State Veterans' Homes (SVH) Corrective Action Plan
Michigan Veteran Homes at Chesterfield Twp.
Annual Survey 7/18/23-7/21/23

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**
51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation,	Resident #9 was assessed immediately. The care plan was reviewed, in place and appropriate. Resident #9 has not had any negative effects from the deficient practice. His wound continues to make progress and he continues to be followed by wound care.	All residents with pressure wounds have the potential to be affected by the deficient practice. All residents with pressure wounds have been assessed by the wound care nurse. Their care plans have been reviewed. None of the residents have had any negative effects resulting from the deficient practice.	Policies and procedures have been reviewed and deemed appropriate. All licensed staff will complete education on the importance of following treatment orders and policies and procedures as it relates to infection control and wound treatments. Licensed staff will be competency tested on infection control practices as it relates to wound care dressing changes.	Director of Nursing or designee will conduct five random audits of wound care treatments will be performed weekly x3, biweekly x1, then monthly x1. Director of Nursing will report findings during monthly QAPI to be monitored by committee for compliance.	10/25/2023

interview, and record review, the facility failed to complete the pressure ulcer (PU) treatment as ordered and failed to use appropriate infection control technique for one (1) of five (5) residents reviewed for PUs.					
51.120 (n) Medication Errors. The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. Based on observations, interviews, record review, and review of facility policies, the facility failed to ensure that medications were administered correctly for two (2) of four (4) residents observed during the medication pass. Resident #14 administered 4 sprays of Flonase into one nare, and 7 sprays of Flonase into the other nare; the resident was not advised on the dosage, nor was he corrected	Resident #14 was assessed, remains at baseline, and did not incur any harm due to the deficient practice. Resident #15 was assessed, remains at baseline, and did not incur any harm due to the deficient practice.	All residents residing in the facility who self-administer nasal sprays or take multiple inhalers have the potential to be affected by the deficient practice. All residents that self-administer prescribed nasal spray(s) were assessed for appropriateness and re-educated to their prescribed dosage. All residents prescribed inhalers were identified and assessed and found to not have had any negative outcomes due to the deficient practice.	The facilities policies and procedures were reviewed. All licensed nurses will be re-educated to the policies and procedures and the 5 rights of medication pass.	Director of Nursing or designee will conduct five random audits of wound care treatments will be performed weekly x3, biweekly x1, then monthly x1. Director of Nursing will report findings during monthly QAPI to be monitored by committee for compliance.	10/25/2023

during administration. Resident #15 received					
51.200 (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. <u>Smoke Barriers and Sprinklers</u> 1. Based on records review and interview, the facility failed to inspect the Fire Alarm in accordance with the code. The deficient practice affected two (2) of two (2) smoke compartments in the Main Building, two (2) of two (2) smoke compartments in the Heritage Building, two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a capacity for 128 beds with a census of 103 on the first day of the survey.	1. Education of semi-annual visual inspection of the fire alarm system for Maintenance Director and Maintenance Staff. 2. Educate the Maintenance Director and Maintenance Staff to NFPA 101 19.7.1.4 through 19.7.1.7. 3. Educate Maintenance Director and Maintenance Staff to NFPA 99 10.5.6.2.	1. Utilize the fire alarm systems device report to verify that the system is running as “normal”, equipment is in proper condition, and there are no obvious breaks, corrosion, or damaged connections. Document each device. 2. Complete a schedule for quarterly fire drills that completed as scheduled per standard of the Code. 3. Facility to purchase and Electronic Analyzer and implement a testing plan to be completed annually. Contact the respiratory equipment vendor for documentation showing completion of equipment testing prior to delivery & annually thereafter.	1. The visual inspection has been added to the TELS system as a task that is set to be completed semi-annually. 2. Add the Fire Drill schedule to TELS system as a task so the Administrator can assure sustained compliance which will be audited monthly. 3. Test all PCREE and document on each device once the analyzer is received (sample document attached). Add PCREE testing as an annual task to TELS system.	1. Documentation of visual inspections of smoke compartments and barriers were provided to Administrator upon completion. Administrator will continue to monitor TELS for on-going compliance. 2. Administrator will review TELS system for on-going compliance. 3. Administrator will be provided copy of completed testing once completed.	1. 8/27/2023 2. 8/27/2023 3. 9/24/2023

Fire Safety and Operations 2. Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected two (2) of two (2) smoke compartments in the Main Building, two (2) of two (2) smoke compartments in the Heritage Building , two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a capacity for 128 beds with a census of 103 on the first day of the survey. Electrical Systems 3. Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on the Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected two (2) of two (2) smoke compartments in the					

Main Building, two (2) of two (2) smoke compartments in the Heritage Building , two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a capacity for 128 beds with a census of 103 on the first day of the survey					
51.200 (b) Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are	Educate Maintenance Director and Maintenance Staff to NFPA 110 8.4.2 & 8.4.2.3 Testing Frequency and Load of Generators.	Load bank testing have been performed and completed on 8/22/2023	Load Bank task in TELS to reflect the new annual load bank test. 2024 Annual inspection currently scheduled.	Administrator to monitor TELS for completion during the quarter in which its due.	8/22/2023

used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Based on records review and interview, the facility failed to inspect and test the emergency generator in accordance with the code. The deficient practice affected two (2) of two (2) smoke compartments in the Main Building, two (2) of two (2) smoke compartments in the Heritage Building , two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a					

capacity for 128 beds with a census of 103 on the first day of the survey.					
51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources	Resident #16 no longer resides in the Home.	The Home has audited and determined that no other members receive outside resources from the VAMC.	Upon Admissions, Veteran and/or responsible party is made aware of the available on-site mental health services available through a contracted provider-Behavioral Care Solutions (see attached contract).	Administrator will conduct an audit of the next ten admissions reviewing the “Admission Agreement” which outlines that “the member must use MVH provided services to the extent they are available upon admissions” to ensure all signed acceptance of all in-house services provided at the SVH. Administrator will report findings during monthly QAPI to be monitored by committee for compliance.	5/31/2024

outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.					
§ 51.210 (j) Credentialing and Privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologists, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance.	Administrator has complied records of all current health care practitioners and reviewed and completed a credentialing review with the Home's Medical Director.	The Home has audited and determined that no health care practitioners were out of compliance with their current credentials for their specific scope of work.	Administrator as assigned the Clinic Coordinator to notify Administrator when a new practitioner or a change in practitioner's status to the Home so that the Administrator and Medical Director can viewed for current credentials are valid prior to performing services within the Home.	Administrator will review annually in addition as needed all health care practitioners providing services to the Home for valid credentials.	9/01/2023

(1) The facility management must uniformly apply credentialing criteria to licensed practitioners applying to provide resident care or treatment under the facility's care. (2) The facility management must verify and uniformly apply the following core criteria: current licensure; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. (3) The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credentials file must indicate that these criteria are uniformly and individually applied. (4) The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility.					

(5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. (6) The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted.					

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