State Veterans' Homes (SVH) Corrective Action Plan
New Jersey Veterans Memorial Home at Vineland –
May 14 – 17, 2024

Important: Attestation by the SVH leadership, including the SVH nurse leader, of actions to assure timely completion of goals and establishment of oversight to assure continued improvement in areas identified for correction. The Corrective Action Plan (CAP) should include input from all levels of staff and affected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assessment and Assurance.

State the Issue **Identify the Regulation and Findings**	**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with Quality Assessment and Assurance fundamentals)	**Address how the SVH will identify other residents having the potential to be affected by the same deficient practice**	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**	**How does the SVH plan to monitor its performance to make sure that solutions are sustained** (Actions should align with Quality Assessment and Assurance)	**Proposed Completion Date** (i.e. when corrective action will be fully implemented and sustained)
51.41 (c) (2) Payments under State home care agreements. The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a VA provider agreement. Also, as a condition of receiving payments under paragraph (c) of this section, the State home must agree not to accept foot care and psychiatric services from VA provided under 38 U.S.C. 1712 (d) on behalf of veterans covered by this section and corresponding VA regulations (payment under paragraph (c) of this section includes payment for drugs and medicines.	The New Jersey Veterans memorial Home at Paramus will amend the five (5) written agreements between the 3rd party providers noted in the survey. Dental, Laboratory, Foot Care, Psychiatry, and Radiology to have all prevailing rate veteran's services billed to the facility. The vendors will be made aware by August 15, 2024, to send all invoices for services rendered to the facility for all prevailing rate veterans. This will include those vendors or services identified during the systems level review of all contracts.	All prevailing rate residents were affected.	As of August 15, 2024, all contracts for dental, lab, footcare, psychiatry, and radiology will be amended and vendors made aware of the change to include invoicing the facility for services rendered to prevailing rate veterans. This will include contracts for vendors identified in the systems level review. Each month the vendors noted in this citation as well as those identified in the service level review will be provided with an updated prevailing rate veterans list. They will be advised to bill the facility for all services beginning September 1, 2024. Two (2) new business office staff members will be hired and trained to ensure compliance with this citation.	The Business Office will review the monthly list of prevailing rate residents to ensure the lists coincides for correct billing to facility for vendors listed in this citation. The Business Manager or designee will conduct a monthly audit of the invoices billed to the facility for the five (5) services cited in this survey as well as those identified in the service level review noted to ensure all prevailing rate veterans services are being properly paid by the facility. Any discrepancies will be corrected immediately. A new QAPI project will be implemented August 15, 2024. The new QAPI committee will review the audit results of the prevailing veterans' invoices for services cited by the vendors in this survey as well as those noted in the systems level review of vendors. The established threshold for full compliance is 100%.	November 1, 2024 due to the time needed to hire and train two staff members

51.110 (e) (2) Comprehensive Care Plans A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	Resident #6's care plan was revised to include the recommendations noted on the 11/17/23 incident case report - "move wheelchair away from bedside to deter self-transfer" and "place bedside mat at bedside when resident is in bed." In addition, staff were reminded to adhere to care planned interventions in place, "lower the bed to the lowest position after care has been rendered for the resident's safety."	All residents who are at risk for falls have the potential to be affected by this practice.	The facility has recently transitioned into using an Electronic Incident Reporting Program. This program assists the reporting staff member and the nursing supervisor in identifying the root cause of the fall and therefore initiating interventions promptly to reduce the risk of a future fall. The program also creates a ***Fall Details Report*** that examines factors such as care prior to fall, environmental conditions, preventive measures at time of fall and resident footwear. All nurses and Supervisors of Nursing Services have been training and are using the new program exclusively. During daily morning clinical meetings, all fall incident reports from the previous 24 hours or on Monday from the previous 48 hours will be reviewed to ensure root cause has been identified and care planned interventions to prevent reoccurrence have been identified and added to the care plan. The weekly falls meeting format will be revised. The falls meeting will take place each Wednesday and will review fall incident reports from the previous week. The incident reports will be reviewed by the committee to ensure root cause has been identified and care planned interventions have been placed in the care plan.	Currently the facility has a Quality Assurance Improvement Program – Performance Improvement Project in place to reduce falls. The QAPI committee will review all minutes and audits from the falls meetings to ensure compliance. In addition, the Quality Assurance Specialist will conduct monthly audits of at least 50% of all the fall incident case reports to ensure fall reduction interventions are in place. Deficient findings will be corrected immediately. The audit will be provided to the Administrator for analysis. The audits will be conducted for 2 months. An audit by choosing a random selection of 25% of the previous weeks fall incident reports will be evaluated for care planned interventions by visiting the resident and ensuring the interventions are in place. The committee will consist of the Administrator/Chief Executive Officer, both Clinical Assistance Chief Executive Officers, Director of Nursing Services, Supervisor of Nursing Services, Life Enrichment, Social Work Supervisor, Rehab Supervisor, and Nurse Investigator. Two of the committee members each week will be assigned to conduct the resident visit and report their findings. The audits will be conducted for two months. Any non-compliance will be addressed immediately. Minutes will be completed and audit results tabulated and forwarded to the Quality Assurance Specialist and Administrator/CEO. A threshold of 100% compliance will determine if CAP is fully implemented for all audits listed. If threshold is not met, auditing will continue until threshold is met.	May 17, 2024 for Resident #6 Audits: Initiated August 1, 2024 PCD: October 1, 2024
51.120 (i) Accidents The facility management must ensure that –	Resident #6 – The root cause of the resident's fall was determined, and the fall risk	All residents who are at risk for falls have the potential to be affected by	The facility has recently transitioned into using an Electronic Incident Reporting Program. This program assists the reporting staff member and	An audit by choosing a random selection of 25% of the previous weeks fall incident reports will be evaluated	Audits: Initiated August 1, 2024

(1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	assessment was completed. The identified interventions were put in place to reduce the risk for falls for Resident #6	this practice.	the nursing supervisor in identifying the root cause of the fall and therefore initiating interventions promptly to reduce the risk of a future fall. The program also creates a ***falls details report*** that examines factors such as care prior to fall, environmental conditions, preventive measures at time of fall and resident footwear. All nurses and Supervisors of Nursing Services have been training and are using the new program exclusively. The fall risk assessment and interventions policy (form #AL1003) will be revised by the Quality Assurance Improvement Program Committee on falls to include the most recent fall risk assessment being utilized as we also have recently transitioned to utilizing WellSky Electronic Medical Record and are utilizing the user defined assessment (UDA) fall risk assessment. Additionally, the defined fall risk assessment frequency will now be completed quarterly during the residents MDS evaluation. Due to the new risk watch program and its comprehensive fall risk assessment in the incident report, the team feels there is no longer evidence to support the completion of an additional fall risk assessment. During daily morning clinical meetings, all fall incident reports from the previous 24 hours or on Monday from the previous 48 hours will be reviewed to ensure root cause has been identified and care planned interventions to prevent reoccurrence have been identified and added to the care plan. The weekly falls meeting format will be revised. The falls meeting will take place each Wednesday and will review fall incident reports from the previous week. The incident reports will be reviewed by the committee to ensure root cause has been identified and care planned interventions have been placed in the care plan. The committee will consist of the Administrator/Chief Executive Officer, both Clinical Assistance Chief Executive Officers, Director of Nursing Services, Supervisor of Nursing Services, Life Enrichment, Social Work Supervisor, Rehab Supervisor, and Nurse Investigator.	for care planned interventions by visiting the resident and ensuring the interventions are in place. The committee will consist of the Administrator/Chief Executive Officer, both Clinical Assistance Chief Executive Officers, Director of Nursing Services, Supervisor of Nursing Services, Life Enrichment, Social Work Supervisor, Rehab Supervisor, and Nurse Investigator. Two committee members each week will be assigned to conduct the resident visit and report their findings. The audits will be conducted for 2 months. Any non-compliance will be addressed immediately. Minutes will be completed and audit results tabulated and forwarded to the Quality Assurance Specialist and Administrator and presented to the QAPI Committee listed below. Currently the facility has a Quality Assurance Improvement Program – Performance Improvement Project in place to reduce falls. The QAPI committee will review all minutes and audits from the falls meeting to ensure compliance. In addition, the Quality Assurance Specialist will conduct monthly audits of all least 50% of all fall incident case reports to ensure fall reduction interventions are in place. Deficient findings will be corrected immediately. The audit will be provided to the Administrator for analysis. The audits will be conducted for 2 months. A threshold of 100% compliance will determine if CAP is fully implemented for all audits listed. If threshold is not met, auditing will continue until threshold is met.	PCD: October 1, 2024

§ 51.200 (b) Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	The facility contacted a state vendor to provide a load bank to conduct a 4 hour load test on the main generator for the resident care building. The 4 hour load test was conducted on June 28, 2024	All residents have potential to be affected by this practice.	The facility has contracted with Modern Group to conduct the 36 month, 4 hour load test. A work order has been put in place to alert the Maintenance Department 34 months from the date of the test so that the 36 month test can be scheduled and completed.	Life safety regulations will periodically be added to the agenda of the Support Services Morning Stand up meetings. Compliance to standards will be discussed and non-compliance rectified immediately.	June 28, 2024

§ 51.210 (n) (1) Radiology and other diagnostic services. (1) The facility management must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet all applicable certification standards, statutes, and regulations. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations. (iii) Radiologic and other diagnostic services must be available 24 hours a day, seven days a week.	Resident #6 – the resident had already received treatment based on the radiology services report. Resident # 12 - the resident had already received treatment based on the radiology services report.	All residents who orders to receive radiology services have the potential to be affected by this practice.	Due to the identified concerns during our previous audits and findings during this survey, the facility terminated the agreement with the radiology provider and have entered into a new agreement with a different radiology provider. In addition, during clinical morning meetings x-ray orders are noted on the 24-hour report and are monitored for completion with delays, if any, rectified immediately by calling the radiology provider or arranging radiology services in an outpatient setting.	A monthly audit has already been in place to review daily x-ray orders and completion times and dates. This audit is monitored daily by the Quality Assurance Specialist with deficient findings being corrected immediately. The audit is provided to the Administrator for analysis. The audits will continue to be conducted for 2 months. The monthly audits will be presented to the QAPI committee listed below. A 100% threshold of compliance will be used to determine fully implemented CAP. If threshold is not met, auditing will continue until threshold is met. Currently the facility has a Quality Assurance Improvement Program – Performance Improvement Project in place reviewing processes and addressing concerns in consulting services and appointments for residents. The concern with delays in radiology services will be added to the agenda of the next QAPI committee meeting.	Audits: Initiated August 1, 2024 PCD: October 1, 2024

- This Corrective Action Plan is to be electronically submitted to the Pod-specific National SVH Program Manager for Quality and Oversight