

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 12/18/2025
NAME OF PROVIDER OR SUPPLIER New Jersey Veterans Memorial Vineland		STREET ADDRESS, CITY, STATE, ZIP CODE 524 North West Blvd Vineland, NJ 08360	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0693</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Incident 2684633Based on interviews, review of the medical records, and review of other pertinent facility documentation, it was determined that the facility failed to properly administer tube feeding as ordered, and to monitor a severely cognitively impaired resident (Resident #2) on tube feeding; which caused the resident to receive 800 milliliters (ml) of tube feeding in 4 hours instead of the physician ordered 60ml per hour (which should be 240 ml in 4 hours). Nursing staff found Resident #2 with symptoms of respiratory distress on [DATE] at approximately 10:30 PM., and their oxygen saturation (the amount of oxygen circulating in the blood) reading at 63% (healthy levels 95 - 100%) on room air. At that time, the facility called 911 emergency to transport Resident #2 to the hospital. The resident was then sent to the hospital and was admitted with diagnosis of aspiration pneumonia (pneumonia caused by liquid in the lungs). The resident expired in the hospital on[DATE]. This deficient practice was identified for 1 of 5 residents reviewed for tube feeding management.The facility's failure to implement their tube feeding policy led to Resident #2's expiration. This posed the likelihood of serious physical harm and psychological, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation.The IJ began [DATE], when LPN#1 did not thread the feeding tube through the pump and monitor the feeding pump to ensure it functioned properly. The facility was notified of the IJ on [DATE] at 3:58 PM. The facility submitted an acceptable Removal Plan (RP) on [DATE] at 3:03 PM. The surveyor verified the implementation of the RP on-site survey and determined that the immediacy for F693 was removed as of [DATE] at 10:56 AM. The evidence was as follows:A review of the facility's policy titled, Tube Feedings Nasogastric, Gastrostomy, Duodenostomy, Jejunostomy revised [DATE], included I. Policy: All tube feedings will be administered by a Registered Nurse or a License Practical Nurse in accordance with the procedures of the [name redacted]. [.] III. Procedure: A. All feedings through a nasogastric, gastrostomy, duodenostomy, or jejunostomy tube must be ordered by the physician on the Physician's Order Sheet. B. The Physicians Order must, in addition to diagnosis and indication for use include: 1. Name of feeding 2. Amount of each feeding 3. Amount of flush. 4. Route. 5. Rate of flow. 6. Frequency of administration [.] IV. Responsibilities: Pump Feedings A. Check order for type, amount, and frequency of feedings. [.] F. Check to ensure tube is secure in nose or stomach. G. Set feeding pump to appropriate rate of flow. H. Aspirate using piston syringe to ascertain that tube is in appropriate position. I. Return aspirant to stomach, duodenum or jejunum. J. Place feeding liquid in feeding bag and run through tubing to expel air. K. Insert end of feeding tubing into nasogastric, gastrostomy, duodenostomy, or jejunostomy tube. L. Start Feeding pump. M. Observe that pump is functioning properly and that resident is tolerating the feeding.A review of the Facility Reported Event (FRE) dated [DATE], submitted to the New Jersey Department of Health (NJDOH) included the following:Nurse hung the prescribed enteral feeding at 5:00 pm as ordered. At 9:00 pm, the nurse noted that 800 ml of feeding had infused to the resident; and that the resident was supposed to receive 60ml/hr. Feeding was immediately stopped. Resident was assessed by Registered Nurse (RN) and oxygen applied, Medical Doctor (MD) notified. Resident sent to emergency room (ER) for evaluation.A further review of the FRE indicated that Resident #2 was totally dependent on staff for all ADL care and had care plan for total ADL care. The resident had physician's order for enteral feeding and for the resident to not receive Nothing by Mouth (NPO). The tube feeding order stated to deliver the enteral feeding through a tube feed machine at the rate of 60 ml/hour for 8 hours with 2 hours rest.The facility provided a summary of the investigation related to the FRE, which stated that the Licensed Practical Nurse (LPN#1) did not follow policy for administration of enteral feeding, resulting in Resident #2's hospitalization. The summary further stated that LPN#1 did not set the enteral feeding rate and that she may not have connected the tubing to the pump correctly.According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia (significant, progressive decline in memory) and malignant neoplasm of the larynx (cancerous tumor forming in the voice box tissue).According to the comprehensive Minimum Data Set (MDS), an assessment tool, dated [DATE], Resident #2's Cognitive Patterns under Section C indicated that the resident was severely cognitively impaired.A Plan of Care with an Original Date of [DATE] and an Effect. Date of [DATE] contained a Problems/Strengths of [Resident name] has feeding tube R/T [related to] NPO status/Dysphagia . The goals were that the resident will have no complications from the feeding tube, and the resident will have no s/s (signs and symptoms) of aspiration Interventions included but was not limited to Ensure flow rate of</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 12/11/25, it was determined that the facility failed to ensure staff wore the appropriate Personal Protective Equipment (PPE) when providing care for patients on Enhanced Barrier Precautions (EBP) for a resident (Resident #4). The facility also failed to follow their policy titled Enhancer Barrier Precautions. This deficient practice was identified for 1 of 5 residents reviewed for infection prevention and was evidenced by the following: According to Resident #4's admission Record (AR), the resident was admitted with diagnoses that included but were not limited to: cerebral infarction (the death of brain tissue due to a prolonged lack of blood flow), aphasia (a language disorder, that affects your ability to communicate by impairing speech, writing, and understanding spoken or written language), and dysphagia (difficulty swallowing). According to the Minimum Data Set (MDS), an assessment tool dated 12/3/25, Resident #4's Cognitive Skills for Daily Decision Making was a 3 which indicated that Resident #4's ability to make decisions regarding tasks of daily life are severely impaired. According to Resident #4's Plan of Care (POC) with a last reviewed date of 12/9/25, under Problems/Strengths stated: Resident #4 has feeding tube. Size: 18 French (FR). Rev. #3, under Interventions: Enhanced barrier precautions Rev. #3. On 12/11/25 at 10:10 AM, the surveyor observed the Registered Nurse (RN) who was taking care of Resident #4 enter their room to flush their feeding tube and disconnect them from their feeding without a gown. As the surveyor and RN were leaving Resident #4's room, the surveyor observed the Certified Nursing Assistant (CNA) entering the room with the proper enhanced barrier precaution PPE. On 12/11/25 at 11:23 AM, the surveyor interviewed the CNA who stated that she wore gown and gloves when providing care to Resident #4 because Resident #4 has a tube feed and per facility policy that is protocol. She further stated that there is a sticker outside Resident #4's door to indicate that Resident #4 required enhanced barrier precautions. On 12/11/25 at 11:24 AM, the surveyor interviewed the RN who stated that Resident #4 is a tube feed resident who is on EBP, and confirmed that she did not put on appropriate PPE. The RN also stated that she could recall the CNA having her PPE on correctly earlier in the day when providing care for Resident #4 while she did not. Review of the facility policy titled, Enhanced Barrier Precautions with a revision date of 3/13/24 under Purpose states: to follow CDC guidance in implementing the use of additional personal protective equipment (PPE), when providing high contact resident care to residents who have infection or potential for colonization of bacteria or fungi that may be Multidrug-resistant Organisms (MDRO), to reduce the spread of the organisms to other individuals in the facility through contaminated hands and clothing. Under High-Contact Resident Care Activities: Staff should implement the use of Enhanced Barrier Precautions (use of gown and gloves) when providing high contact resident care activities. High contact care activities include: .providing tube feeding, injecting or infusing medications, indwelling medical device care or use. Under Facility Process for Implementing the Use of Enhancer Barrier Precautions: The facility will educate staff regarding the use of Enhanced Barrier Precautions, including the need to perform hand hygiene and change PPE when providing care. N.J.A.C. 8:39-19.4(n)</p>		