

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 08/30/2024
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37547 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 include physician prescribed interventions for a wound treatment and oral antibiotic administration that were implemented after a resident-to-resident altercation. This deficient practice was identified for 1 of 12 residents (Resident #186) reviewed for abuse. 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 Certified Nursing Assistant (CNA) at the bedside. The resident closed their eyes and did not respond 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: unspecified dementia, unspecified severity, with agitation, and Post-Traumatic Stress Disorder (PTSD). A review of Resident #186's Quarterly Minimum Data Set (MDS), an assessment tool dated 06/20/24, indicated that the resident's Brief Interview for Mental Status (BIMS) score of 03 out of 15, revealed that the resident was severely cognitively impaired. A review of the Interdisciplinary Progress Notes (IPN) revealed an entry dated 04/05/24 at 4:45 AM, indicated that .At approximately 03:26 AM heard commotion on couch in day room. This nurse and LPN (licensed practical nurse) went to resident and separated him/her from another resident. Upon skin assessment in his/her room noted skin tear to rt. (right) arm measuring 2.5 cm (centimeters) x 3.0 cm x 0.1 cm, 100% red tissue with scant serosanguineous drainage . (continued on next page)		

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

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

TITLE

(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A further review of Resident # 186's IPN revealed an entry dated 04/05/24 at 5:17 AM, Resident and another resident were sleeping against each other on couch appeared both residents startled each other upon waking up. Upon reviewing footage with supervisor and security both residents hit each other and other resident bit this pt.'s rt. (right) arm acquiring skin tear. On 04/05/24 at 2:42 PM, .Resident with a 6 cm round discoloration on right forearm with two skin tears with flaps in middle .No swelling and no pain noted. Skin tears associated with incident with another resident. Skin tears cleaned, ABT (antibiotic) applied and four steri strips applied and DSG (dressing) applied. New order for [sic.] days of oral ABT ordered . A review of Resident # 186's Physician's Orders revealed an order dated 04/05/24 at 4:58 AM, for Tx (treatment) to: right arm cleanse with NSS (normal saline solution) apply Triple Antibiotic Ointment cover up with foam dressing times 7 (seven) days Treatment once daily. A second order was reviewed dated 04/05/24 at 5:15 PM, for Augmentin (Amoxicillin/Clavulanate Potassium 875 mg (an oral antibiotic) (milligrams)-125 mg tablet 1 (one) tab oral for 7 (seven) days twice daily for prophylaxis (action taken to prevent disease) for skin tear. The medication was scheduled for administration at 9:00 AM and 9:00 PM. A review of Resident # 186's Medication Record revealed that Augmentin (Amoxicillin/Clavulanate Potassium 875 mg-125 mg tablet 1 (one) tablet oral for 7 (seven) days twice daily for prophylaxis for skin tear was documented that the medication was administered to the resident as ordered from 04/05/24 through the completion date of 04/12/24.A review of the resident's Treatment Record revealed that the entry for Tx to right arm cleanse with NSS apply Triple Antibiotic Ointment cover up with foam dressing times 7 (seven) days treatment once daily was administered to the resident as ordered from 04/05/24 through the completion date of 04/11/24. 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 skin tear to their right arm because of a resident-to-resident altercation which resulted in the need for the resident to receive a physician prescribed oral antibiotic and wound treatment. A review of the Supervisory Nursing Services Twenty-Four Hour Report dated 04/05/24, revealed that Resident #186 was involved in a resident-to-resident altercation on 04/05/24 during the 11-7 shift. It detailed that the resident was asleep on the couch in the day room, startled and swung R (right) arm and resident grabbed and bit his/her R arm. The resident sustained ST (skin tear) on R arm 2.5 x 3 x 0.1 cm. Skin protocol in place . A review of the Nursing Services Twenty-Four Hour Report dated 04/06/24 revealed that Resident #186 was involved in a resident-to-resident altercation on 04/05/24 (11-7) ABT (antibiotic) for skin tear . On 08/22/2024 at 9:13 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that if any interventions were placed, or a new treatment was ordered as a result of a resident-to-resident altercation, it should be reflected on the Care Plan by the Registered Nurse Assessment Coordinator (RNAC). The ADON further stated that a nurse or a supervisor could type into the care plan and notify the RNAC that they made some adjustments to the Care Plan. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON) who stated that when a resident-to-resident incident occurred, if a wound treatment was required due to an injury, it should get carried over into the interdisciplinary progress notes and the RNAC then transcribed the occurrence into the Care Plan and included an antibiotic or treatment if they were ordered. On 08/22/2024 at 11:43 AM, the surveyor interviewed the RNAC 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 RNAC stated she also reviewed the resident's Interdisciplinary Progress Notes to determine if there were changes. The RNAC 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 resident-to-resident altercation was on 04/07/24, when the Pain Care Plan was updated to include, If resident becomes drowsy return him/her to his/her room. The RNAC stated that was a mistake and should have instead been included in the resident's behavioral care plan. The RNAC stated that she was aware that the resident did receive a bite and was getting an antibiotic. The RNAC stated that she would have thought that they would have added the antibiotic and treatment for the bite to the resident's Care Plan, but she just could not find it on there. The RNAC further stated, Honestly, we were never told that we had to put skin tears or wound treatments on the Care Plan. On 08/22/2024 at 1:03 PM, the surveyor interviewed the Chief Executive Officer (CEO) who stated that her expectation was for the Care Plan to be updated with new interventions or revisions soon after an occurrence. The CEO stated that in morning meeting we look at all new antibiotic starts, and make sure that it was care planned for. The CEO clarified that the process to include wound treatments and antibiotics 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 Charge Nurse. LPN #3 stated that when she served as Charge Nurse, she reported any changes in resident status to the Nursing Supervisor, and then passed on the information on the 24-Hour Report, and at shift change. LPN #3 further stated that the Nursing Supervisor reported a change in resident status to the RNAC, who was responsible to update the Care Plan. On 08/27/2024 at 1:06 PM, the surveyor interviewed the CEO regarding Resident #186's Care Plan that was not updated to include both a physician prescribed antibiotic and wound treatment. The CEO stated that there was a lack of communication that did not occur. The CEO stated that any Registered Nurse could update the Care Plan. The CEO further stated that the portion of the Incident Case Report that prompted a conversation to be had between the Nursing Supervisor and the RNAC 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. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50919 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 Food Service Director (FSD), 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 FSD stated that the expectation was that staff should have observed that cans were dented before putting it on the shelf. The FSD further stated that the expectation was that the cook should check the cans for dents prior to opening the cans. 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 FSD stated that Styrofoam products should have been covered. The FSD 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 FSD confirmed there was debris on the can opener blade used to open cans. The FSD stated he was unsure of when the can opener was last used. The FSD 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 FSD stated that all bread products should be sealed and not opened to air. The FSD 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 FSD 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 Food Service Supervisor (FSS) confirmed that the reach in freezer did not have a thermometer in it. The FSD 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 FSD stated there were approximately five pounds of ribs in the bag. The FSD stated that food should have been properly covered. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 FSD confirmed that the white vinegar jar was not dated. The FSD 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 FSD 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 FSD 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 FSD stated the deli slicer should be cleaned after each use. The FSD 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 FSD stated it was important to monitor canned goods for dents to prevent contamination. The FSD stated that it was important that meats and breads are covered so they do not become contaminated. The FSD further stated that it was important that all freezers have internal thermometers to ensure food was held at a proper temperature. The FSD stated that it was important for paper and Styrofoam products to be covered to prevent contamination. The FSD 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 FSD, 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 FSD stated all hair should have been inside the hairnet, so that hair does not get into food. The FSD 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 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. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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)		