resident Accidents and Incidents Reporting" (Revised: June 2024) revealed that Responsibilities of the Nursing Supervisor: ...Review current care plan and indicate if any changes are needed to reduce the risk of the incident occurring in the future. Endorse Care Plan initiatives or changes to RNAC. NJAC 8:39-11.2	F 656		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		10/11/24

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F 812	Continued From page 8 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to consistently handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 08/19/2024 from 9:21 to 10:21 AM, the surveyors, accompanied by the US FOIA (b)(6) [redacted], observed the following during the initial kitchen tour: 1. In the dry storage area, on the canned food rack, there was a dented 6-pound 10 oz can of tomato puree and a dented 46 fluid oz can of pineapple juice. There was a bin labeled "dented cans" in front of the canned food racks. The US FOIA [redacted] stated that the expectation was that staff should have observed that cans were dented before putting it on the shelf. The US FOIA [redacted] further stated that the expectation was that the cook should check the cans for dents prior to opening the cans.	F 812	What corrective action (s) will be accomplished for those residents affected by the deficient practice? All residents have the potential to be affected by this deficient practice. All deficient practices observed during the initial kitchen tour were immediately rectified (dented cans were discarded, Styrofoam bowls were covered, can openers were replaced, dinner rolls were secured and sealed, salad dressing was discarded, thermometer was placed in the overflow ice cream freezer, the ribs were covered, the jar of vinegar was discarded, debris under sink was cleaned, stand up mixer was covered, and deli slicer was cleaned). All Food Service workers received training on addressing the deficient practices identified in the initial kitchen tour. The date the corrective actions were implemented by the Food Service Director was 08/19/24. Education	

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F 812

Continued From page 9

2. In the dry storage area, on the top shelf of a five-tiered wire rack, there was an opened box of Styrofoam bowls that were not covered by clear plastic wrap and were exposed to the air. The US FOIA (b) stated that Styrofoam products should have been covered. The US FOIA further stated that if the staff observed the Styrofoam to be opened, they would dispose of them.

3. In the bread storage area, there was a can opener laid on its side with unidentified debris on the tip of the blade. The US FOIA (b) confirmed there was debris on the can opener blade used to open cans. The US FOIA stated he was unsure of when the can opener was last used. The US FOIA (b) further stated after the can opener was used, it should have been cleaned.

4. In the bread storage area, on the third shelf from the top of a multi-tiered metal cart, there was an 18 oz opened bag of 16 count dinner rolls. The dinner rolls were exposed to the air. The US FOIA (b) stated that all bread products should be sealed and not opened to air. The US FOIA stated that storeroom personnel and kitchen staff were responsible for discarding bread items.

5. In Walk-In Refrigerator #3/Produce Box, on the third shelf, there was a one-gallon jar of lite salad dressing that was previously opened and was undated. The US FOIA stated that the expectation was that salad dressing should have been dated when opened.

6. Observation of the reach-in/overflow ice cream freezer revealed there was no internal thermometer and no temperature log sheet. The US FOIA (b)(6) confirmed that the reach in freezer did not have a thermometer

F 812

provided by the Food Service Director began on 08/21/24, occurred again on 09/10/24 and 09/11/24.

All Food Service workers were reeducated on the importance of restraining hair when in the kitchen area.

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 have the potential to be affected by this deficient practice, no individual resident was involved and no resident was affected by the deficient practice. Weekly audits will be conducted of the main kitchen and satellite kitchens by the Food Service Director, Asst. Food Service Directors, Nutritionists, and Asst. CEO-Support Services. The audits will be assigned by the Administrator. Deficient practices will be addressed and rectified immediately.

The audits will utilize a comprehensive audit tool that has been created to identify any deficient practices especially those cited during this survey. Audits will be conducted for two months. To ensure no residents are affected by the deficient practices the Food Service Director and Asst. Food Service Directors will monitor the corrective actions put in place daily.

What measures will be put into place or what systemic changes made to ensure that

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F 812	Continued From page 10 in it. The [US FOIA] stated that there was no thermometer in the reach in freezer because ice cream mainly was stored in the walk-in freezer. 7. In the Walk-in Refrigerator #1, on the top shelf of a rolling rack, there was a black bag with a hole in it with meat exposed from the bag. The [US FOIA] stated there were approximately five pounds of ribs in the bag. The [US FOIA] stated that food should have been properly covered. 8. In the small storage room, on the second rack of a four-tiered wire rack, a one gallon previously opened jar of white vinegar had no dates. The [US FOIA] confirmed that the white vinegar jar was not dated. The [US FOIA] stated the expectation was that items should be dated when opened. 9. In the Food Prep Area, there was unidentified debris under the sink. The [US FOIA] stated debris should have been cleaned by staff. 10. In the Food Prep Area, there was an uncovered stand mixer that was in use. There were mixer parts stored inside the mixing bowl. The [US FOIA] stated the mixer had not been used yet for the day. 11. In the Food Prep Area, there was an uncovered deli slicer not being used with unidentified debris on the base of it. The [US FOIA] stated the deli slicer should be cleaned after each use. The [US FOIA] further stated that the deli slicer normally does not get covered since it is constantly being used. During a follow-up interview with the surveyors on 08/26/2024 at 9:44 AM, the [US FOIA] stated it was important to monitor canned goods for dents to	F 812	the deficient practice will not recur? The completed weekly audits will be forwarded to the Quality Assurance Specialist and the Administrator for review. Trending of deficient practices will be conducted to identify additional remediation or reeducation. All Food Service-related policies will be reviewed and updated as needed based on evidence-based practices to ensure service of the highest quality is being provided to our residents. All food service-related policies were reviewed by the Food Service Director. This review was completed on 09/18/24. Revisions to the policy identified during the review we anticipate will be completed by 09/27/24. All food service workers will be educated monthly by the Food Service Director and Asst. CEO-Support Services for the next four (4) months on policy updates as well as deficient practices identified during audits. 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 Quality Assurance Performance Improvement (QAPI) PIP project will be initiated in October 2024. The QAPI will as its focus identify and addressing deficient practices noted in the survey as	

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 ______	C 08/30/2024

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

F 812

Continued From page 11

prevent contamination. The [US FOIA (b)] stated that it was important that meats and breads are covered so they do not become contaminated. The [US FOIA (b)] further stated that it was important that all freezers have internal thermometers to ensure food was held at a proper temperature. The [US FOIA (b)] stated that it was important for paper and Styrofoam products to be covered to prevent contamination. The [US FOIA (b)] confirmed that the deli slicer was to be cleaned daily to prevent contamination.

On 08/26/2024 at 11:16 AM, the surveyors, accompanied by the [US FOIA (b)] observed the following during the lunch tray meal line:

1. The Senior Food Service Handler (SFSH #1) was at the start of the lunch tray line with hair protruding out of the front and sides of their hairnet and was exposed. The [US FOIA (b)] stated all hair should have been inside the hairnet, so that hair does not get into food. The [US FOIA (b)] further stated that the supervisor was responsible for checking to ensure hair nets were being worn properly by staff.

On 08/26/2024, the surveyors identified the following deficient practice for 2 out of 5 unit nourishment rooms where resident food was stored:

At 10:38 AM, on the Liberty Unit in the presence of the Registered Nurse/Charge Nurse (RN/CN#1). There was an opened 48 fl. oz bottle of cranberry juice undated in the refrigerator. There were four unopened 48 fl. oz orange juice bottles with printed date of 8/7/2024 on top of lids in the nourishment room cabinets. The CN#1 stated she assumed date printed on lids were

F 812

well as review data collected during weekly audits. QAPI PIP Food Service will meet every 2 weeks for the next 2 months and thereafter as needed based on findings of the Audits. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks until sustained compliance is achieved.

Members of the (QAPI) PIP shall include the Food Service Director, Asst. Food Service Directors, Three (3) members of the Food Service Department, ACEO-Support Services, Infection Control Coordinator, Quality Assurance Specialist, Nutritionist, and the Administrator.

Daily Supervisor rounds, reeducation of staff, and frequent auditing have been put in place to ensure the deficient practices identified during survey do not occur so that no residents will be affected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 812 | F 812

Continued From page 12
expiration dates.

At 11:36 AM, on the Justice Court unit in the presence of CN #3, there was a 48 fl. oz orange juice bottle with a printed date of 8/7/2024 on the lid in the refrigerator. CN#3 stated the date printed on the lid indicated the expiration date. CN #3 further stated night shift was responsible for cleaning the nourishment room and the charge nurse was responsible for checking the dates on items.

Review of facility food service policy titled, "Handling of Damaged Food Products" with a reviewed date of May 2019 revealed under "Procedure", "Generally, dented, bulging, or otherwise damaged canned products are included in the definition of damaged products. 1. whenever an item is discovered that is damaged, spoiled, or of question-able quality in the department, notify the Supervisor and manager in charge of the area, when applicable."

Review of the undated facility food service policy titled, "Infection Control" revealed under "Personnel", "6. Hair is effectively restrained." Revealed under "Equipment Environment", "Generally equipment and contact surfaces are cleaned and sanitized between uses."

Review of the facility food service policy titled, "Storage" with a reviewed date of August 2005 revealed under "Purpose", "The objective is to maintain high quality food at approved temperature and conditions to ensure retention of quality, safe condition and nutritive value." Revealed under "Philosophy", "3. Food is covered when stored on shelves and off floors. 4. Temperature records are maintained daily on

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	315496	A. BUILDING ______ B. WING ______	C 08/30/2024

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NEW JERSEY VETERANS MEMORIAL VINELAND	524 NORTH WEST BLVD VINELAND, NJ 08360

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F 812	Continued From page 13	F 812		

refrigerators and freezers."

Review of the facility food service policy titled, "Storage of Meats" with a reviewed date of August 2005 revealed under "Purpose", "The purpose of this procedure is to help provide safe, high-quality meats for use in hospital meals by ensuring proper storage of the raw meat products." Revealed under "Procedure", Once issued, the production area wraps, labels, and dates any meat item for return to the storage area."

Review of the facility checklist titled "Cooks Main Kitchen Sanitation Inspection Checklist" revealed under "Description", "1. Kettles, Mixers, Braiser and Drain Trough are clean, sanitized. 3. Blenders, Food Processors, Slicers, and Chopper are clean and sanitized. 13. Can Openers, Base, and Blades are clean and good order. 15. Floor area and walls are clean and free of hazards."

Review of the facility food service policy titled, "Cleaning and Sanitizing the Slicer" with a revised date of August 2005 revealed under "Procedure", "Note: Slicer should be cleansed after each use. Bacteria from raw meat could be transferred to cooked meat if slicer is not cleansed properly."

Review of the undated facility nursing services policy titled "Nourishment Room Maintenance Policy" revealed under "6. Food Safety", "Stock Rotation: Implement a first in, first-out (FIFO) system for all food items stored and ensure all food items are within use by dates. Labeling: Ensure all food items are clearly labeled with the use by dates and removed if out of date."

NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315496	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/30/2024

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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	050625	A. BUILDING: ______ B. WING ______	C 08/30/2024

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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S 000	Initial Comments The facility was 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 deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	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 documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. For the week of Complaint staffing from 03/12/2023 to 03/18/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts, for the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts, for the week of Complaint staffing from 04/31/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts, for the week of Complaint staffing from 05/05/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents	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. To further correct this deficient practice, census goals for each nursing unit have been adjusted down by 10 residents to protect residents who may be affected by this deficient practice. This has allowed	10/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 on 1 of 7 day shifts, for the week of Complaint staffing from 06/02/2024 to 06/08/2024, for the facility was deficient in CNA staffing for residents on 1 of 7 day shifts, for the week of Complaint staffing from 07/07/2024 to 07/13/2024, for the facility was deficient in CNA staffing for residents on 2 of 7 day shifts, for the 2 weeks of staffing prior to survey from 08/04/2024 to 08/17/2024, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts. Findings include: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One 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 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. On 08/19/2024 at 11:10 AM, during the group	S 560	the facility to consistently meet mandatory 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? All residents have the potential to be affected by this deficient practice. The staffing department contracts with two (2) 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 third year the facility has participated in the VA grant opportunity. As the Home is state owned and operated, staff salaries are created and maintained	

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S 560	Continued From page 2 meeting/resident council meeting, Resident #7 stated that the only concern that he/she had with the facility was that there were call outs on the weekends during the summer. 1. For the week of Complaint staffing from 03/12/2023 to 03/18/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -03/12/23 had 20 CNAs for 208 residents on the day shift, required at least 26 CNAs. -03/13/23 had 22 CNAs for 208 residents on the day shift, required at least 26 CNAs. -03/14/23 had 24 CNAs for 208 residents on the day shift, required at least 26 CNAs. -03/18/23 had 21 CNAs for 210 residents on the day shift, required at least 26 CNAs. 2. For the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: --1/02/24 had 22 CNAs for 210 residents on the day shift, required at least 26 CNAs. 3. For the week of Complaint staffing from 04/31/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -04/31/24 had 24 CNAs for 226 residents on the day shift, required at least 28 CNAs. 4. For the week of Complaint staffing from 05/05/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:	S 560	by the Civil Service Commission (CSC) of New Jersey. Recently approval was received from CSC to initiate significant increases in CNA salaries. This has improved recruitment; however, a significant CNA shortage still exists in our area. 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 Administration of the Home will continue to review daily DOH staffing reports containing staffing ratios of CNAs for every shift for adherence to mandated ratios to ensure solutions are sustained. The reviews of the staffing reports will be provided to the QAPI Coordinator and reviewed during Performance Improvement Plan (PIP) meetings. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks for the next two months.	

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S 560	Continued From page 3	S 560		

-05/05/24 had 25 CNAs for 226 residents on the day shift, required at least 28 CNAs.

5. For the week of Complaint staffing from 06/02/2024 to 06/08/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:

-06/02/24 had 17 CNAs for 227 residents on the day shift, required at least 28 CNAs.

6. For the week of Complaint staffing from 07/07/2024 to 07/13/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows:

-07/07/24 had 20 CNAs for 230 residents on the day shift, required at least 29 CNAs.
-07/13/24 had 26 CNAs for 228 residents on the day shift, required at least 28 CNAs.

7. For the 2 weeks of staffing prior to survey from 08/04/2024 to 08/17/2024, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows:

-08/04/24 had 24 CNAs for 223 residents on the day shift, required at least 28 CNAs.
-08/10/24 had 23 CNAs for 221 residents on the day shift, required at least 28 CNAs.

-08/11/24 had 20 CNAs for 220 residents on the day shift, required at least 27 CNAs.
-08/12/24 had 23 CNAs for 220 residents on the day shift, required at least 27 CNAs.
-08/13/24 had 26 CNAs for 220 residents on the day shift, required at least 27 CNAs.
-08/16/24 had 26 CNAs for 220 residents on the day shift, required at least 27 CNAs.
-08/17/24 had 24 CNAs for 220 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4 day shift, required at least 27 CNAs. During an interview with the surveyor on 08/26/2024 at 10:44 AM, Licensed Practical Nurse (LPN #1) said I help with staffing. When asked what the ratios for CNA's were she replied, 11-7 shift 1 CNA for 14 residents, 3-11shift 1 CNA for 10 residents and 7-3 shift 1 CNA for 8 residents. When asked are you consistently meeting the ratios, she responded, "Yes, we are consistently meeting the ratios." On 08/26/2024 at 12:03 PM, a review of a facility policy titled Nursing Staffing Plan with revised date of January 2022 revealed under the Purpose section: C. Nursing care delivery staff is provided in compliance with the New Jersey Veterans' Memorial Home in Vineland, Department of Nursing organizational plan in accordance with mandatory DOH CNA ratios; 1-8 day shift; 1-10 evening shift; 1-14 night shift.	S 560		

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)	10/14/2024 (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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 10/11/2024	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 10/11/2024	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	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
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	
8/30/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
050625 (Y1)	A. Building B. Wing (Y2)	10/14/2024 (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 10/11/2024	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
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	ID Prefix Reg. # LSC	Correction Completed
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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 ______	**08/30/2024**

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
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 8/29/24 and 8/30/24. New Jersey Veterans Memorial Home was found to be in non-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 2005. The facility has concrete flooring, block bearing walls and metal protected stud roofing. The facility is noted to be Type II (222) protected construction 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. The facility floor plans indicate the following: 3rd floor has -Honor Circle with 28 beds Justice Court with 60 beds 2nd floor has- Freedom Center with 60 beds Liberty Square with 60 beds 1st floor has- Old Glory (secured unit, dementia) 32 beds The facility is licensed for 300 beds and is currently occupying 225.	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		10/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/17/2024

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.

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 ______	**08/30/2024**

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K 353	Continued From page 1 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/30/24 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to maintain the fire sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101: 2012 Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13: 2010 Edition, Section 6.2.7.1 and NFPA 25: 2011 Edition, Section 5.1, 5.2.2.1. These deficient practices were identified for 15 of 15 electrical rooms and telecom closets observed, had the potential to affect all residents, and was evidenced by the following: Observation made throughout the tour of the	K 353	What corrective action (s) will be accomplished for those residents affected by the deficient practice? Fire stop caulk was placed in all identified drop ceiling tile gaps around small and large electrical conduit pipe and BX cables, as identified in the following areas: 21EC-1 electrical room; 21TC-1 telecom closet; 21EC-2 electrical room; 21TC-2 telecom closet; 22ED-2 electrical room; 22TC-2 telecom closet; 20TC-2 telecom closet; 20EC-2 electrical room; 11EC-2 electrical room; 11EC-1 electrical room; 32EC-2 electrical room; 32EC-1 electrical room; 31EL-2 electrical room; 31EL-1 electrical room; 1OTC electrical room.	

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 ______	08/30/2024

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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K 353	Continued From page 2 facility on 08/30/2024 and 08/29/2024 with the US FOIA (b)(6), revealed the lower level, floor #2 and floor #3 electrical rooms and telecom closets had oversized drop ceiling tile gaps around small and large electrical conduit pipe and BX cables in the following identified areas: 1. 21EC-1 electrical room 2. 21TC-1 telecom closet 3. 21EC-2 electrical room 4. 21TC-2 telecom closet 5. 22EC-2 electrical room 6. 22TC-2 telecom closet 7. 2OTC-2 telecom closet 8. 20EC-2 electrical room 9. 11EC-2 electrical room 10. 11EC-1 electrical room 11. 32EC-2 electrical room 12. 32EC-1 electrical room 13. 31EL-2 electrical room 14. 31EL-1 electrical room 15. 1OTC electrical room In an interview at the times of observation, the US FOIA (b)(6) confirmed the findings. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 8/30/24. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	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 have the potential to be affected by this deficient practice. All janitorial, telecom and electrical closets will be inspected to ensure no gaps exists in ceiling tiles ensuring an effective smoke barrier. Any deficiencies noted upon inspection will be addressed and rectified immediately. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? Maintenance staff will conduct weekly audits of the closets noted above for two (2) months. Weekly audits will be forwarded to the Quality Assurance Specialist, Asst. CEO-Support Services and CEO to ensure solutions are sustained. 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.	

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	315496	A. BUILDING 02 B. WING ___	08/30/2024

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K 353	Continued From page 3	K 353	After the 2-month period, audits will become part of the repairman□s preventative maintenance rounds to be conducted each month. The weekly audits will be provided to the QAPI Coordinator and reviewed during Performance Improvement Plan (PIP) meetings. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks for the next two months.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.	K 923		10/11/24

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	315496	A. BUILDING **02** B. WING ______	**08/30/2024**

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K 923	Continued From page 4 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/30/24 in the presence of the US FOIA (b)(6) , it was determined that the facility failed to provide storage of compressed oxygen cylinders so empty cylinders were segregated from full cylinders, or appropriately labeled full and empty in accordance with NFPA 99: 2012 Edition, Sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient practice was evidenced for 1 of 2 oxygen storage rooms observed, had the potential to affect 50 of 225 residents, and was evidenced by the following: Observations at 1:02 PM with the US FOIA revealed the main oxygen storage room identified as room #2059 contained 3-portable oxygen carts with 28 E-cylinders, 7 H-cylinders, and various small D-cylinders. It could not be determined what cylinders were full or empty as they were not segregated and not marked to identify which were full or empty. The surveyor observed 2 carts with full oxygen cylinders, but the (2) carts indicated	K 923	What corrective action (s) will be accomplished for those residents affected by the deficient practice? The full oxygen cylinders were immediately placed in the appropriate full oxygen cylinder cart segregating them from the empty oxygen cylinder. All other areas within the facility that store oxygen canisters (treatment rooms on nursing units) were also inspected to ensure oxygen cylinders were being stored properly. 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 are prescribed oxygen therapy have the potential to be affected	

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K 923	Continued From page 5 "empty oxygen cylinders do not use". In an interview at the time, the US FOIA confirmed the observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 8/30/24. NJAC 8:39-31.2(e) NFPA 99	K 923	by this deficient practice. Storeroom staff were reeducated on the importance of segregating full oxygen cylinders from empty oxygen cylinders. Additional oxygen storage carts have been ordered and received and labeled appropriately to ensure proper segregation of full and empty oxygen cylinders. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur? A weekly inspection of oxygen storage rooms will be conducted for the next two (2) months. Deficient practices will be addressed and rectified immediately. 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. Weekly completed audits will be forwarded to Quality Assurance Specialist, Asst. CEO-Support Services and the Administrator for trending and analysis to ensure solutions are sustained. The audits will be provided to the QAPI Coordinator and reviewed during	

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K 923	Continued From page 6	K 923	Performance Improvement Plan (PIP) meetings. The team will follow the Plan-Do-Study-Act (PIP Process). PIP teams meet every two weeks for the next two months.	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315496	A. Building 02 - NEW JERSEY VETS - VINELAND B. Wing	10/14/2024

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 Reg. # NFPA 101 LSC K0353	Correction Completed 10/11/2024	ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 10/11/2024	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	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
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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO