State of New Jersey
Commission of Investigation

An Investigation into the State of New Jersey's COVID-19 Response at the Veterans Memorial Homes

October 2023

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October 2023

Governor Phil Murphy
The President and Members of the Senate
The Speaker and Members of the General Assembly

The State Commission of Investigation, pursuant to N.J.S.A. 52:9M-1 to -20, herewith submits its final report of findings and recommendations stemming from an investigation into the State of New Jersey's response to the COVID-19 pandemic at the Veterans Memorial Homes.

Respectfully,

Tiffany Williams Brewer
Chair

John P. Lacey
Commissioner

Robert J. Burzichelli
Commissioner

Kevin R. Reina
Commissioner

Introduction

New Jersey was among the earliest and hardest hit states when the COVID-19 virus first arrived in early March 2020, spreading quickly and proving particularly dangerous for vulnerable populations, such as the elderly and the infirm, especially those living in group settings such as nursing homes.

While the virus ravaged nursing residences throughout New Jersey and beyond, in the first months of the pandemic, the Veterans Memorial Homes operated by the State of New Jersey fared among the worst. Outbreaks of COVID resulted in an astounding number of deaths in mere weeks at the state-run veterans homes in Paramus and Menlo Park. All told, more than 200 residents and staff members at the three state-run veterans homes, including the Vineland residence, would die from COVID.[1]

Three years later, with the federal public health emergency now over and more than 35,000 New Jerseyans' lives lost to COVID-related causes, the public deserves a full accounting of what led to the extreme devastation inside the veterans homes. What has already emerged in media accounts and previous inquiries so far has revealed the State was wholly unprepared for the devastating virus and the havoc it would wreak inside the residences. Most recently, a federal Department of Justice (DOJ) investigation found the State failed in its obligation under the United States Constitution to keep the veterans homes' residents in its care safe. Further, it found ongoing failures by management continue to leave them in peril.

The findings made by the State Commission of Investigation (SCI or the Commission) in its inquiry into the State's COVID response at the veterans homes underscore those points, but also reveal how the pandemic presented a perfect storm of circumstances that exposed enduring flaws within the management, operation and structure of the residences. Among the conditions and decisions that impeded the ability of the State and homes to respond appropriately to the crisis:

- The veterans homes were entirely overwhelmed by massive absenteeism among nurses and other frontline staff in the initial weeks of the pandemic, leaving them unable to provide basic care to residents. In Menlo Park, there was a 480% increase in "call-outs" by workers in the weeks after COVID arrived at the home.
- There was no realistic strategy to get employees to report to work or to find replacement staff. Staffing agencies were unwilling to send nurses and other medical personnel to the veterans homes to replace absent staff because the per diem rates paid by the State were fixed and not competitive with pay at other healthcare facilities.
- The rapidly changing guidance on virus management from the Centers for Disease Control and Prevention (CDC) was not well communicated by state health officials to the veterans homes' managers or within the homes, creating confusion and upending planned strategies.

[1] At least 190 COVID-related deaths occurred at Menlo Park and Paramus alone.

- No system existed to ensure family members of the residents received regular and reliable communication from the homes' staff with information on their loved ones. As a result, some families received limited to no updates or, in some cases, inaccurate information.
- The physical layout and outdated infrastructure of the Menlo Park and Paramus veterans homes were not designed or equipped to handle isolation or quarantine situations.

The SCI's Investigation

The SCI began investigating the State's pandemic response in October 2020 after receiving a request from a group of state legislators. Soon after, the SCI's efforts to advance the inquiry were impeded by multiple factors, including the need to pause the inquiry in deference to concurrent criminal state and federal investigations, some of which remain ongoing. After almost two years, the Commission recently resumed its fact-finding and refocused the inquiry on the veterans homes.

The Commission's inquiry aimed to uncover what had occurred behind the scenes in the management and oversight of the veterans homes during the COVID pandemic and the systemic flaws in their operation that caused breakdowns in care, leaving elderly residents vulnerable in a public health emergency. Equally important was the SCI's charge to put forth meaningful and sensible recommendations to better arm government officials on ways to avoid a similar catastrophic outcome in the future.[2]

In light of the compelling public interest in this matter, and given that other state and federal investigations into the State's pandemic response were nearing their conclusion, the SCI is presenting its independent fact-finding and reform proposals to guide legislators and regulators in their oversight roles.

To conduct this inquiry, the SCI interviewed 60 people, including veterans homes' staff and management, administrators of private nursing homes in the state, veterans homes' residents, their family members and relatives of residents who had died during the pandemic. The SCI also subpoenaed and reviewed thousands of pages of documentary evidence provided by numerous state agencies and the homes, including scores of data examined and analyzed by Commission investigators. Further, SCI staff visited all three of the veterans homes in New Jersey.

New Jersey's Veterans Homes

The tradition of providing state-operated residences for veterans dates to 1866 when the New Jersey Soldiers' Home opened in Newark to house disabled Civil War soldiers and veterans. Today, the State Department of Military and Veterans Affairs (DMAVA) owns and operates three homes in Menlo Park (Edison Township), Paramus, and Vineland, providing housing and medical care for up to 948 residents.[3] Honorably discharged veterans, a veteran's spouse, and spouses

[2] N.J.S.A. 52:9M-1 to -20.

[3] There were 572 residents of the veterans homes as of September 2023, according to the DMAVA website.

and parents of members of the military who were killed in action during a period of war are eligible for residency.

Although the Division of Healthcare Services in DMAVA oversees the homes, each facility has a Chief Executive Officer who oversees administrative, medical and support staff. The New Jersey Department of Health (DOH) inspects and licenses the homes. DOH is also responsible for issuing guidance to the homes corresponding with directives from the CDC. Additionally, the United States Department of Veterans Affairs annually inspects the homes.

At the start of the COVID pandemic, the resident occupancy in the Menlo Park and Paramus homes was near capacity. Currently, the Menlo Park facility, which has 312 beds, is slightly above 50 percent capacity. Paramus, which can house up to 336 residents, now has less than 200.

The fiscal year 2024 New Jersey State budget allocated $277.1 million for DMAVA, including $100.7 million for the operations of the three homes, an increase of 2.7% from the prior year. These monies include $115.5 million in State funds, $154.6 in federal funds and $7 million in other funds.

Staffing Issues

The Commission found the massive absenteeism from work by nurses and other frontline healthcare workers in the early weeks of the pandemic left the Menlo Park and Paramus homes overwhelmed and unable to provide proper care for residents. Additionally, efforts to execute established strategies to ensure replacement staff and personnel were available – including hiring nurses from staffing agencies and deploying the New Jersey National Guard and nurses from the U.S. Department of Veterans Affairs – were mismanaged.

On March 9, 2020, Governor Murphy issued Executive Order 103, which enabled the executive head of any state government entity to waive, suspend or modify any existing rules detrimental to public welfare, including allowing the Civil Service Commission to take appropriate steps to protect State, county and municipal employees. Most employees at the three veterans homes are Civil Service employees. A day after the Governor declared a State of Emergency for New Jersey, the Civil Service Commission issued a letter establishing relaxed sick leave rules for Civil Service or State employees for COVID-related absences. The relaxed rules enabled State employees to stay home from work without using their accumulated paid time off for certain COVID-related excused absences. The acceptable circumstances in which employees could take the excused absences included a COVID diagnosis, exposure to the virus, and caring for an individual in quarantine or isolation due to COVID. Additionally, the guidelines specifically addressed the ability of essential employees to use COVID-19 Family Leave, which extended the permissible excused absences to include paid time if their child's school was closed or their childcare provider was unavailable due to COVID-related restrictions.

The letter caused conflict in the veterans homes because direct care staff are both State employees whose employment parameters are governed by the Civil Service Commission but they are also designated as essential personnel by DMAVA and required to report to work in emergencies. DMAVA officials told the Commission they failed to hold the employees to their

essential status because they did not believe they could enforce it in light of communications from Civil Service and the DOH.

The guidance enabling State government workers, including those designated as essential employees, to stay home from work for COVID-related reasons disrupted the continuity of operations (COOP) and continuity of government (COG) plans that were supposed to guide the veterans homes during an emergency. Even when CDC guidance allowed asymptomatic workers to report to work, DOH purportedly reiterated in a conference call that State employees could not be compelled to report to work and could only be incentivized with overtime. As one DMAVA administrator testified:

> *Well, when COVID had hit, 40 to 50 employees called out all at one time. For a building that was either a four or five star in quality metrics for staffing, which is very good across the nation, to all of a sudden have your entire workforce walk out the door, and as a facility, we couldn't hold them to essential status…*

According to DMAVA personnel and former administrators, the attendance rate of employees reporting to work at the Menlo Park and Paramus homes in the early weeks of the pandemic dropped by nearly half. The SCI's analysis of available DMAVA records reflecting the number of workers who called out from work revealed the situation was indeed dire. Comparing the daily call-outs of employees at the two northern homes during the first week of March 2020 to those in mid-to-late April showed Paramus with a 100% increase in call-out rates. Menlo Park's rate spiked to a 480% increase in the number of employees calling out from work.[4]

The homes were limited in what they could offer to encourage employees to report to duty. Under the veterans homes' infectious disease outbreak plan, the first strategy used in staffing shortages where employees cannot work or return to work due to illness was to offer overtime shifts to current staff. However, the concept of overtime pay was not a sufficient incentive for employees who could stay home and receive their salaries without the need to use leave time.

Complicating the situation was that employees were genuinely fearful about contracting the highly contagious virus early in the pandemic and concerned about the lack of safeguards to protect them. Employees told the Commission they feared contracting the virus and bringing it home to loved ones due to inadequate personal protective equipment (PPE) and scarce testing. After interviewing administrators and personnel at all three homes, investigators discovered the availability of proper PPE varied at each home. Menlo Park and Paramus personnel indicated they had little to no equipment, or that the PPE provided was unsuitable. One staff member at Menlo Park told SCI investigators that in the pandemic's initial days, some workers were wearing plastic bags over their heads.

In contrast, Vineland, where COVID infection rates were far lower, had a warehouse full of equipment with no shortages.

[4] The SCI could not determine the impact the callouts had on the staffing levels due to incomplete data provided by DMAVA**.**

The distrust between staff and management also grew due to the ever-changing rules during the pandemic that required employees to readjust how they did their jobs. A prime example was the complete turnaround on safety protocols regarding wearing facemasks to guard against the virus. At the pandemic's start, the CDC had publicly stated masking was unnecessary for healthy individuals. The SCI heard several conflicting accounts concerning threats of discipline for veterans homes' staff who wore masks during that time. However, the Commission found no evidence indicating this alleged threat was upheld.

With limited resources to carry out efforts to ensure veterans homes' staff who called out from work for COVID-related reasons had proper documentation and were not abusing leave policies, DMAVA personnel switched their strategy from convincing employees to return to work to securing per diem temporary staff. But those efforts largely failed, according to DMAVA personnel, because the State did not offer competitive pay rates to temporary workers.

According to testimony, the fixed government rates left the veterans homes unable to compete with other private healthcare facilities seeking workers during the pandemic. DMAVA administrators testified that they heard from certain staffing agencies that some private nursing facilities paid almost double the government rate. As a result, the agencies allegedly elected to send their nurses to higher-paying jobs instead of the veterans homes.

The SCI found efforts by DMAVA to pursue a rate increase were lackadaisical. One DMAVA administrator told the SCI they had made calls regarding the need for the homes to offer higher per diem rates but did not follow up or further push the matter.

SCI investigators encountered difficulties when seeking more information about the process used to set or increase the contract rates utilized by the State for temporary nursing and medical replacement staff at the homes. DMAVA personnel cooperated and promptly responded to the SCI's requests; however, the answers were often incomplete, unclear or conflicted with previous information provided to the Commission.

Next, DMAVA turned to deploying the National Guard**,** an action already approved by Governor Murphy, and seeking assistance from U.S. Department of Veteran Affairs (VA) nurses. While Executive Order 103, issued on March 9, 2020, authorized the activation of the National Guard, DMAVA did not call upon them until almost a month later on April 8, 2020. Once deployed**,** **t**he National Guard helped relieve some of the burden at the homes, but according to their personnel, true relief only occurred when VA nursing staff arrived at the end of April.

Communication Breakdowns

The SCI found significant communication breakdowns between the DOH and DMAVA in the early stages of the pandemic regarding the rapidly changing COVID management guidelines caused confusion and frustration in the homes.

At the time, the CDC was issuing swiftly changing guidance on the virus. Typically, the DOH would first receive the information, interpret it and then forward it to DMAVA, other agencies and health and medical facilities across the state. The conflicts arose due to the oscillating CDC guidance**,** delays in the State's interpretation of the federal directives**,** flip-

flopping on strategies and the sheer volume of the policies, according to DMAVA personnel. New mandates from the DOH were issued at a rate of two to four per day, with details encompassing hundreds of pages. Previously, new rules were typically sent out no more than twice a year, according to one CEO. Further, DMAVA administrators said reaching anyone at DOH at the pandemic's start was also difficult. They also claimed DOH gave inconsistent answers to inquiries concerning virus management.

Communications between the staff at the homes and families of residents also faltered during the pandemic, leaving relatives in the dark about the welfare of the nursing home residents and conditions inside the residences. At the nursing homes, social workers are primarily responsible for communication with family and loved ones regarding the status and care of residents. But in the early weeks of the pandemic, many social workers were among those who called out from work. At Paramus, all of the social services staff called out from work at one point, according to an administrator. Despite the employee shortage, the remaining staff at the facilities tried to perform the same services. Family members and loved ones reported getting little to no information and, in some cases, inaccurate information during that time.

The Commission uncovered heartbreaking accounts from family members and loved ones of those who died in the veterans homes during the pandemic. One woman**,** whose brother died of COVID-related causes at the Menlo Park home in April 2020, said she had no idea what was happening with him during the early weeks of the pandemic. When she finally reached a doctor at the home, she was told her brother did not have COVID and was okay. Yet, shortly after that, he was taken to the hospital and died. Later, when she went to the home to retrieve his belongings, a staff member said they were looking for him. Employees at the veterans home did not even know he had died.

The daughter of a couple, both of whom died at the Menlo Park residence in 2020 due to complications from COVID, told a similar story. She had previously communicated with a social worker at the residence, who had given her updates on her parents, but that social worker had quit. Subsequently, in April 2020, the daughter spoke with a nurse practitioner at the Menlo Park residence, who told her that her father was fine. Her father died less than 24 hours later. Before the COVID pandemic, the quality of care at the home was satisfactory, but after the virus arrived, the daughter said it was haphazard and often negligent. She told the SCI she had to beg the staff to test her mother for COVID. At the end of her life, her mother had bed sores and the staff had lost her dentures. In a final blow, when the daughter picked up her mother's belongings following her October 2020 death, she was given teeth that belonged to someone else.

Conditions were equally bad at the Paramus veterans home, according to a man whose father died there from COVID in April 2020. What had once been a wonderful living experience for his elderly parent – with friends and a caring staff – became a solitary and frightening existence once the virus arrived and the facility was locked down. The man said that communication from the staff to relatives dwindled to the point it was nearly nonexistent. When he inquired about his father's health status, the staff could not provide answers. Only after his death did he learn his father had COVID.

Exacerbating the already trying conditions with limited staff available to assist residents and respond to their loved ones was the lack of communication tools and technology in the homes. While the homes' residents had access to some electronic devices, they were shared amongst all the inhabitants. At Menlo Park, for example, a few dozen tablets were donated during the pandemic for the residents to use for FaceTime calls and other communications with their families and friends. However, the devices were shared among more than 300 residents. Given that the home is a skilled nursing facility with many residents unable to complete simple tasks independently, some also required staff assistance making phone calls or using the devices.

Additionally, the northern New Jersey homes did not have wireless access to the Internet. The lack of Wi-Fi meant that staff had to carry hotspots – a wireless access point that permits connection to the Internet – to enable residents and themselves to connect to the Internet. One administrator said staff required the hotspots to conduct online meetings with other government departments or offsite participants.

Menlo Park was recently outfitted with Wi-Fi. However, the limited service is unsuitable for the facility's wireless needs, according to staff. Consequently, residents and staff still need to use portable hotspots for wireless internet connection. Meanwhile, the Paramus home still lacked Wi-Fi capability as of August 2023, requiring reliance on hotspot devices.

Adding to the lack of up-to-date communications technology, the Commission found that Menlo Park still uses an analog phone system. When residents were relocated from their usual rooms to other areas for COVID management, the phone numbers assigned to the residents were not easily transferred. As a result, family members needed to contact direct care staff to get in touch with a loved one.

Another practice out of step with modern healthcare technology is the reliance on a paper-based record-keeping system for many residents' medical records. The homes record some medical information electronically; however, it is limited to initial intake information and overall plans for care. Daily recording of health updates and notes are still handwritten and kept on paper in patient files. Patient files are stored in file rooms, requiring a staff member to go to the designated space to obtain the patient record and interpret written notes. This system undoubtedly contributed to the difficulty faced by staff in acquiring up-to-date patient information in a timely fashion in response to calls from family.

Even though $546,000 was allocated in New Jersey's fiscal year 2023 budget for software to implement an electronic medical records system for the veterans homes, that upgrade has not yet been fully implemented. The homes are in the process of being converted to a completely electronic system, with at least one home in the test phase.

Facility Design Challenges

COVID management protocols advise isolating and quarantining individuals infected or exposed to the virus. However, the physical layouts of the two northern New Jersey veterans homes were not designed with this need in mind. Keeping residents separated during the initial stages of the pandemic was challenging.

Built in 1999, the Menlo Park home is located on a 109-acre campus in Middlesex County and can house up to 312 residents. It was designed with several wings, all opening into a common area known as a town square. While it has some single rooms, most of the home is comprised of double occupancy rooms in which two rooms connect to a half bathroom. Showers and bathing areas are in a separate area.

At the start of the pandemic, the home was at capacity, making it difficult to move and isolate residents. Eventually, the veterans homes implemented cohorting, placing residents in units based on their COVID status or potential exposure. Communal dining and other activities were suspended. Residents were prohibited from co-mingling with other residents. Still, four residents shared the same bathroom facilities in both Menlo Park and Paramus.

Currently, the Menlo Park home is slightly above 50 percent capacity, making it easier to transport, separate and quarantine residents, if necessary. The fiscal year 2024 State budget signed into law in June by Governor Murphy, earmarked $400,000 to convert double occupancy rooms in the veterans homes to single occupancy rooms. The current estimate for converting rooms at Menlo Park is sometime in 2025, with no target date yet for Paramus.

Opened in 1986, the Paramus home is the oldest building of the three veterans homes. The home can currently house 336 residents with two residential buildings connected through a single hallway lined with residential rooms on both sides. Staff told the Commission the design of the building made it impossible to move COVID-positive patients through the facility without exposing residents who resided in the residential hall that connected the two buildings. Later, after resident numbers dwindled due to the pandemic, the residential hall was no longer used to house residents and was converted into an office space. Like Menlo Park, most rooms are double occupancy with two adjoining rooms opening to a shared half bathroom. A communal shower room, shared amongst residents of each residence wing, is located separately. In Paramus, each wing has approximately 30 double occupancy rooms. As of August 2023, the Paramus home had fewer than 200 residents.

While both Menlo Park and Paramus are older buildings with institutional-type layouts more akin to hospitals than contemporary residential senior living arrangements, the Vineland home is a modern facility that starkly contrasts with the other properties. Redesigned in 2005, it can accommodate up to 300 residents. Currently, just over 200 residents live there.

The entire facility has sufficient Wi-Fi and offers residents access to amenities, including a bowling alley, a movie theater, a barbershop, a salon and a bank. It also has communal living spaces throughout the facility, sometimes with multiple areas in each wing. Some of Vineland's additional services and recreational spaces, including an expansive patio area, were funded through partnerships with private entities and donations from local businesses.

Some of the building's features, and given that COVID infection rates were lower in the southern portion of New Jersey and at the Vineland home during the pandemic, enabled it to more easily cohort residents, reduce the spread of the virus and permit residents to continue to engage in activities. Although most rooms are double occupancy, unlike Menlo Park and

Paramus, each room has a half bathroom, reducing the number of residents that use the same bathroom from four to two.

Recommendations

The Commission's findings of systemic and persistent problems within the operation and oversight of the Veterans Memorial Homes bolster recent conclusions reached by other investigative bodies – including the DOJ – that during the pandemic, the homes' residents did not, and still do not, receive the level of care they are entitled to from the State of New Jersey.

In response to the pandemic's devastation at the Menlo Park and Paramus homes, the Murphy administration implemented numerous reforms and policies to improve conditions, including installing private managers to oversee the two homes and requiring DMAVA's Director of Veterans Healthcare Services to have clinical experience.[5] The Commission recognizes these and other efforts as essential steps toward restoring proper and effective oversight of the veterans homes. However, much more must be done to demonstrate to citizens that the State has prioritized protecting the health, safety and welfare of the homes' residents entrusted to its care. To address those matters, the Commission makes the following recommendations for statutory and regulatory reforms:

- **Reassignment of Veterans Homes from DMAVA Oversight**

To increase accountability and efficiency in their operation and better protect residents' health and safety, the Commission recommends the Legislature and Governor consider removing the oversight of the veterans homes from DMAVA and transferring responsibility to a newly created cabinet-level agency or commission with specific authority for the homes. Apart from the operation of the homes, DMAVA's responsibilities pertain primarily to military-related matters, including coordinating the New Jersey Army and Air National Guard, veterans outreach programs and burial services. Most leadership within DMAVA has traditionally been current or retired military members without medical backgrounds or the necessary knowledge of nursing homes.[6] At a minimum, the Commission recommends that any government entity responsible for overseeing the veterans homes be led and staffed by professionals with significant clinical experience in skilled nursing, institutional care and other requisite medical backgrounds necessary to operate in a nursing home setting.

[5] N.J.S.A. 38A:3-2(c) (2021).

[6] Brigadier Lisa J. Hou, appointed by Governor Murphy on October 18, 2020 to serve as the Adjutant General for DMAVA, is a physician. In 2018, she became the first Joint Surgeon of the New Jersey National Guard, overseeing medical readiness and personnel statewide.

- **Reaffirm "Essential Employee" Status of Medical and Frontline Staff at Veterans Homes**

One fundamental conclusion drawn from the findings of this investigation is that regardless of where the veterans homes' functions are housed, the essential status of medical and frontline employees must be reaffirmed. To achieve clarity on this matter, the Commission recommends that any future directive from the state government regarding a public health emergency should include language specifically designating skilled nurses and other frontline staff at the three veterans homes as essential workers deemed necessary for the continued safe operation of the residences. Administrators overseeing the homes should clearly understand their authority to enforce this obligation.

Any such mandate requiring staff to report to work must also safeguard employees and residents by ensuring workers receive and use appropriate personal protective equipment and other necessary precautions while performing their job duties.

- **Offer Competitive Rates for Replacement Healthcare Staff**

Given the need to provide uninterrupted care to residents in a public health emergency or any other crisis, the contract rates for temporary healthcare workers to supplement staff should be suspended, or temporarily increased to allow the veterans homes to remain competitive with the private sector.

At a minimum, emergency preparedness plans should include a systematic guide outlining the process needed to modify the rates. Further, the State should consider re-evaluating its rates to determine if they remain competitive and whether the per diem pay for skilled healthcare workers should be higher to attract high-quality temporary workers.

- **Update the Homes' Information Technology Infrastructure and Fully Implement Electronic Storage of All Personal Health Information of Residents**

The Commission found the veterans homes lacked specific modern technology necessary for the optimal operation of its medical supervision of its residents and to allow residents and staff access to a reliable wireless internet connection. Among the technology upgrades lacking at the homes are sufficient Wi-Fi, updated digital phone systems and appropriate video capabilities for all residents to keep pace with telehealth advancements, allow for remote social services care and communicate with loved ones.

The technological updates should be among the priorities for the homes as the planned conversion to an electronic medical records system would be ineffective or counterproductive without it. State funds have already been reserved for switching to the electronic records system but have yet to be fully implemented at the homes.

- **Establish Work-from-Home Protocols for Social Services Staff in Public Health Emergencies**

While work-from-home policies were relatively uncommon in many sectors before COVID, the pandemic proved that some professionals could successfully perform their job duties remotely. Although many job classifications at the veterans homes cannot be performed offsite due to their direct care responsibilities, some social services duties, such as providing updates to keep residents' families informed of their care and condition, can be accomplished remotely.

The Commission found a significant cause of the communication breakdowns between the homes and the loved ones of residents occurred due to the loss of many of the social services staff, who are primarily responsible for maintaining communications with family members regarding the residents' status and well-being. To prevent this in the future and to avoid crippling certain functions, the veterans homes should establish work-from-home protocols for social service professionals. Such work-from-home protocols for non-direct care workers could be implemented during any infectious outbreak or in other specialized circumstances determined by the homes.

The planned conversion of the paper record-keeping system now used for most medical records at the veterans homes to an electronic system will also aid social services workers in their ability to easily and timely access health and status information about residents both on-site and remotely.

- **Prioritize the Conversion of Menlo Park and Paramus Units into Single Bed Rooms**

The State budget signed by the Governor in June designated $400,000 in funding to convert the homes from double occupancy to single bedrooms. While the planned completion of the conversions at Menlo Park is 2025, Paramus has no target date yet.

Considering the recent findings by the DOJ that infection control measures remain lacking at the northern New Jersey homes, along with the possibility of the homes returning to capacity, the Commission urges the State to prioritize the conversion of both facilities to single bed units. In the interim, home residents remain less protected and vulnerable to another outbreak.

- **Establish Greater Equity and Collaboration Among the Veterans Homes**

Although all three homes now operate under DMAVA, each operates separately and independently with minimal collaboration with the other two facilities. There is some coordination regarding infectious control practices among the three homes through sharing an infectious disease coordinator; however, the facilities could benefit from greater collaboration and sharing of personnel, information and supplies.

The Commission found the Vineland home successfully expanded amenities offered to residents, including expanding the facility, building an outside patio area, and engaging private entities and local businesses to help fund the work. The Menlo Park and Paramus homes also

should consider entering into public-private partnerships such as those undertaken by the Vineland home that have resulted in several projects that improved the facility.

The Commission recommends establishing a task force, or a position within the DMAVA framework or within any government entity created to oversee the homes, to work towards establishing uniformity among the three homes by elevating the facilities and practices of the two northern facilities and implementing successful programs, purchases or procedures utilized in one facility in the sister facilities.

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