Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Vineland Veterans Memorial Home

Location: 524 N West Blvd., Vineland, NJ 08360

Onsite / Virtual: Onsite

Dates of Survey: 5/14/24 – 5/17/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 300

Census on First Day of Survey: 225

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from May 14, 2024, through May 17, 2024, at the Vineland Veterans Memorial Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 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.	Based on observations, interviews, and record review, the facility failed to revise the Plan of Care to include interventions to reduce the risk of falls for one (1) of six (6) residents reviewed for accident hazards from a total of 28 residents sampled (Resident #6). The findings include: A review of Resident #6's medical record revealed an initial admission date of [DATE]. Resident #6's medical history included Dementia and Fracture of the Right Femur. Resident #6's cognition was impaired, and they required staff assistance with most activities of daily living (ADLs). Review of Resident #6's Plan of Care revealed a focus area for falls. Interventions included directives to staff to keep Resident #6's bed in "the lowest position." On 5/15/24, at 10:35 a.m., an interview was attempted with Resident #6 in their room. They were lying in bed with their

Level of Harm – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	eyes closed, and the bed was noted to be elevated to a working height. There was no fall mat observed at the bedside. On 5/15/24, at 2:33 p.m., a second interview attempt with Resident #6 was made in their room. Resident #6 was again lying in their bed, and the bed was again noted to be elevated to a working height. There was no fall mat observed at the bedside. Review of Resident #6's Nursing Progress Notes revealed an entry, dated [DATE], which indicated that Resident #6 was found sitting on the floor in front of their wheelchair. A coinciding Fall Investigation Report, dated [DATE], revealed there was no determination of a root cause(s). Staff noted on the report that a bedside mat would be used, and that the resident's wheelchair would be removed from the bedside to "deter unassisted transfers." However, review of Resident #6's Plan of Care revealed no revisions were made to include a bedside mat or to remove Resident #6's wheelchair from the bedside. Continued review of Resident #6's Progress Notes revealed an entry dated [DATE]. Resident #6 was found sitting on the floor of their room between their wheelchair and bed. A coinciding Fall Investigation Report, dated [DATE], revealed there was no determination of a root cause(s). A "Supervisor's Nursing Assessment" on the Fall Investigation Report read: "Current safety interventions to remain in place. Staff to monitor." Continued review of the Fall Investigation Report and Resident #6's Plan of Care revealed there were no immediate safety interventions implemented to reduce the risk of falls. Continued review of Resident #6's Progress Notes revealed an entry, dated [DATE], which indicated Resident #6 was found on the floor of their room. A subsequent Progress Note, dated [DATE], revealed Resident #6 complained of soreness to their right hip, and an x-ray was ordered to rule out a fracture. A subsequent Progress Note, dated [DATE], at 9:58 p.m., revealed the radiology report was received, which identified an acute fracture of Resident #6's right femur. Resident #6 was transferred to the emergency room and subsequently underwent surgical repair of the fracture. Review of an x-ray report, dated [DATE], confirmed that an acute fracture of Resident #6's right femur was identified. Review of a Fall Investigation Report, dated [DATE], revealed there was no determination of a root cause(s). Continued review of the Fall Investigation Report and Resident #6's Plan of

	Care revealed there were no immediate safety interventions implemented to reduce the risk of falls. On 5/16/24, at 1:30 p.m., an interview was conducted with Administrative Nurse A regarding the facility's practices for revising the Plan of Care with interventions to reduce the risk of falls after a fall had occurred. Administrative Nurse A explained that a Fall Investigation Report should be conducted after a resident sustained a fall, and that the report should include the root cause(s) of each fall and any applicable interventions added to reduce the risk of falls. Administrative Nurse A stated they were unsure whether the interventions for a bedside mat or relocation of Resident #6's wheelchair had actually been implemented, and was unable to confirm whether either intervention was in place at the time of Resident #6's fall on [DATE].
§ 51.120 (i) Accidents. The facility management must ensure that— (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. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to prevent accident hazards to the extent possible by failing to 1) Conduct a thorough investigation of, and determine the root cause for, residents who sustained falls, and 2) Conduct a revised fall risk assessment after each fall in accordance with the facility's policy, and 3) Implement safety interventions to reduce the risk of falls for one (1) of six (6) residents reviewed for accident hazards from a total of 28 residents sampled (Resident #6). The findings include: The facility's policy regarding standards of practice for the prevention and management of falls was reviewed. The policy, titled, "Fall Risk Assessment and Interventions," was dated May, 2014. Section C of the policy directed staff to complete a Fall Risk Assessment and Interventions Form on admission, after every resident fall, and quarterly to coincide with the Minimum Data Set (MDS) review. A review of Resident #6's medical record revealed an initial admission date of [DATE]. Resident #6's medical history included Dementia and Fracture of the Right Femur. Resident #6's cognition was impaired and they required staff assistance with most activities of daily living (ADLs). Review of Resident #6's Plan of Care revealed a focus area for falls. Interventions included directives to staff to keep Resident #6's bed in "the lowest position." On 5/15/24, at 10:35 a.m., an interview was attempted with Resident #6 in their room. They were lying in bed with their eyes closed, and the bed was noted to be elevated to a working height. There was no fall mat observed at the bedside.

	On 5/15/24, at 2:33 p.m., a second interview attempt with Resident #6 was made in their room. Resident #6 was again lying in their bed, and the bed was again noted to be elevated to a working height. There was no fall mat observed at the bedside. Continued review of Resident #6's medical record revealed a Fall Risk Assessment, dated [DATE], which was conducted on admission. The assessment revealed Resident #6 was at a high risk for falls, and that they had a history of falls prior to admission to the facility. Review of Resident #6's Nursing Progress Notes revealed an entry, dated [DATE], which indicated Resident #6 was found sitting on the floor in front of their wheelchair. Resident #6 was found to be awake and oriented only to themselves. A coinciding Fall Investigation Report, dated [DATE], revealed there was no determination of a root cause(s). The facility requested an evaluation by Physical and/or Occupational Therapy. Additionally, staff noted on the report that a bedside mat would be used, and that the resident's wheelchair would be removed from the bedside to "deter unassisted transfers." However, review of Resident #6's Plan of Care revealed no revisions were made to include a bedside mat or to remove Resident #6's wheelchair from the bedside. Additionally, a revised Fall Risk Assessment was not conducted after this fall in accordance with the facility's policy. Continued review of Resident #6's progress notes revealed an entry, dated [DATE]. Resident #6 was found sitting on the floor of their room between their wheelchair and bed. A coinciding Fall Investigation Report, dated [DATE], revealed no root cause identification was made. A "Supervisor's Nursing Assessment" on the Fall Investigation Report read: "Current safety interventions to remain in place. Staff to monitor." Continued review of the Fall Investigation Report and Resident #6's Plan of Care revealed there were no immediate safety interventions implemented to reduce the risk of falls. Continued review of the medical record revealed that a revised Fall Risk Assessment was not conducted after this fall in accordance with the facility's policy. Continued review of Resident #6's progress notes revealed an entry, dated [DATE], which indicated Resident #6 was found on the floor of their room. A subsequent progress note, dated [DATE], revealed Resident #6 complained of soreness to their right hip and an x-ray was ordered to rule out a fracture. A subsequent progress note, dated [DATE], at 9:58 p.m., revealed

	the radiology report was received which identified an acute fracture of Resident #6's right femur. Resident #6 was transferred to the emergency room and subsequently underwent surgical repair of the fracture. Review of an x-ray report, dated [DATE], confirmed that an acute fracture of Resident #6's right femur was identified. On 5/16/24, at 1:30 p.m., an interview was conducted with Administrative Nurse A regarding the facility's practices for fall prevention and management. Administrative Nurse A confirmed that a revised Fall Risk Assessment should be conducted after a resident experienced a fall. Administrative Nurse A also confirmed that a revised Fall Risk Assessment was not conducted after Resident #6's falls on [DATE], and [DATE]. Administrative Nurse A explained that a Fall Investigation Report should be conducted after a resident sustained a fall, and that the report should include the root cause(s) of each fall and any applicable interventions that were added to reduce the risk of falls. Administrative Nurse A stated they were unsure whether the interventions for a bedside mat or relocation of Resident #6's wheelchair had actually been implemented, and confirmed that the Plan of Care had not been revised to include those interventions.
§ 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	**Electrical Systems** 1. Based on records review and interview, the facility failed to inspect and test all components of the emergency generator. The deficient practice affected 15 of 15 smoke compartments, staff, and all residents. The facility had a capacity for 300 beds with a census of 225 on the first day of the survey. The findings inlcude: Records review, on 5/15/24, at 10:15 a.m., of emergency generator inspection and testing records revealed there was no documentation of the generator having the four-hour load test conducted within the past 36 months, as required by section 8.4.9.2 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview with Maintenance Staff A, on 5/15/24, at 1:25 p.m., revealed they were unaware the generator required a four (4) hour test every 36 months. The census of 225 was verified by Administrative Staff A on 5/14/24, at 1:00 p.m. The findings were acknowledged by Maintenance Staff A and verified by Maintenance Staff B during the exit interview on 5/15/24, at 2:00 p.m.

accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	**Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** **8.4.2*** Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating **8.4.2.1** The date and time of day for required testing shall be decided by the owner, based on facility operations. **8.4.2.2** Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. **8.4.2.3** Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate KW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. **8.4.9*** Level 1 EPSS shall be tested at least once within every 36 months. **8.4.9.1** Level 1 EPSS shall be tested continuously for the duration of its assigned class *(see Section 4.2)*. **8.4.9.2** Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.
§ 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.	Based on interviews and record reviews, the facility failed to obtain radiology services to meet the needs of its residents. This deficient practice affected two (2) of two (2) residents reviewed for radiology services from a total of 28 residents sampled (Resident #6 and Resident #12). The findings include: 1. A review of Resident #6's medical record revealed an initial admission date of [DATE]. Resident #6's medical history included Dementia and Fracture of the Right Femur. Resident #6's cognition was impaired, and they required staff assistance with most activities of daily living (ADLs). A review of Resident #6's progress notes revealed an entry, dated [DATE], at 1:30 a.m., which indicated Resident #6 was found on the floor of their room.

(iii) Radiologic and other diagnostic services must be available 24 hours a day, seven days a week. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	A subsequent progress note, dated [DATE], at 1:38 p.m., revealed Resident #6 complained of soreness to their right hip and an x-ray was ordered to rule out a fracture. Review of Resident #6's Physician Orders revealed an order, dated [DATE], at 9:49 a.m., for an x-ray of the right hip and leg to rule out a fracture related to a fall. Continued review of Resident #6's progress notes revealed an entry, dated [DATE], at 9:58 p.m. The entry explained that the radiology report was received which identified an acute fracture of Resident #6's right femur. An x-ray report, dated [DATE], as reviewed. The x-ray was performed on Resident #6's right femur. The report identified an acute fracture of Resident #6's right hip. The report was electronically signed by Consultant Staff A on [DATE], at 8:46 p.m. A fax time of [DATE], at 9:01 p.m., was at the top of the x-ray report. On 5/16/24, at 1:30 p.m., an interview was conducted with Administrative Nurse A regarding the facility's standards of practice for radiology services. Administrative Nurse A stated: "We are aware of a problem with that, and we have a backup service that we use sometimes." When asked what the expected time frame would be for an x-ray to be completed, Administrative Nurse A stated: "We hope it would be done within 24 hours." When asked whether that time frame would be acceptable when attempting to rule out a fracture from a fall, Administrative Nurse A stated: "No, not really." 2. Record review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Ataxic Gait, Generalized Muscle Weakness, Anxiety Disorder, Dementia, and Difficulty in Walking. Record review of Resident #12's Nursing Progress Note, dated [DATE], at 3:29 p.m., revealed: "M.D. [Medical Doctor] notified pain in left extremity. N/O [new order] X-ray lower extremity and upper left leg STAT." Record review of Resident #12's Physician Order, dated [DATE], at 4:21 p.m., revealed: "X-ray 2 [two] – view left hip re: pain STAT." Record review of Resident #12's Nursing Progress Note, dated [DATE], at 8:11 p.m., revealed: "Pt. [patient] has X-ray of left hip STAT pending to be completed R/T [related to] complaint of pain status post fall."

	Record review of Resident #12's Nursing Progress Note, dated [DATE], at 1:50 a.m., revealed: "A STAT X-ray of left hip is ordered and pending completion." Record review of Resident #12's Nursing Progress Note, dated [DATE], at 5:24 p.m., revealed: "Resident had X-ray with negative findings of fracture." Record review of Resident #12's two (2) left hip x-ray results revealed the results were electronically signed by Consultant Staff A on [DATE], at 11:09 a.m., EDT (Eastern Daylight Time).