



State of New Jersey  
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS  
POST OFFICE BOX 340  
TRENTON, NJ 08625-0340

CHRIS CHRISTIE  
Governor  
Commander-in-Chief

☆  
MICHAEL L CUNNIFF  
Brigadier General  
The Adjutant General

**VETERANS AFFAIRS BULLETIN**  
No. **1-15\***

**1 April 2015**

**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 10<sup>th</sup> of each month for the previous month.
- Format as Attachment 2.

**c. Monthly Quality Improvement Report:**

- Due the 15<sup>th</sup> of each month for the previous month.
- Format as Attachment 3.

**d. Monthly Admissions Report:**

- Due the 15<sup>th</sup> of each month for the previous month.
- Format as Attachment 4.

**e. Pressure Ulcer Monthly Tracking Report:**

- Due the 15<sup>th</sup> 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 15<sup>th</sup> of each month.
- Format as provided by Chuck Robbins.

**g. Offline Audit/Reconciliation Report:**

- Due the 21<sup>st</sup> of each month for the previous month.
- Format as Attachment 6.

**h. Monthly Future Activities Report:**

- Due the 25<sup>th</sup> of each month to reflect the next month's activities.
- Format as Attachment 7.

**i. Advisory Council Minutes:**

- 30<sup>th</sup> of each month in which a meeting occurs.

**j. Quality Improvement Minutes:**

- 30<sup>th</sup> of each month in which a meeting occurs.

**k. Quarterly Staffing/Salary Report:**

- Due the 15<sup>th</sup> 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](mailto: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



**CRITICAL VACANCIES  
(List Top Five)**

<b>VMH</b>	<b>DIRECT CARE</b>	<b>SUPPORT/ADMIN</b>
<b>Menlo Park</b>		
<b>Paramus</b>		
<b>Vineland</b>		

"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			
<b>TOTALS</b>			

OVERTIME	HOURS	\$ AMOUNT
Direct Care Staff		
Support Staff		
Per Diem		
Agency		
<b>TOTALS</b>		

REVENUE	\$ AMOUNT
VA Per Diem	
Members Care & Maintenance	
Medicare Part A & B	
<b>TOTAL</b>	

# ADMISSIONS	# DISCHARGES	# APPLICATIONS REC'D	# DENIALS
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DENIAL NAME	DATE	REASON

3. **CONSTRUCTION AND IMPROVEMENTS:**

4. **MEETINGS:**

5. **TRAINING:**

6. **UNION ACTIVITIES:**

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						
<b>TOTAL WOUNDS</b>						

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									
<b>TOTAL HOSP.</b>									

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

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
Number This Month				Change in NCP Following Fall?



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

Intravenous	Reason				
	Number This Month	Medication	Dehydration	Fluid/Electrolytes	Other

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

Residents in Isolation Rooms	Reason		
	Number This Month	Behavior	Infection

### INFECTION CONTROL

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

### PHARMACY

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

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

<b>APPLICATIONS</b>	<b>Breakdown</b>				
	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					

<b>ADMISSIONS</b>	<b>Breakdown</b>		
	Skilled Nursing	Secured Unit	TOTAL
Number This Month			

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

<b>DISCHARGES</b>	<b>Breakdown</b>		
	Expired	Other Medical Facility	Discharged to Home
Number This Month			

<b>APPROVED WAITING LIST</b>	<b>Breakdown</b>			
	Veterans	Non Veterans	Couples	TOTAL
Number This Month				

<b>DEFERRED WAITING LIST</b>	<b>Breakdown</b>			
	Veterans	Non Veterans	Couples	TOTAL
Number This Month				

<b>AVERAGE WAITING TIME IN MONTHS</b>	<b>Breakdown</b>		
	Veterans	Non Veterans	Couples
Number This Month			

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

Paramus   
  Menlo Park   
  Vineland   
 \_\_\_\_\_ Month and Year: \_\_\_\_\_

(Please Select Correct VMH)

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

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

**(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



**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.

Institutional Department Specific Titles	Non- Exempt	FTE Staffing #	Filled #	Part-Time Filled #	Salary Filled Amount \$	Salary Vacant Amount \$
<b>FIS PROGRAM CODE 990000</b>						
<b>Administration</b>						
CEO						
Section Chief						
Secretarial Assistant 1						
Secretarial Assistant 2						
Total						
Add Total						
<b>Business Office</b>						
Business Manager 2						
Asst. Business Manager						
Administrative Analyst 4						
Special Staff Officer						
Technical Asst. 1, Purchasing						
Supervisor of Accounts						
Total						
Add Total						
<b>Human Resources</b>						
Manager 1, Human Resources						
Secretarial Assistant 2						
Personnel Assistant 3						
Employee Relations Coord.						
Supervising Payroll Clerk						
Technical Asst., Personnel						
Total						
Add Total						
<b>Information Systems</b>						
Administrative Analyst 1						
Staff Assistant 2						
Total						
Add Total						
<b>Housekeeping</b>						
Housekeeping Supr. 2						
Asst. Hskpg. Supr. 2						
Head Housekeeper						
Residential Services Worker						
Total						
Add Total						
<b>Maintenance</b>						
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						
<b>Storeroom</b>						
Staff Assistant 1						
Storekeeper 2						
Stores Clerk						
Total						
Add Total						
<b>Administrative Support</b>						
Charge Nurse - QI						
Principal Clerk						
Total						
Add Total						



Institutional Department	Non-Exempt	FTE Staffing #	Filled #	Part-Time Filled #	Filled Amount \$	Vacant Amount \$
<b>FIS PROGRAM CODE 200000</b>						
<b><u>Business Office</u></b>						
Clerk Typist						
Total						
Add Total						
<b><u>Recreation</u></b>						
Supervisor of Recreation						
Asst. Supervisor of Rec.						
Sr. Therapy Program Asst.						
Therapy Program Assistant						
Therapy Aide						
Total						
Add Total						
<b><u>Food Service</u></b>						
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						
<b><u>Nursing</u></b>						
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						
<b><u>Medical</u></b>						
Physician Specialist						
Sup. Clinical Nutritionist						
Clinical Nutritionist						
Charge Nurse-Infection Control						
Charge Nurse-Clinic						
Total						
Add Total						
<b><u>Social Services</u></b>						
Social Worker Supervisor 2						
Asst. Social Worker Supervisor						
Social Worker 1						
Social Worker 2						
Admitting Officer						
Principal Clerk Typist						
Total						
Add Total						
<b><u>Administrative Support</u></b>						
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:**

- |  |   |
|--|---|
| <input type="checkbox"/> Elopement               | <input type="checkbox"/> Involuntary Relocation     |
| <input type="checkbox"/> Environmental Emergency | <input type="checkbox"/> Medication Error           |
| <input type="checkbox"/> Financial Exploitation  | <input type="checkbox"/> Resident Care              |
| <input type="checkbox"/> Injury                  | <input type="checkbox"/> Resident-to-Resident Abuse |
| <input type="checkbox"/> Interruption of Service | <input type="checkbox"/> Staff-to-Resident Abuse    |
| <input type="checkbox"/> Involuntary Discharge   | <input type="checkbox"/> 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
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Notifications:**

MD, Specify:

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

Other, Specify:

**FOR NJDHSS USE ONLY**

<b>Reviewed By: (Surveyor ID Number and Initials)</b> <input type="text"/>	<b>Date (MM/DD/YY)</b> <input type="text"/>
<b>Other Review: (ID Number and Initials)</b> <input type="text"/>	<b>Date (MM/DD/YY)</b> <input type="text"/>

**Disposition:**

Pending

No Action

Complaint Investigation

Referral, Specify:

Closed, Specify Date Closed:

**Comments:**