State Veterans' Homes (SVH) Corrective Action Plan
(New Jersey Veterans Memorial Home – Vineland 5/16/23-5/19/23)

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 effected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assurance/Performance Improvement activities (QAPI).

State the Issue **Identify the Standard and Findings**	**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with QAPI 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 QAPI)	**Proposed Completion Date**
§51.70 (c)(5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. SS=D	Based on record review and interview the facility failed to ensure upon the death of a resident with personal funds deposited with the facility to convey those funds within 90 calendar days and supply a final accounting of those funds to the appropriate individual or entity for three (3) residents: Resident # 23, Resident #24 and Resident # 29. The individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, for the three (3) residents' estates will be contacted to make them aware of the available interest from the deceased residents' accounts that was not provided to them in the final check disbursement. Based on the individual as described above instructions the interest will be provided to them or if they wish donated to the Welfare Fund in the name of the deceased.	All residents who have funds deposited in the facility account have the potential to be affected by the deficient practice.	The Business Office policy *"Unclaimed Property at Death by Escheat and Settlement of Resident's Account"* was updated to reflect clear disposition of resident account funds after death as well as disbursement of interest accrued in their account prior to the date of closure to the account. All appropriate business office staff will be educated on the updated policy and procedures.	A monthly audit will be conducted for three (3) months by the Business Manager on all resident accounts after death of resident. The audit will ensure any interest accrued will be dispersed to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity. Additionally, the audit will ensure the account is closed within 90 days of the death of a resident. Any irregularities or noncompliance will be rectified immediately The completed audit will be forwarded to the QAPI supervisor for trending and analysis.	December 1, 2023

§51.120(a) (1)-(2) Reporting of Sentinel Events (a) Reporting of Sentinel Events— (1) Definition. A sentinel events is an adverse event that results in the loss of life or limb or permanent loss of function. (2) Examples of sentinel events are as follows: (i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or (ii) Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or (iii) Any elopement of a resident from the facility resulting in death or a major permanent loss of function; or (iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or (v) Assault, homicide or other crime resulting in patient death or major permanent loss of function; or (vi) A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall. SS=D	Based on observation, interview, clinical record review and review of Facility policy, the facility failed to identify a sentinel event for one (1) of 30 sampled residents, Resident #11 who fell on 12/22/22 and sustained a left femoral neck fracture which resulted in the resident's permanent loss of function. While my team disagreed with this citation and then coding of this situation as a Sentinel Event, we did notify the appropriate contact at the Wilmington VA Medical Center of a Sentinel Event while the survey was still being conducted that we were reporting a Sentinel Event. The representative advised my team that she would be conducting an education session on reporting of Sentinel Events. The education session has been scheduled for August 3, 2023.	The rehabilitation and clinical team will identify all residents who have fallen and subsequently have not returned to pre-fall baseline functioning. These resident falls with injury will all be reported as Sentinel Events, as we now understand the interpretation of "Major Permanent Loss of function". Additional criteria will be utilized as noted in the IDR response dated July 17, 2023, that any resident prior to their fall who did not require assistance with a mechanical lift and post fall does, will be reported as a Sentinel Event to the Wilmington VA Medical Center.	The QAPI Team will track all resident falls with injury and the residents return to previous fall baseline. If the resident does not return to baseline as per rehabilitation services or requires the assistance of a mechanical lift post fall The QAPI team will notify facility Administration to report the resident fall with injury with permanent loss of function as a Sentinel Event. All data will be gathered, and the Sentinel Event will be reported to Wilmington VA Medical Center. Facility Administration will maintain a log of all Sentinel Events reported.	Facility Administration will conduct a monthly audit for the next three (3) months of all residents who have fallen and sustained injury in the previous month and identify their status. Any resident who has not returned to baseline or is requiring additional assistance of a mechanical lift to transfer should be considered a Sentinel Event. The audit will ensure proper notification to facility administration of a Sentinel Event has been completed. Any irregularities or noncompliance will be rectified immediately. A QAPI, Performance Improvement Project (PIP) committee will also be established to review the incidents of Sentinel Events reported to the Wilmington VA Medical Center to identify any areas of improvement.	December 1, 2023
§51.180(c) Drug regimen review. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon.	Based on interview, clinical record review, and review of facility policy, the facility failed to ensure drug regimens were reviewed monthly for 3 of 30 sampled residents. (Resident #12, Resident #13 and Resident #15). The Consultant Pharmacist reviewed the three (3) residents who had missing drug regimen reviews to ensure the noncompliance did not adversely affect	All residents receiving medications have the potential to be affected by this deficient practice.	The Consultant Pharmacist will be provided with a worksheet for each unit containing all residents' names, and the date for the residents' previous monthly drug regimen review. Unit Secretaries will utilize the same worksheet to ensure that	An audit will be conducted on a monthly basis by a QAPI team Nurse to ensure compliance with monthly drug regimen reviews for residents. Any deficient practices will be addressed immediately by reporting it to the Director of Nursing/designee. The audit will be conducted for 10% of the resident population on each unit	December 1, 2023

SS=D	the wellbeing of the residents. No negative effects were noted.		each resident's monthly drug regimen review is completed within the month. Any irregularities or noncompliance will be reported to Nursing Administration for immediate correction.	per month. The completed audits will become part of the QAPI process and will be forwarded to the QAPI supervisor for analysis and trending. This audit will be conducted for three (3) months beginning August 2023.	
§51.180(d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. SS=E	Based on observations, staff interviews and review of medication labels and review of facility policy, the facility failed to ensure medication labels identified appropriate and cautionary instructions by failing to identify the dose to be administered, the root of administration, and any specialized instructions on the pharmacy labels on all individualized medications distributed by the facility pharmacy. The state contracted Pharmacy provider Partners Pharmacy will configure the labeling process of all medications to ensure all appropriate data is included on the medication label. This will include prescribed dose, strength, expiration date, route of administration, indication for use, appropriate administration instructions and precautions.	All residents receiving medication in the facility could be potentially affected.	# 1 All new orders generated on or after the start date of 8/1/23 will contain complete labeling information. #2 All medication refills requested after 8/01/23 will contain the proper labeling data: prescribed dose, strength, expiration date, route of administration, indication for use and appropriate instructions and precautions.	The Quality Assurance team will audit the medication blister packs dispensed from the pharmacy for at least 10% of the residents on each unit. This audit will be conducted monthly for the next three (3) months. Any irregularities or noncompliance will be addressed immediately. The completed audits will become part of the QAPI process and will be analyzed and trended by the QAPI supervisor.	December 1, 2023
§51.200(a) Life Safety for fire. SS=F The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.					

	Based on observations interviews and record reviews the facility failed to inspect and test the fire dampers installed throughout the facility the deficient practice affected 12 of the 12 smoke compartments staff and all residents the facility. fire dampers must be tested every four years The facility had initiated an every six (6) year inspection cycle which was not compliant with NFPA Standard 80 Standard Fire Doors and other opening protectives (2010).	All residents have the potential to be affected by the deficient practice.	Facility administration contacted a state contracted vendor and executed a contract to conduct inspection of all fire dampers in the facility	The four (4) year inspection schedule will be monitored by facility administration for adherence to NFPA Standards and will also be added to the Facility Assessment to ensure inspections are conducted timely. The QAPI process will be employed to review all applicable NFPA Standards to ensure compliance.	August 3, 2023
	Based on observations record reviews and interview the facility failed to document the inspection and testing of the required fire doors installed throughout the facility. The facility immediately initiated inspections of all identified fire doors utilizing the detailed inspection highlighted in NFPA 80 Standard for Fire Doors and other Opening Protectives.	All residents have the potential to be affected by the deficient practice.	The Engineer in Charge of Maintenance created an annual Preventative Maintenance P/M program encompassing all inspection elements outlined in NFPA.	The P/M will be completed and monitored for compliance by the QAPI and facility administration to ensure compliance to NFPA Standards. Noncompliance will be addressed immediately.	May 25, 2023
	Based on record review observation and interviews the facility failed to maintain documentation of inspections on patient care related electrical equipment (PCREE). The facility immediately contacted a state vendor that specializes in inspections of PCREE.	All residents have the potential to be affected by the deficient practice.	Facility Administration has contracted with ACE Medical Equipment, INC to inspect all PCREE in the facility.	The inspection of all PCREE will be conducted yearly. This will be monitored by the QAPI and facility Administration to ensure compliance to NFPA Standards. Any concerns noted during inspections, i.e. repairs, decommissioning of equipment, etc.…will be initiated immediately.	August 20, 2023

- This Corrective Action Plan is to be sent to the Medical Center Director of jurisdiction and VACO Pod Manager