State Veterans' Homes (SVH) Corrective Action Plan
Illinois Veterans Home-Anna 7/16/24-7/18/24

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 affected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assessment and Assurance.

State the Issue **Identify the Regulation and Findings**	**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with Quality Assessment and Assurance 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 Quality Assessment and Assurance)	**Proposed Completion Date** (i.e. when corrective action will be fully implemented and sustained)
Section 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.	1.Affected resident's room was inspected to ensure no unprescribed medications at bedside. 2.Current nursing policies and procedures have been reviewed. 3.Administration has updated policy and procedure manual to include *"Resident Safety and Supervision."* 4.Administration has reviewed and updated policy and procedure manual including *Self Administration of Medication Screener, Medication Storage and Incident Reports.* 5.Affected staff will be provided education regarding new and updated policies and procedures. 6.Director of Nursing held mandatory nurse meetings to include training and education regarding incidents/accidents and incident report investigation. 7.Education provided to Activity staff regarding increased monitoring of residents while on shopping activities in the community.	1.Current nursing policies and procedures have been reviewed. 2.Administration has updated policy and procedure manual to include *"Resident Safety and Supervision."* 3.Administration has reviewed and updated policy and procedure manual including *Self Administration of Medication Screener, Medication Storage and Incident Reports.* 4.Affected staff will be provided education regarding new and updated policies and procedures. 5.Director of Nursing held mandatory nurse meetings to include training and education regarding incidents/accidents. 6.Education provided to Activity staff regarding increased monitoring of residents while on shopping activities in the community.	1.All accident hazards (potential or noted) will be reviewed at the weekly clinical meeting with the interdisciplinary team and during Quality Assessment Performance Improvement meetings; either quarterly or as needed. 2.Affected staff will be provided education regarding new and updated policies and procedures. 3.Nursing policies and procedures will continue to be reviewed yearly and as needed. 4.Activity staff will provide supervision and assistance at checkout while residents are on shopping outings. They will notify nursing staff of any purchases made that could be deemed as unsafe if unable to prevent resident's purchase. 5.Upon new admission, nursing staff to supervise and ensure resident's room is free of unprescribed medications. Inventory sheet is completed by staff, logging all items	1.As part of the facility's ongoing quality assurance plan, the Administrator, Director of Nursing and interdisciplinary team will be responsible for continued compliance. 2. All accident hazards (potential or noted) will be reviewed at the weekly clinical meeting x4 weeks with the interdisciplinary team and will continue to be reviewed on a regular basis thereafter. All accident hazards (potential or noted) will be reviewed at the Quality Assessment Performance Improvement meetings; either quarterly or as needed. 3.Recommendations for resident care will be provided during this time and reviewed with the interdisciplinary team. 4.New and updated policy and procedure staff education to be completed by September 15, 2024. Start Date: 07/18/2024 End Date: 09/15/2024 Compliance:100%	09/15/2024

	8.Education provided to affected resident regarding possession of unprescribed medications at bedside on July 18, 2024. 9.Education was documented in the electronic health record.		brought into the facility upon admission.		
§ 51.140 (h) Sanitary conditions. The facility must: 1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly.	The corrective action the facility has taken for all residents affected by this practice include: Policy updated to include the covering of items on the hall cart. Inservice of dietary staff regarding policy of covering items on hall trays. Audits will be performed for compliance of covering items on the hall trays.	It was identified that all fifteen residents have the potential to be affected by the deficient practice	It is the policy of the Illinois Veterans Home-Anna that meals served outside the Dining Room will be served on room trays with lids or coverings to prevent food contamination and hold temperature	As part of the facility's ongoing quality assurance plan the Dietary Manager will complete audits weekly x 4 weeks then monthly x 3 months. The Dietary Manger will submit her audits to the Administrator for review. Any trends noted and follow ups required will be reported at the facility's quality assurance meetings. The Dietary Manager will be responsible for continued compliance. Start Date:8/20/24 End date:12/13/24 Compliance: 100%	12/13/24
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	The corrective action the facility has taken for all residents affected by this practice include: Conducting Fire Drills on each shift. Drills shall be conducted quarterly on each shift to familiarize facility personnel and residents with the signals and emergency action required under varied conditions. Education and sign in sheets to be completed by all staff present. A Fire Drill Tracker form has been implemented showing the shift that fire drill needs to be conducted. The Tracker will be turned in monthly the Administrator	It was identified that all residents and employees have the potential to be affected by the deficient practice.	It is the policy of the Illinois Veterans Home-Anna that Fire Drills will be conducted quarterly on each shift per Life Safety Code. Drills shall be conducted quarterly on each shift to familiarize facility personnel and residents with the signals and emergency action required under varied conditions. Education and sign in sheets to be completed by all staff present. A Fire Drill Tracker form has been implemented showing the shift that fire drill needs to be conducted. The Tracker will be turned in monthly the Administrator	As part of the facility's ongoing quality assurance plan the Building, Grounds and Maintenance dept., will conduct a monthly fire drill alternating shifts as outlined on the Fire Drill Tracker form. The form will be turned in to the Administrator for review monthly x 3 months. Any trends noted and follow ups will be reported at the facility's quality assurance meeting. The Building, Grounds, and Maintenance worker and Administrator are responsible for compliance. Start Date: 7/8/24 End Date: 9/5/24 Compliance: 100%	09/05/2024

- This Corrective Action Plan is to be electronically submitted to the Pod-specific National SVH Program Manager for Quality and Oversight