State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
POST OFFICE BOX 340
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CHRIS CHRISTIE
Governor
Commander-in-Chief

MICHAEL L CUNNIFF
Brigadier General
The Adjutant General

VETERANS AFFAIRS BULLETIN **1 April 2015**
No. 15-1

REQUIRED RECURRING REPORTS
NEW JERSEY VETERANS MEMORIAL HOMES

1. The following reports are to be forwarded to the Director, Division of Veterans Healthcare Services by the date specified. These reports are applicable only to the New Jersey Veterans Memorial Homes.

a. Weekly Status Reports:
- Due each Wednesday for the previous week.
- Format as Attachment 1.

b. Monthly Administrative Report:
- Due the 10th of each month for the previous month.
- Format as Attachment 2.

c. Monthly Quality Improvement Report:
- Due the 15th of each month for the previous month.
- Format as Attachment 3.

d. Monthly Admissions Report:
- Due the 15th of each month for the previous month.
- Format as Attachment 4.

e. Pressure Ulcer Monthly Tracking Report:
- Due the 15th of each month for the previous month.
- Format as Attachment 5.

This Veterans Bulletin, with attachments, replaces VA Bulletin 2-12, with attachments, dated 14 February 2012.

f. Key Performance Indicators Report:
- Due the 15th of each month.
- Format as provided by Chuck Robbins.

g. Offline Audit/Reconciliation Report:
- Due the 21st of each month for the previous month.
- Format as Attachment 6.

h. Monthly Future Activities Report:
- Due the 25th of each month to reflect the next month's activities.
- Format as Attachment 7.

i. Advisory Council Minutes:
- 30th of each month in which a meeting occurs.

j. Quality Improvement Minutes:
- 30th of each month in which a meeting occurs.

k. Quarterly Staffing/Salary Report:
- Due the 15th of March, June, September and December
- Format as Attachment 8.

l. Reportable Event Record/Report:
- As required by N.J.A.C., NJDOH and DVHA Policies and Procedures Manual.
- Format as Attachment 9.

2. Each paragraph/subparagraph delineated is to be addressed. If no activity/action is planned, then note "Negative Report."

3. Questions or inquiries concerning this bulletin should be addressed to BG Steven Ferrari, Director, Division of Veterans Healthcare Services, at 609-530-6967 or e-mail steven.ferrari@dmava.nj.gov.

The proponent office for this Bulletin is the Director, Division of Veterans Healthcare Services, DMAVA. Users are invited to send comments for improvements to NJDMAVA, ATTN: DVHS, 101 Eggert Crossing, Lawrenceville, NJ 08648.

OFFICIAL:

MICHAEL L. CUNNIFF
Brigadier General, NJARNG
The Adjutant General

DAVID S. SNEDEKER
Chief Information Officer
Director, Information and Administrative
Services Division

Attachments

Distribution: A, E

STATE OF NEW JERSEY

DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

NEW JERSEY VETERANS MEMORIAL HOME – (LOCATION)

M E M O R A N D U M

Date:

TO: BG Steven Ferrari, Director
DVHS

FROM:
Chief Executive Officer

SUBJECT: Status Report – Week of 00/00/00 – 00/00/00

CENSUS

VMH	# Beds	# Residents	# Admitted	# Discharged	(+/-) for Week	Vacant Beds	Isolation Beds	# In Hospital	# Non-Vets	70% Svc Disability
Menlo Park										
Paramus										
Vineland										

QUALIFIED ADMISSIONS LIST

VMH	# APPROVED		# APPROVED DEFERRED ADMISSION		# IN PROCESS	
	VETERANS	NON-VETERANS	VETERANS	NON-VETERANS	VETERANS	NON-VETERANS
MENLO PARK						
PARAMUS						
VINELAND						

PERSONNEL

VMH	OMB # FTE Authorized		# FTE Positions Filled		(+/-) FTE		# Non-Pay Status Employees		(+/-) FTE minus Non-Pay	
	DIR	SPT	DIR	SPT	DIR	SPT	DIR	SPT	DIR	SPT
Menlo Park										
Paramus										
Vineland										

CRITICAL VACANCIES
(List Top Five)

VMH	DIRECT CARE	SUPPORT/ADMIN
Menlo Park		
Paramus		
Vineland		

"Serving Those Who Served"

STATE OF NEW JERSEY

DEPARTMENT OF MILITARY AND VETERANS AFFAIRS NEW JERSEY

VETERANS MEMORIAL HOME – (LOCATION)

TO: **BG Steven Ferrari, Director** **Date: 00 XXX 0000**
DVHS

FROM:
Chief Executive Officer

SUBJECT: MONTHLY ADMINISTRATIVE REPORT FOR MONTH OF XXXX 0000

1. INSPECTIONS COMPLETED:

a. Internal:

b. External:

2. STAFFING/REVENUE/ADMISSIONS:

STAFFING	NUMBER FILLED	NEW HIRES	LOSSES
Direct Care Staff			
Support Staff			
Part-time Staff			
Per Diem			
TOTALS			

OVERTIME	HOURS	$ AMOUNT
Direct Care Staff		
Support Staff		
Per Diem		
Agency		
TOTALS		

REVENUE	$ AMOUNT
VA Per Diem	
Members Care & Maintenance	
Medicare Part A & B	
TOTAL	

# ADMISSIONS	# DISCHARGES	# APPLICATIONS REC'D	# DENIALS

DENIAL NAME	DATE	REASON

3. **CONSTRUCTION AND IMPROVEMENTS:**

4. **MEETINGS:**

5. **TRAINING:**

6. **UNION ACTIVITES:**

7. **ISSUES AND CONCERNS:**

(Location) Veterans Memorial Home
Monthly Quality Improvement Report

Report for the month of _____, 20XX

Number of Reportable Incidents: _____

NURSING

Wounds / Breakdown	New this month	New Facility Acquired	New Community Acquired	Total Pressure Ulcers (old and new)	Residents with multiple wounds	NCP Includes Skin Precautions
Pressure Ulcers						
Vascular						
Other						
TOTAL WOUNDS						

Restraints / Breakdown	Total Number of Residents With Restraints	MD Orders	NCP Includes Restraint Use/Release
Number This Month			

Hospitalizations / Reason	Fall	Respiratory	UTI	Cardiac	Psych	Cellulitis	Sepsis	GI	Other
Number for Month									
TOTAL HOSP.									

Re-Hospitalizations 30 Days or Less / Reason	UTI (has catheter)	Dehydration/Electrolytes	Sepsis/Infection	Respiratory	Cardiac	Medication	Psych	Other
Number for Month								
TOTAL RE- HOSP.								

Weight Loss (5 lbs. or more) / Reason	Residents with 5 Pounds or Greater Weight Loss	Residents with Weight Loss Due to Illness	Planned Weight Loss	Unplanned Weight Loss	Dietary Informed/Documented	Change in Dietary/Plan of Care
Number This Month						

Falls / Breakdown	Number of Unintentional Falls This Month	Number of Intentional Falls This Month	Resident Had More Than 1 Fall This Month	Injuries? MAJOR	Change in NCP Following Fall?
Number This Month					

Skin Tears / Location	Upper Extremity	Hand	Lower Extremity	Explained	Unexplained	TOTAL
Number This Month						

Intravenous / Reason	Medication	Dehydration	Fluid/Electrolytes	Other	TOTAL
Number This Month					

Residents on 1:1 Supervision / Reason	Behavior	Elopement	Other
Number This Month			

Residents in Isolation Rooms / Reason	Behavior	Infection	Other
Number This Month			

INFECTION CONTROL

Urinary Tract Infections / Breakdown	Number of Residents with Foley Catheter	Number of Residents w/ Suprapubic Cath.	UTIs in Residents **WITH** Catheter	UTIs in Residents **WITHOUT** Catheter	Other Infections / Breakdown	Influenza	Norovirus	Respiratory	Skin	Other
Number This Month					Number This Month					

PHARMACY

Medication Errors / Breakdown	Transcription	Omission	Wrong Dose	Failure to Sign MAR	Other	Psychoactive Medication Use / Breakdown	Residents on psychoactive medications	Residents receiving 2 or more psychoactive medications	Reduction/D/C Efforts	Reduction/D/C Success
Number This Month						Number This Month				

Number of Residents on Dialysis: _____ Number of Wound Vacs: _____

ABUSE/NEGLECT ALLEGATIONS

Date of Incident	Brief Description of Incident	Staff Member Suspended/Removed? Y/N	Substantiated? Y/N	Investigation Complete? Y/N

FRACTURES OF UNKNOWN ORIGIN

Date of Discovery	Brief Description	Dx of Osteoporosis? Y/N

ELOPEMENTS

Date of Elopement	Successful? Y/N	Brief Description of Event	NCP Updated? Y/N

(Location) Veterans Memorial Home
Monthly Admissions Report

Report for the month of _____, 20XX

APPLICATIONS Breakdown	Total Number of Applications Received	Number Reviewed by the Adm. Comm.	Number Approved to Waiting List	Number Denied	Deferred/Need Add'l Info
Number This Month					

ADMISSIONS Breakdown	Skilled Nursing	Secured Unit	TOTAL
Number This Month			

DENIALS Reason	No need for LTC	Unresolved Behavior Issues	Substance/Alcohol Abuse	Danger to Self/Others	OTHER	TOTAL
Number This Month						

DISCHARGES Breakdown	Expired	Other Medical Facility	Discharged to Home
Number This Month			

APPROVED WAITING LIST Breakdown	Veterans	Non Veterans	Couples	TOTAL
Number This Month				

DEFERRED WAITING LIST Breakdown	Veterans	Non Veterans	Couples	TOTAL
Number This Month				

AVERAGE WAITING TIME IN MONTHS Breakdown	Veterans	Non Veterans	Couples
Number This Month			

New Jersey Veterans Memorial Homes (VMH) Pressure Ulcer Monthly Tracking Form

☐ Paramus ☐ Menlo Park ☐ Vineland (Please Select Correct VMH)

Month and Year: _____

Nursing Unit	Number of Pressure Ulcers Acquired by Source During the Past Month			Pressure Ulcers by Stage					
	Acquired in VMH	Acquired from home	Acquired from another facility	Stage 1	Stage 2	Stage 3	Stage 4	Unstageable	Number Completely Healed

Comments:

DUE: To the Director, DVHS the 15th of each month for the previous month.

Attachment 5

(name of home)Veterans' Memorial Home
Monthly Offline Account Audit/Reconciliation Certification

From: Veterans Memorial Home Business Manager

To: Veterans Memorial Home Chief Executive Officer
Director, Division of Veterans Health Care Services
Director, Fiscal Division

I certify that I have reviewed the account audits/reconciliations for all of the veterans home offline accounts/funds as indicated on the attached list. All of the listed accounts have been audited and reconciled.

_____

Signature of Business Manager Date

(name of home) MONTHLY ACCOUNT AUDIT AND RECONCILIATION

ACCOUNT NAME	ACCOUNT NUMBER	BANK NAME	RECONCILED BY	REVIEWED BY			

Attachment 6

DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
DIVISION OF VETERANS HEALTHCARE SERVICES

MONTHLY FUTURE ACTIVITY REPORT - _____
Month/Year

NEW JERSEY VETERANS MEMORIAL HOME AT: _____

The planned activities reported are for the upcoming month:

1. **INSPECTIONS PLANNED:**

   a. Internal: Inspections completed, with dates, by the VMH administrative staff.

   b. External: Inspections/audits conducted by regulatory agencies – DOHSS, VA, OLS, complaint investigations, etc. with dates.

2. **ACTIVITIES/MEETINGS (Bullet Comments in chronological order with dates):**

   a. Resident: Trips, Resident Facility Council meetings, concerts, shows, etc.

   b. CEO and Staff: Committee Meetings, celebrations, VIP visits, etc.

   c. Unions: Meetings, etc.

NEW JERSEY VETERANS MEMORIAL HOME AT _____

Quarterly Staff/Salary Report- (DATE)

Attachment 8

Institutional Department Specific Titles	Non- Exempt	FTE Staffing #	 Filled #	Part-Time Filled #	Salary Filled Amount $	Salary Vacant Amount $
FIS PROGRAM CODE 990000						
Administration						
CEO						
Section Chief						
Secretarial Assistant 1						
Secretarial Assistant 2						
Total						
Add Total						
Business Office						
Business Manager 2						
Asst. Business Manager						
Administrative Analyst 4						
Special Staff Officer						
Technical Asst. 1, Purchasing						
Supervisor of Accounts						
Total						
Add Total						
Human Resources						
Manager 1, Human Resources						
Secretarial Assistant 2						
Personnel Assistant 3						
Employee Relations Coor.						
Supervising Payroll Clerk						
Technical Asst., Personnel						
Total						
Add Total						
Information Systems						
Administrative Analyst 1						
Staff Assistant 2						
Total						
Add Total						
Housekeeping						
Housekeeping Supr. 2						
Asst. Hskpg. Supr. 2						
Head Housekeeper						
Residential Services Worker						
Total						
Add Total						
Maintenance						
Engineer in Charge Maint.						
Asst. Engineer in Charge Maint						
Head Grounds Worker						
Asst. Head Grounds Worker						
Operating Engineer						
Carpenter						
Electrician						
Plumber/Steamfitter						
Painter						
Mechanic, Non-Automotive						
Repairer						
Sr. Repairer						
Motor Vehicle Operator						
Truck Driver, Single Axle						
Prin. Clerk Typist						
Total						
Add Total						
Storeroom						
Staff Assistant 1						
Storekeeper 2						
Stores Clerk						
Total						
Add Total						
Administrative Support						
Charge Nurse - QI						
Principal Clerk						
Total						
Add Total						

Institutional Department Specific Titles	Non-Exempt	FTE Staffing #	Filled #	Part-Time Filled #	Filled Amount $	Vacant Amount $
FIS PROGRAM CODE 200000						
Business Office						
Clerk Typist						
Total						
Add Total						
Recreation						
Supervisor of Recreation						
Asst. Supervisor of Rec.						
Sr. Therapy Program Asst.						
Therapy Program Assistant						
Therapy Aide						
Total						
Add Total						
Food Service						
Food Service Supervisor 2						
Asst. Food Serv. Super. 3						
Sup. Of Fd. Serv. Area Oper.						
Head Cook 1						
Head Cook 3						
Cook						
Sr. FS Handler						
Sr. FS Worker						
Sr. FS Worker (P/T) 2=1 FTE						
Total						
Add Total						
Nursing						
DON						
ADON						
SNS						
Staffing Coordinator						
Charge Nurse						
Staff Nurse						
Sr. Practical Nurse						
Practical Nurse						
Sr. HST						
HST						
HSA						
Secretarial Asst. 3						
Clerk						
Total						
Add Total						
Medical						
Physician Specialist						
Sup. Clinical Nutritionist						
Clinical Nutritionist						
Charge Nurse-Infection Control						
Charge Nurse-Clinic						
Total						
Add Total						
Social Services						
Social Worker Supervisor 2						
Asst. Social Worker Supervisor						
Social Worker 1						
Social Worker 2						
Admitting Officer						
Principal Clerk Typist						
Total						
Add Total						
Administrative Support						
RNACs						
Medical Records Supervisor						
Nursing Services Clerk						
Instructor of Nursing						
Clerk Typist						
Total						
Add Total						
Total						

New Jersey Department of Health and Senior Services
Division of Long Term Care Systems
Assessment and Survey Program / Complaint Unit
P. O. Box 367
Trenton, NJ 08625-0367

Hotline: 1-800-792-9770, Select #1
Off Hour Emergencies: 609-392-2020
Fax: 609-943-4977 or 609-633-9060

REPORTABLE EVENT RECORD/REPORT

Please answer all questions fully and address only one event per report.

Today's Date (MM/DD/YY)

Date of Event (MM/DD/YY)

Time of Event ☐AM ☐PM

Was This a Significant Event? ☐ Yes ☐ No

Was Significant Event Called In? ☐ Yes ☐ No

Date (MM/DD/YY)

Time ☐AM ☐PM

Full Name of Facility

Street Address

City

State

Zip Code

Facility Telephone Number

Facility License Number

Provider ID Number

Person Reporting

Title

Type of Facility:

- ☐ Assisted Living or Comprehensive Personal Care Home
- ☐ Adult/Pediatric Day Health Services
- ☐ ICF/MR
- ☐ Nursing Home
- ☐ Residential
- ☐ Sub-Acute Care
- ☐ Other, Specify:

Exact Location of Incident:

REPORTABLE EVENT RECORD/REPORT
(Continued)

Type of Incident:

- ☐ Elopement
- ☐ Environmental Emergency
- ☐ Financial Exploitation
- ☐ Injury
- ☐ Interruption of Service
- ☐ Involuntary Discharge
- ☐ Involuntary Relocation
- ☐ Medication Error
- ☐ Resident Care
- ☐ Resident-to-Resident Abuse
- ☐ Staff-to-Resident Abuse
- ☐ Unexpected Death
- ☐ Other, Specify:

Resident Name	Unit and Room Number	Date of Birth

Narrative:

1) Describe the event, to include timeframes/risk factors related to the incident/event (relevant resident Dx):

2) Prior to the event, was a plan of care developed that addressed this issue, and were planned interventions in place when the event occurred? For example, chair alarm and/or lap buddy in place.

☐Yes ☐No If Yes, please describe:

3) What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, CNA suspended. Please describe investigative findings/conclusions:

REPORTABLE EVENT RECORD/REPORT
(Continued)

Nurse Aide Involvement:

If the event is an allegation of abuse, neglect, or misappropriation of resident funds by a nurse aide, please provide the certification number and certificate expiration date. For a nurse aide with no certification, please provide the Social Security Number.

Name	Certification Number	Expiration Date

Notifications:

☐ MD, Specify:

☐ OOIE (Ombudsman), Specify Date: Time: ☐AM ☐PM

☐ Other, Specify:

FOR NJDHSS USE ONLY

Reviewed By: (Surveyor ID Number and Initials) Date (MM/DD/YY)

Other Review: (ID Number and Initials) Date (MM/DD/YY)

Disposition:

☐ Pending

☐ No Action

☐ Complaint Investigation

☐ Referral, Specify:

☐ Closed, Specify Date Closed:

Comments: