State Veterans' Homes (SVH) Corrective Action Plan
Claremore Veterans Home-5/16/23 to 5/19/23

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 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)
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility.	All residents have the potential to be affected until ODVA financial plan assures the security of all personal funds of residents and is approved by the VA Under Secretary of Health. ODVA's original report/request for approval of its current financial coverage was reviewed by the VA 1/31/23. The VA then requested ODVA to provide additional information 3/28/23 as its submitted package was deemed incomplete. As of 9/1/23 the VA has not received requested information from ODVA central office. This facility has been in continuous monthly communications with ODVA Central Office determining the status of this request and will continue to do so until resident	Beginning 5/23/23 Administrator will complete monthly audit verifying status of request from the Under Secretary of Health via ODVA State Homes Director. Efforts will continue until the security of all residents' personal funds is assured per 51.70(c)(6) regs. Administrator or designee is responsible for maintaining the Assurance of Financial Security Audit Log. Business Office continues to conduct monthly audits, with no end date, to identify Patient Trust account balances nearing, or in excess of current crime policy limit for all residents. For residents whose balance exceeds current crime policy	Beginning 5/23/23 Administrator will complete monthly audit verifying status of request from the Under Secretary of Health via ODVA State Homes Director. Efforts will continue until the security of all residents' personal funds is assured per 51.70(c)(6) VA regs. Audits will continue for three consecutive months with results presented at quarterly QAPI meetings, beginning July, 2023.	Audit results will be brought to quarterly QAPI meetings beginning July, 2023, for further evaluation and to ensure compliance with 51.70(c)(6) and will continue until 100% compliance is achieved. Audits will continue until ODVA secures approval from the Under Secretary of Health utilizing 2023 VA Annual Survey Audit Log (tab 1). Business Office continues to conduct monthly audits, with no end date, to identify Patient Trust account balances nearing, or in excess of current crime policy of $100,000, addressing as applicable.	4/30/24

	funds are secure per 51.70(c)(6) VA regs.	limit ($100,000) the facility will contact the resident or financial designee and request a drawdown of funds, or where applicable a new payee to be named for the resident's monies, Social Security or any other financial entitlements.			
§ 51.70 (f) (1) – (2) Grievances. A resident has the right to— (1) Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	Recreation Manager and Social Services met to address and resolve Resident Council grievances (written and verbal concerns) including Resident #32 concern, and issue of opening mail 6/19/23. Concerns from May 2023 Resident Council meeting have been acknowledged/resolved, with notification to resident, and documented utilizing Grievance Audit Log. As of 6/19/23, residents have been assigned a Social Worker specific to their unit, unless requesting otherwise, eliminating the current rotational process which might have proved confusing to residents. Past grievances/issues and their resolution are discussed under "old business" during Resident Council meetings and are a part of Resident Council minutes. Additionally, all resident grievances (verbal/written) are reviewed in-person with the	Beginning May 2023, Social Services Manager or designee will complete weekly review of documentation, and resident interview audits, to ensure resident grievances, documented from Resident Council meetings, and those reported by residents and staff, are resolved promptly per VA regs. and ODVA policy for 3 consecutive months until a minimal of 90% compliance is achieved utilizing Grievances Audit Log. Recreation Mgr. to collaborate and provide to Social Services Mgr. copies of Resident Council meeting minutes (May, 2023 and forward) that documents resident grievances (written and verbal) to ensure they are promptly resolved and documented utilizing Grievances Audit Log. Recreation Mgr. will continue	Weekly audits began on 5/30/23 and will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly at the 2023 QAPI meetings. Recreation Mgr. will continue to provide to the Social Services Mgr. copies of the Resident Council meeting minutes to ensure grievances (concerns both written and verbal) are promptly resolved and documented, with interview of and notification to resident, utilizing Grievances Audit Log. The facility policy was reviewed, but no changed made. A need for education on the policy was noted and addressed below: From 8/16/23-8/18/23 Social Services, Recreation and Administrator staff were educated, demonstrating competency on ODAV policy "Resident Grievance" and 51.70(f) VA regs. Facility will continue to educate residents and family of the grievance	As of May 2023, Grievances (written and verbal concerns) from Resident Council meetings will be monitored utilizing Grievances Audit Log to ensure grievances are fully and promptly resolved with notification to resident. Weekly review of documentation and resident review audits will continue for a minimum three consecutive months starting on 05/30/23 and ending on 10/31/23 until a minimal of 90% compliance is achieved with results presented at 2023 quarterly QAPI meeting. Facility Grievance policy will continue to be reviewed annually and updated as necessary and in accordance with VA 51.70(f)(1-2) regs. Social Workers will follow up on with all current cognitive residents to ensure understanding of the policy and allow for questions by 10/31/23. This will be documented the	10/31/23

	resident to ensure the resident is satisfied with the outcome (and within VA/OSDH/ODVA regs.)	to document and address resident concerns, and their resolution as a part of meeting minutes.	policy and process at the time of admission by their Social Worker. As of 9/12/23, Facility will educate all current staff on the facility grievance policy and process with an expected completion date of 10/31/23. New staff will be educated upon hire, all staff thereafter annually and as needed. Facility will provide quarterly, ongoing education, to all residents of facility grievance policy/process via Recreation Department staff starting 9/13/23. Education consists of physically handing out a copy of our policy to all residents and reviewing it with them. Facility will provide quarterly, ongoing education to resident representatives and family of facility's grievance policy/process by Administrator staff via email starting 9/12/23. Grievance policy and procedures are posted throughout the facility. All resident grievances (verbal/written) are reviewed in-person with the resident to ensure the resident is satisfied with the outcome (and within VA/OSDH/ODVA regs.) and demonstrate our process is working. Past grievances and resolutions are included in meeting minutes under "old business".	Grievance Policy Education Follow-up sheet. For any new residents, the social worker will follow-up within their first month to ensure understanding of the grievance process and document in their chart. To further ensure the resident education was effective, the Recreation Manager will follow-up on the grievance policy education and offer another opportunity for residents to ask questions or get clarification during the next resident council meeting.	

			This proposed CAP has been reviewed in QAPI. Our Root Cause Analysis showed that staff needed more consistent training to ensure solutions are sustained concerning ODVA's Grievance policy. As of 9/12/23, Facility will educate all current staff on facility the grievance policy and process with an expected completion date of 10/31/23. New staff will be educated upon hire, all staff thereafter annually and as needed. .		
§ 51.70 (i) Mail. The resident must have the right to privacy in written communications, including the right to— Send and promptly receive mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense.	Recreation Manager has met with residents #31 and #32 to address and correct concerns regarding unopened mail and authorization to do so. Current mail handling processes, including the Mail Authorization form, have been revised to ensure residents' right to receive mail unopened is respected, and handling of is per resident's request. Beginning 6/20/23 the new Mail Authorization form has been completed for all new admissions. For residents who admitted prior to 6/20/23, facility has requested those residents, or their legal representative, to complete the updated form and we are still receiving these.	Beginning 6/20/23 Recreation Manager/Patient Services Manager/Administrator or designee will complete, and is responsible for conducting, weekly resident interview audits utilizing Mail Audit Log to ensure residents receive all mail unopened or per resident's voluntary request. Weekly audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings beginning July, 2023, for further evaluation and to ensure compliance with 51.70(i). Current mail handling processes, including the Mail Authorization form, have been revised to ensure	Beginning July, 2023, weekly resident interview audit results will be brought to quarterly QAPI meetings for further evaluation and to ensure compliance with 51.70(i). Current mail authorization form has been revised to: 1. Clarify that completion of the form is entirely optional and not mandatory, providing the resident the opportunity, if they so wish, to exercise their right to self-determination towards handling of their mail. 2. Include explicit language that authorizes ODVA-Claremore to open only specific items of mail per resident wishes, of time-sensitive items (VA benefits and Social Security offices).	Recreation Manager/Patient Services Manager/Administrator or designee will complete weekly resident interview audits utilizing Mail Audit Log to ensure residents receive all mail unopened or per resident's voluntary request. Weekly audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at 2023 quarterly QAPI meeting. Current mail handling processes, including the Mail Authorization form, have been revised to ensure residents right to receive mail unopened is respected and per resident's voluntary request. Switchboard, Business Office, Transport, Medical Records, Recreation .Admin. staff were educated August, 2023 on revised form, mail protocol and	9/30/23

		residents right to receive mail unopened is respected and per resident's voluntary request.		VA 51.70 regs..(resident rights) concerning right to receive unopened mail.	
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	Nursing and Dietary staff will be educated on addressing and treating residents with dignity and respect. Nursing staff will be educated on maintaining an environment that promotes dignity and privacy. 1D unit: As of 5/31/23 facility is serving meals with plates removed from trays or per resident preference. Residents are receiving meals on undivided plate or per resident preference. Meat entrees are being served whole unless directed by a food order or recipe. Main Dining Room: As of 5/20/23 posted signs (i.e. desserts and cost of; purchase of meal tickets) have been removed eliminating possible confusion to residents. Facility is currently auditing to ensure residents are served first, prior to serving staff.	Beginning 5/31/23 DON or Designee will complete weekly direct observation audits utilizing Dignity-Nursing Audit Log to ensure residents are addressed with dignity and respect (using proper names); meals are served with tray removed or per resident preference; residents are cared for in a manner that ensures dignity and privacy. Beginning 6/19/23 Dietary Manager or Designee will complete weekly direct observation audits utilizing Dignity-Dining Audit Log to ensure residents are treated with dignity and respect, with meals served on appropriate dishes (divided plate only with order for); meat entrees served whole unless directed by food order or recipe; staff allowing residents to be served first; any inappropriate or confusing signage in resident area is removed.	Nursing and Dietary audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings beginning July, 2023, for further evaluation and to ensure compliance with 51.100(a). "The Dining Experience: Staff Responsibilities" policy has been revised to include initiation and revision dates.	As of 6/13/23 direct observation for Dignity has been added to ongoing Grand Rounds Nursing (completed by Nursing Administrative staff; 1 unit each week) verifying residents are addressed with respect; and privacy ensured. As of 6/21/23 direct observation for Dignity has been added to ongoing Grand Rounds Dietary (completed by Dietary Mgmt.; 1 unit each week) verifying residents are residents are being served first, served on appropriate dishes; and foods are served whole. Nursing and Dietary audit results will be brought to quarterly QAPI meetings beginning July, 2023, for further evaluation and to ensure compliance with 51.100(a).	9/30/23
§ 51.120 (d) Pressure sores. Based on the comprehensive	Resident #3 - Care Plan was revised 6/15/23 to include interventions for dressing and heel protectors.	Beginning 5/21/23 DON or Designee will complete weekly direct observation audits utilizing Pressure	Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at	As of 6/13/23, direct observation verifying pressure reducing interventions are in place have been added to ongoing Grand	9/30/23

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.	Resident #5 - attending staff have been educated on proper cleaning technique for wound care. Staff now able to access Kardex thru POC. Personal Information Worksheets (PIWs) updated 6/19/23 to refer staff to Kardex which includes documentation for heel protectors. 5/19/23 wound care staff were educated on proper wound care cleaning techniques.	Sores Audit Log to ensure pressure reducing interventions are in place per physician's order; the care plan matches the provider's orders; interventions in the care plan are listed on the Kardex; PIW has referral to Kardex; wound care treatment is provided using proper wound cleaning techniques.	quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.120(d). As of 6/13/23, direct observation verifying pressure reducing interventions are in place have been added to ongoing Grand Rounds Nursing (completed by Nursing Administrative staff; 1 unit each week). Staff now able to access Kardex thru POC to see Care Plan details - including pressure reducing interventions.	Rounds Nursing (completed by nursing administration; 1 unit each week). Staff are now able to access Kardex thru POC to see Care Plan details - including pressure reducing interventions.	
§ 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.	Residents #1, #2, #3, #4 - individualized fall interventions are currently in place; falling Star placed on door frames; restorative documentation now includes how often residents should receive services. Resident #1 – resident is being observed for redirection if found in another resident's room. Resident #2 – staff now able to access Kardex thru POC. PIWs (Personal Information Worksheets) updated 6/19/23 to refer staff to Kardex which	Beginning 6/20/23, DON or Designee will complete weekly direct observation audits utilizing Accidents-Falls Audit Log to ensure the following: Fall interventions are in place and reviewed for effectiveness; Interventions in the care plan are listed on the Kardex; PIW has referral to Kardex; Care plan lists how often resident should receive	Audits began on 6/20/23 will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings for further evaluation and to ensure compliance with 51.120(i). Staff now able to access Kardex thru POC to see Care Plan details - including fall interventions and number of transfer persons. As of 6/13/23, direct observation verifying fall interventions are in place have been added to ongoing Grand Rounds Nursing (completed	As of 6/13/23, direct observation verifying individualized fall interventions are in place have been added to ongoing Grand Rounds Nursing (completed by nursing administration; 1 unit each week). Continued, on the spot training as needed is a part of Grand Rounds Nursing. Staff are accessing Kardex thru POC to see Care Plan details - including fall interventions and number of transfer persons. Fall Prevention Program training has been added to our new hire	10/31/23

	includes interventions for mobility, transfer status and safety. Resident #3 – currently auditing for provision of alternative furniture when resident is using wheelchair as footrest. Resident #4- staff now able to access Kardex thru POC. PIWs updated 6/19/23 to refer staff to Kardex which includes interventions for safety, and number of transfer persons. Resident in appropriate chair; wheelchair with inoperable brakes removed from unit.	restorative services. Falling star is placed on resident door frame/room as appropriate Staff member who is dedicated to the common area is providing assistance as needed. If a resident is observed using a wheelchair as a footrest alternative furniture is provided. If a resident is observed resting in another resident's room they are directed back to their room.	by nursing administration; 1 unit each week) to ensure systemic improvement. Current nursing staff were educated on the fall prevention program during two live sessions on 6/23/23 and 6/26/23. Staff that did not attend a live session were educated through a written in-service which was completed by 07/31/23. All education forms included a competency exam. Staff have been educated on the Falling Star Program (star sticker) and what the program entails - understanding that the Star is a visual reminder which signifies the following: • Assist residents off chairs/bed slowly. • Encourage residents to sit a moment before getting out of bed/chair. • Assist residents to stand and get their balance before walking. • Use gait belt for transfers as indicated on the Personal Information Worksheet •Educate Residents by encouraging them to: - lock brakes before getting in or out of their chair - use a grabber when retrieving an item from the floor - move footrests out of the way when standing up so as not to trip Every resident currently in a Broda	and annual proficiency checklists and our annual Skills Fair for all staff. . Unit Watchlist Huddles (WLH) have been implemented for residents at high risk for falls and are held on each unit daily. WLH's use a whole team approach (i.e. housekeeping, dietary, nursing, etc.), to address or prevent resident decline. They encourage and facilitate communications between staff to address various concerns. Notes from daily Watchlist Huddles are reviewed during Fall Meetings and are used to help identify appropriate interventions, gained from root cause analysis, and evaluate their effectiveness. OT, PT, ST, nursing and DON will continue to attend the monthly Fall Meetings. During Falls Meetings a deeper look at (residents with the highest number of falls) reviewing what has been done to decrease falls; where and why the resident fell; discussing and/or implementing alternative interventions such as room re-arrangement, additional	

			chair per facility policy has been evaluated by PT and changes implemented accordingly.	equipment (whether it be a different walker or w/c, anti-rollback chair, etc.) or referring the resident back to therapy as indicated. The facility utilizes the PT/OT consult staff during the facility's morning meetings, fall meetings, and specialty meetings. They provide PT/OT services to the facility, ongoing annual assessments for all residents, and consults as needed. Their role in the facility CAP is to evaluate and provide therapeutic recommendations as well as assisting with staff education and fall prevention.	
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified.	Resident #4 - staff auditing to ensure resident receives nutritional supplements per provider order. Care plan was updated 5/31/23 to include provider orders for nutritional supplements when meal consumption is less than 50%. Staff currently documenting in the MARs nutritional supplements per provider orders. Resident #5 – Diet Slip has been updated to reflect provider orders and Care Plan for regular, pureed diet with nectar consistency liquids and fortified foods/supplements. All residents with PRN orders for	Beginning 6/19/23, DON or Designee will complete weekly direct observation audits utilizing Nutrition Audit Log to ensure the following: provider orders for nutritional supplements when meal consumption is less than 50% is included in the care plan; MARs documentation verifies nutritional supplements were given per provider orders. Beginning 6/19/23, Dietary Manager or Designee will complete weekly direct observation audits to ensure diet slips include the diet list for fortified food per provider orders; that residents with a	Audits began on 6/16/23 will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings for further evaluation and to ensure compliance with 51.120(j). As of 6/13/23 direct observation verifying residents with orders for nutritional supplements are provided as ordered, included in the care plan and charted in PCC have been added to Grand Rounds Nursing; completed by nursing administration; 1 unit each week. As of 6/22/23, direct observations verifying meal tickets are used to ensure correct diet have been added to ongoing Grand Rounds Dietary to	As of 6/13/23, observations verifying residents with orders for nutritional supplements are provided as ordered, included in the care plan and charted in PCC have been added to ongoing Grand Rounds Nursing (completed by nursing administration; 1 unit each week) to ensure systemic improvement. As of 6/22/23, direct observations verifying meal tickets are used to ensure correct diet have been added to ongoing Grand Rounds Dietary to ensure systemic improvement. Dietary staff were educated,	10/31/23

	supplements were reviewed and corrected accordingly June, 2023 in compliance per 51.70(c)(5) standards and facility policy, to ensure nutritional supplements were care planned, and given with documentation of, per provider orders. Nursing Root Cause Analysis: CMAs did not review the order in full; supplements were ordered PRN with no prompt to review. Corrective action has since been implemented that includes - all supplement orders have been revised and are now scheduled which prompts staff to review the need for a supplement. Dietary Root Cause Analysis: Dietary management was using an inaccurate report (Tray Card System) to audit dietary orders including supplements and fortified foods, and any order changes, with the diet ticket. Corrective action has since been implemented that includes using the Order Listing Report from PCC system instead of the Tray Card System Report to audit dietary orders, and any order changes, with the diet ticket. (We have repeatedly audited the Order Listing Report to verify that it is accurate.)	fortified diet are served a fortified meal. A Root Cause Analysis has been completed revealing the following: - CMAs did not review the order in full - Supplements were ordered PRN with no prompt to review. Corrective action has since been implemented that includes - all supplement orders have been revised, and are now scheduled, which prompts staff to review the need for a supplement.	ensure systemic improvement. Nursing Root Cause Analysis: CMAs did not review the order in full; supplements were ordered PRN with no prompt to review. Corrective action has since been implemented that includes - all supplement orders have been revised and are now scheduled which prompts staff to review the need for a supplement. Dietary Root Cause Analysis: Dietary management was using an inaccurate report (Tray Card System) to audit dietary orders including supplements and fortified foods, and any order changes, with the diet ticket. Corrective action has since been implemented that includes using the Order Listing Report from PCC system instead of the Tray Card System Report to audit dietary orders, and any order changes, with the diet ticket. (We have repeatedly audited the Order Listing Report to verify that it is accurate.)	demonstrating competency 8/21/23 on fortifying diets and 8/10/23 on diet orders. Competencies were validated thru written testing. (Competency is also directly observed for in Dietary Grand Rounds.) Nursing staff were educated, demonstrating competency, June 2023. Competencies were validated thru written testing. Direct observation and return demonstration are performed during our CAP audits. Nutrition training is now included in our annual Skills Fair for Dietary and Nursing staff, and a part of our Nurse new hire/annual proficiency checklist.	

§ 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.	Attending staff for residents #27, #28, and #29 will be educated on proper administration of erythromycin ophthalmic ointment; and the 5 rights for medication administration. Residents with orders to receive ProSource, including orders for resident #29, have been updated to include dosage (5/18/23). Nursing staff will be educated on the 5 rights of proper medication administration.	Beginning 5/31/23, DON or Designee will complete weekly direct observation audits utilizing the Med Errors Audit Log to ensure the following: staff are observing the 5 rights for med pass (right patient, drug, dose, route and time); eye drop treatment is administered per policy; residents with orders for ProSource include dosage.	Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.120(n). As of 6/13/23, observation verifying residents with orders for eye drop treatment are administered per "Instillation of Eye Drops" policy; meds are administered observing 5 R's; have been added to ongoing Grand Rounds Nursing (completed by Nursing Administrative staff; 1 unit each week) to ensure systemic improvement.	As of 6/13/23, observation verifying residents with orders for eye drop treatment are administered per "Instillation of Eye Drops" policy; meds are administered observing 5 R's; have been added to ongoing Grand Rounds Nursing (completed by nursing administration; 1 unit each week) to ensure systemic improvement.	9/30/23
§ 51.140 (c) Menus and nutritional adequacy. Menus must— (1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition	Alternate meal menu for both lunch and dinner is now posted, and offered, on Unit 1D (the same as posted in the main dining room). Posted menu items on 1D are offered and available to 1D residents.	Beginning 6/9/23, Dietary Manager or Designee will complete weekly direct observation audits utilizing the Menus and Nutritional Adequacy Audit Log to ensure the following: posted menus on 1D include the alternate meal menu; 1D residents are offered the	Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.140 (c). As of 6/13/23, the following have	As of 6/13/23, the following have been added to Dietary Grand Rounds, (completed weekly rotating units) to ensure systemic improvement: ongoing direct observation audits verifying alternative meal menu is posted; beverages and alternative meal are offered to residents on 1D unit; residents	10/31/23

Board of the National Research Council, National Academy of Sciences; (2) Be prepared in advance; and (3) Be followed.	"Always available" menu has been retitled to "Also available" and includes information regarding nutritional values. "The Dining Experience: Staff Responsibilities" has been updated to include an initiation and revision date. Facility is currently auditing residents with orders for pureed diet to ensure they receive the same food items as regular diets (including bread and dessert). Both milk and pureed bread are being provided and audited for via CAP audits and Dietary Grand Rounds. All residents have the potential to be affected by the deficient practice.	alternative meal; residents with orders for pureed diets receive the same food items as regular diets.	been added to Dietary Grand Rounds (completed weekly, rotating units) to ensure systemic improvement: ongoing direct observation audits verifying alternative meal menu is posted and offered to residents on 1D unit and other unit residents with orders for pureed diets receive the same food items as regular diets. The systemic changes of Dietary Grand Rounds that was put in place on the 1D unit, is being utilized on the other units. By using similar audits we are able to identify and correct deficient practices with other residents receiving a pureed diet. This proposed CAP is being reviewed in QAPI. CAP audits indicate current practices are resulting in positive systemic changes. No additional training is indicated at this time but this will be guided by audit results and the results of Dietary Grand Rounds.	with orders for pureed diets receive the same food items as regular diets. Dietary staff were educated, demonstrating competency, via written test, on meeting nutritional needs of residents; posting alternate meal menus; and ensuring residents with orders for pureed diet receive the same food items as regular diets 8/21/23. These same items have been added to our annual Skills Training for Dietary staff. 1D Nursing staff will be educated Sept. 2023, demonstrating competency, to offer all items on the menu. Competencies will be validated by education and written testing. To help ensure the systematic changes made by the facility are successful the RD will also perform monthly audits and provide feedback as needed.	
§ 51.140 (d) Food. Each resident receives and the facility provides— (1) Food prepared by methods that conserve nutritive	Alternate meal menu for both lunch and dinner is now posted, and offered, on Unit 1D (the same as posted in the main dining room). "Right to Refuse a Diet" has	Beginning 6/9/23, Dietary Manager or Designee will complete weekly direct observation audits utilizing the Food Audit Log to ensure the following for 1D Unit residents: posted menus	Weekly direct observation audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure	As of 6/13/23, the following have been added to Dietary Grand Rounds, (completed weekly, rotating units): ongoing direct observation audits verifying alternative meal menu is posted and offered to residents on 1D	10/31/23

value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature; (3) Food prepared in a form designed to meet individual needs; and (4) Substitutes offered of similar nutritive value to residents.	been updated to include an initiation and revision date. "The Dining Experience: Staff Responsibilities" has been updated to include an initiation and revision date. Facility is currently auditing residents with orders for pureed diet to ensure they receive the same food items as regular diets (including bread and dessert). All residents have the potential to be affected by the deficient practice.	include the alternate meal menu; residents are offered the alternative meal; residents with orders for pureed diets receive the same food items as regular diets; food substitutes of similar nutritive value are offered; all beverage items are available to residents per the posted menu. The RD was consulted and has assisted in developing CAP processes and audits and has been instrumental in reviewing 1D residents to ensure their individual needs and preferences are met. On 10/04/23 The RD has audited the changes the facility has made and has no further recommendations at this ti**me.**	compliance with 51.140 (d). As of 6/13/23, the following have been added to Dietary Grand Rounds (completed weekly, rotating units): ongoing direct observation audits verifying alternative meal menu is posted and offered to residents on 1D and other unit residents with orders for pureed diets receive the same food items as regular diets. . The systemic changes of Dietary Grand Rounds that was put in place on the 1D unit, is being utilized on the other units. By using similar audits we are able to identify and correct deficient practices with other residents receiving a pureed diet.	unit; residents with orders for pureed diets receive the same food items as regular diets. Dietary staff were educated, demonstrating competency, on verifying residents receive and are offered food according to designated and posted menus; and receive food substitutes of similar nutritive value per their choice 8/21/23. These same items have been added to our annual Skills Training for Dietary staff. 1D Nursing staff will be educated Sept., 2023, demonstrating competency, to offer all items on the menu. Competencies will be validated by education and written testing. This proposed CAP is being reviewed in QAPI. Current audits indicate these new practices are resulting in positive systemic changes. Example: Previously, 1D residents would receive food from the main dietary selection. Dietary is now sending more special order food and food off the alternate menu to 1D residents. No additional training is indicated at this time but this will be guided by audit results, and the results of Dietary Grand Rounds. To help ensure the systematic	

				changes made by the facility are successful the RD will also perform monthly audits and provide feedback as needed.	
§ 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.	Dietary - Dietary staff will be educated on food storage, preparation, distribution and serving under sanitary conditions. "Food Storage" policy has been updated to include initiation and revision date. Salad bar - is currently being audited to ensure food temps (including holding and set-up temps) are documented; food is kept at appropriate food temp; food is stored, discarded/replaced or returned to the kitchen per policy. Kitchen - all opened and undated food, dented cans, and cans with food on the exterior have been disposed of. 1D Unit – all opened and undated food has been disposed of. Nursing - Nursing staff will be educated on food distribution and serving;	Dietary - Beginning 5/30/23, Dietary Manger or Designee will complete weekly direct observation audits utilizing the Sanitary Conditions Audit Log to ensure the following: salad bar temp log is completed; any salad bar food items found to be out of safe temp range are identified and discarded; dented food cans are discarded; opened items are properly packaged and dated; food items are used prior to expiration or use by date; food items in need of refrigeration are stored in the fridge; food items are served with tongs or clean hands (using gloves appropriately and changing out as necessary when handling food and nonfood items). Nursing - Beginning 6/20/23, DON or Designee will complete	Dietary - Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.140 (h). As of 6/13/23, Dietary Grand Rounds have been revised to include ongoing audits to ensure food is stored, prepared, distributed and served under sanitary conditions specific to food temps, food dates/labels, and food storage. Nursing - Audits will continue for three consecutive months and until a	Dietary - As of 6/13/23, Dietary Grand Rounds have been revised to include ongoing audits to ensure food is stored, prepared, distributed and served under sanitary conditions specific to food temps, food dates/labels, and food storage. Nursing - As of 6/13/23, Nursing Infection Prevention Grand Rounds have	9/30/23

	proper use of gloves when assisting residents with eating.	weekly direct observation audits utilizing the Sanitary Conditions Audit Log to ensure the following: staff avoid touching rims or inserting fingers in beverage glasses; staff deliver resident meals using meal tray with covered utensils; staff who are standing near the serving line or are helping serve are wearing a hair restraint; staff wear gloves when assisting a resident with eating unless they are using utensils.	minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.140 (h). As of 6/13/23, Nursing Infection Prevention Grand Rounds have been revised to include ongoing audits to ensure food is distributed and served under sanitary conditions.	been revised to include ongoing audits to ensure food is distributed and served under sanitary conditions.	
§ 51.180 (c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (2) The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon.	Pharmacy staff were educated on 51.180(c) regs. 5/17/23. Pharmacy staff will be educated on ODVA Pharmacy policy as it pertains to the drug regimen review (PT SOP 45). Residents #1, #2, #3, #4, and #11 have all received medication reviews 5/16/23, 5/12/23, 5/16/23 and 5/18/23 respectively.	Beginning 5/18/23, Pharmacy Manager, Administrator or Designee will complete monthly chart audits utilizing the Drug Regimen Reviews Audit Log to ensure all residents medications are reviewed at least once a month by a licensed pharmacist.	Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.180 (c). Pharmacy Manager and/or Administrator will continue to audit all residents utilizing the Drug Regimen Reviews Audit Log, with no end date, to ensure all residents medications are reviewed at least once a month by a licensed pharmacist, per 51.180(c) VA regs. Pharmacy staff were educated on both ODVA Pharmacy policy (PT SOP 45) 8/21/23 and VA regs 51.180. 5/17/23.	Pharmacy Manager and/or Administrator will continue to audit all residents utilizing the Drug Regimen Reviews Audit Log, with no end date, to ensure all residents medications are reviewed at least once a month by a licensed pharmacist per 51.180(c) VA regs.	9/30/23

§ 51.210 (f) Licensure. The facility and facility management must comply with applicable State and local licensure laws.	Resident #14 order for compounding of lidocaine cream and calmoseptine ointment was revised 5/18/23 to eliminate compounding of; meds now applied separately in compliance with 51.210(f) and Oklahoma Pharmacy Act. All residents with orders for compounding of wound creams and ointments were revised 5/17/23 and 5/18/23 to eliminate compounding of.	All residents with orders for compounding of wound creams and ointments were revised 5/17/23 and 5/18/23 to eliminate compounding of. Beginning 5/17/23 DON or Designee will complete weekly chart audits of new admits utilizing the Licensure (Compounding) Audit Log verifying there is no compounding of wound creams and ointment medications.	Pharmacy staff, Nursing Wound Team and Providers will be educated on VA regs, OK Pharmacy Act, and ODVA policy as it pertains to compounding. Audits will continue for three consecutive months and until a minimal of 100% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.210 (f).	Nursing Administrative staff and Nursing Wound Team were educated on ODVA policy, compounding, and VA regs 51.210(f), 5/17/23. Pharmacists were educated 5/17/23 and 8/21/23 on VA regs 51.210(f), ODVA Pharmacy policy, and OK Pharmacy Board rules as it pertains to compounding. Providers were educated 8/22/23 on VA regs 51.210(f), ODVA Pharmacy policy, and OK Pharmacy Board rules as it pertains to compounding. Education will be sustained via Annual Skills Fair for pharmacy, nursing and provider staff.	9/30/23 Nursing Admin. staff, Nursing Wound Team, Pharmacists and Providers have all been educated on VA regs, ODVA policy, and OK Pharmacy Board rules as it pertains to compounding.
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.	Facility is currently communicating with EOVAHCS to establish an agreement for mental health services. Those veterans who are responsible for payment for mental health services greatly prefer to receive such thru the VA and their preference is respected. This facility has requested numerous times an explanation from the VA why a sharing agreement for mental health services is not forthcoming and we have been told this is up to EOVAHCS's legal department.	Beginning 5/24/23, Administrator or Designee will complete monthly audits documenting communication efforts to secure written sharing agreements for mental health services per 51.210(h) regs. for a period of 3 consecutive months beginning May, 2023 and ending after agreements are in place for mental services with VA Muskogee and Grand Lake Mental Health. Of the facility's 242 residents,	Audits will continue for three consecutive months and until a minimal of 100% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.210 (h). To ensure the deficient practice doesn't continue, the facility's admission team will inform potential residents that the facility does not have a sharing agreement with the VA at this time. If new residents are seeking mental health services they	A Contracts Agreements log has been initiated to monitor contracts and expiration of, with no end date, to ensure compliance with 51.210(h) is sustained. Beginning on 10/16/23 the admissions team will audit all potential residents to ensure they are aware the facility does not have a sharing agreement for VA mental health services. This audit will continue for 2 consecutive months and until a	4/30/24

(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 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	On 9/11/23 this facility reached out to EOVAHCS Executive Director apprising him/her of the situation. She/he has directed a staff member to address the issue.	11 residents are receiving mental health care. Of those 11, 2 are utilizing the facility's sharing agreement with Grand Lake Mental Health and 1 is seeking treatment with a private paid provider. The 8 utilizing services with the VA have declined to change providers to the facility's sharing agreement.	will need to utilize the providers that the facility has a sharing agreement with.	minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings for further evaluation and to ensure compliance with 51.210(h). To further ensure effective communication, the Recreation Manager will follow-up with residents during the next resident council meeting, advising them of the current providers for mental health services and advise on the status of the sharing agreement with the VA for mental health services.	

representative of the veteran.					
§ 51.210 (p) (3) Quality assessment and assurance. Identified quality deficiencies are corrected within an established time period. (4) The VA Under Secretary for Health may not require disclosure of the records of such committee unless such disclosure is related to the compliance with requirements of this section.	7/5/23 all Administrators and DON trained with, and received tools from, EOVACS Chief of Quality/Safety/Value for developing a QAPI program that utilizes best practices. 6/21/23 facility Administrator requested and received from WDVA Homes Division Administrator, a guide and template of best practices for QAPI program. Currently in review. Administrator staff has revised its current QAPI program to include increased clarity and documentation of the following for all PIPs: - established time periods (implementation and outcomes) - outcomes of care areas - proof of tracking (documentation) - quality deficiencies corrected within the established time period.	Administrator or Designee will audit, beginning June 2023, QAPI program to ensure quality deficiencies are corrected within established time periods; and to ensure PIPs include the following: - specific time period for implementation; - specific anticipated time period for outcome of the care area being monitored - documentation detailing progress of each resident care area - explanation of how compliance was or was not achieved. If not achieved, was problem identified and resolved.	Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning July, 2023, for further evaluation and to ensure compliance with 51.210 (p)(3).	PIP template has been revised to include and document the following concerning quality deficiencies: - specific time period for implementation; - specific anticipated time period for outcome of the care area being monitored - documentation detailing tracking and progress of each resident care area - explanation of how compliance was or was not achieved. If not achieved, was problem identified and resolved.	9/30/23

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