State Veterans' Homes (SVH) Corrective Action Plan
Claremore Veterans Home –11/28/23 to 12/1/23

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)
§ 51.41 (c) Payments under State home care agreements. (2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a State home care agreement. Also, as a condition of receiving payments under paragraph (c), the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under this paragraph (c) includes payment for drugs and medicines). Rating: Not Met Scope and Severity - C Residents Affected – Many	Upon review of all residents this facility receives payment for care by the Department of Veterans Affairs (VA), none were found to be affected by alleged deficient practice. Of the three veterans cited during survey: <u>Dental:</u> - Residents #27 and #28 received routine dental services via Tulsa VA. We have requested copies of invoices from the VA but they have not been able to provide these. Responsible party for resident #27 stated they and their insurance, have not been charged for services. Resident #28 stated they nor their insurance have been charged for services. - Resident #29 did not receive any dental services. <u>Mental Health</u>	Beginning 12/1/23, to date, Veterans Appointments staff have reviewed all residents this facility receives payment for care by the VA and no veterans or their insurance were identified as requiring reimbursement per VA regs. 51.41(c). Beginning 1/1/24, Veteran Appointments staff or designee will audit monthly all residents this facility receives payment for care by the VA, who have received mental health and/or dental services, verifying the veteran nor their insurance was charged for services rendered this facility is responsible for, utilizing the *Audit Logs Nov 2023 For Cause Survey*, correcting any instances of noncompliance with VA regs.	Appointments, Business Office, and Administrator staff will complete education of VA regs 51.41(c) by 1/5/24. Beginning 12/1/23, Appointments staff are instructing all entities who provide services to those veterans this facility receives payment for care by the VA, that subsequent charges this facility is responsible for are to be charged to this facility and not to the veteran or their insurance. This process will be ongoing, with no end date. Beginning 1/24/24, Appointments staff are sending an *Acknowledgement of Financial Responsibility* letter with each veteran at the time of their appointment helping to ensure the veteran and their insurance will not be charged for services this facility	Survey audits will continue until a compliance rate equal to or better than 90% is sustained for a minimum of three consecutive months. Results will be presented at quarterly Quality Assurance Performance Improvement (QAPI) meetings beginning 1/17/24. Upon completion of monthly audits, facility will continue monitoring its performance utilizing the *Master Audit Log*, a tracking device to help ensure residents, and their insurance, are not charged for services this facility is responsible for.	4/30/24

	- Resident #27 did not receive any services for mental health. - Resident #28 received services thru the VA. We have requested copies of invoices from the VA but they have not been able to provide this. Resident stated they and their insurance have not been charged for services. - Resident #29 was thought to have received routine mental health services at a local clinic; however, upon further review it was discovered this resident did not attend a mental health appointment but instead was sent out for emergency placement (geriatric psychiatry services) due to behaviors including agitation, and psychosis. Beginning 1/1/24, Veteran Appointments staff or designee will audit monthly all residents this facility receives payment for care by the VA, concerning mental health and/or dental services, verifying the veteran nor their insurance was charged for services rendered this facility is responsible for, utilizing the *Audit Logs Nov 2023 For Cause Survey*, correcting any instances of noncompliance with VA regs. 51.41, and where appropriate reimbursing expense to the veteran or their insurance. Survey audits will continue until a compliance rate equal to or better than 90% is sustained for a minimum of three consecutive months.	51.41, and where appropriate reimbursing expense to the veteran or their insurance.	is responsible for. Immediately upon completion of monthly audits, Veterans Appointments staff will continue monitoring its performance, weekly, utilizing the *Master Audit Log*, a tracking device to help ensure residents, and their insurance, are not charged for services this facility is responsible for. This process will be ongoing, with no end date.		

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§ 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. Rating – Not Met Scope and Severity – F Residents Affected – Many	All residents have the potential to be affected until Oklahoma Department of Veterans Affairs (ODVA) financial plan, assuring the security of all personal funds of residents, 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 12/29/23 ODVA has not submitted requested information due to pending request to OMES for an unredacted copy of the insurance policy. Once received ODVA will submit information to the VA. 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 funds are secure per 51.70 VA regs.	Building from our Annual VA Survey 5/23/23, Administrator or Designee continues to complete monthly audits 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. Building from our Annual VA survey, 5/23/23, the Business Office Manager or Designee 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 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. Business Office Manager or Designee is	As of 5/23/23, the Administrator or Designee will continue to complete monthly audits verifying the status of our request to the VA Under Secretary of Health via ODVA State Homes Director. Efforts will continue until the security of all residets' personal funds are assured per 51.70(c)(6) VA regs. utilizing the *Audit Logs Nov 2023 For Cause Survey*. As of 5/23/23, the Business Office Manager or Designee continues to conduct monthly audits of all Patient Trust account balances, with no end date, to identify those nearing, or in excess of current crime policy limit. For residents whose balance exceeds current crime policy 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 utilizing *Audit Logs Nov 2023 For Cause Survey*.	Audit results concerning financial plan approval, and monitoring of trust accounts, will be brought to quarterly QAPI meetings beginning 1/17/24, for further evaluation and to ensure compliance per 51.70(c)(6). Audits utilizing Audit Logs Nov 2023 For Cause Survey will continue until 100% compliance is sustained for a minimum of three consecutive months until ODVA secures approval from the Under Secretary of Health. 100% compliance is defined as VA Under Secretary of Health accepting ODVA financial plan and patient trust accounts not exceeding $100,000 for a period of three consecutive months. The 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 and correcting as applicable.	12/31/24

		responsible for maintaining the Patient Trust Account Balances log.			
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51.90 (a) (1) – (4) Restraints 1) The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention. (i) Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. (ii) Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. (2) The facility management uses a system to achieve a restraint-free environment.	Resident #8 Safety Plan concerning suicidal ideation was completed with resident 11/29/23, and was care planned accordingly 11/29/23. Resident #8 was re-assessed by Physical Therapy for *Safe Operation of a Motorized Chair* 12/18/23. Resident was deemed safe to operate a motorized chair and has access to his electric wheelchair (EWC). His care plan was updated accordingly 12/28/23. The ten-day gap between completion of the EWC assessment and care plan update occurred as therapy did not alert nursing that an evaluation had been completed 12/18/23. To prevent further instances of error, the PCC module was updated 2/13/24 so that all therapy notes (which include assessments) will auto-trigger to show on the 24-Hour Report, a report nursing reviews daily. Resident #8 was moved back to their original room on 1st floor unit,1/17/24 per their request.	Beginning 11/30/23, provision of care and care plans for all residents expressing threat of suicide were reviewed: - to ensure that prior to using a possible restraint, alternatives were documented as ineffective - to identify instances where a restraint was used inappropriately, with correction in accordance per facility policy and VA 51.90 regs. Zero use of restraints were found during the review. ALL residents were reviewed for use of a physical restraint 1/23/24 thru 1-29-24 by therapy department. Two instances of physical restraints were identified and removed. All residents will be reviewed for use of a chemical restraint beginning 2/12/24 and will be completed by 4/12/24.	Beginning 3/15/24, random, weekly direct observation and/or chart audits, with a minimum of five each week, will be completed to ensure any treatment, medications, or interventions do not act as a physical or chemical restraint to the resident. Audits will continue for three consecutive months with results presented at QAPI meetings until 100% compliance is achieved and meeting VA 51.90 regs. and per ODVA Nursing SOP-Restraint policy. Beginning 11/30/23, the Director of Nursing (DON) or designee will audit weekly all residents expressing threat of suicide utilizing the *Audit Logs Nov 2023 For Cause Survey*, to ensure the following: - that prior to using a restraint, alternatives were documented as ineffective - to identify where a restraint was used inappropriately, with correction per 51.90(a)(1) VA regs and facility policy, ODVA Nursing Standard Operating Procedures (SOP)-Restraints. Audits will	Audits will continue until a compliance rate equal to or better than 100% is sustained for a minimum of three consecutive months. Results will be presented at quarterly QAPI meetings beginning 1/17/24. Beginning 1/24/24, ALL residents on the 24-Hour report will be reviewed during daily morning meeting, to identify use of a possible restraint, both chemical and physical, correcting any instance of accordingly, documented using the Daily AM Meeting form. This is an ongoing process, with no end date.	4/30/24

(3) The facility management collects data about the use of restraints. (4) When alternatives to the use of restraint are ineffective, a restraint must be safely and appropriately used. Rating – Not Met Scope and Severity – G Residents Affected – Few			continue until a compliance rate equal to or better than 100% is sustained for a minimum of three consecutive months. Results will be presented at quarterly QAPI meetings beginning 1/17/24. Beginning 1/24/24, ALL residents on the 24-Hour report will be reviewed during daily morning meeting, to identify use of a possible restraint both chemical and physical, correcting any instance of accordingly, documented using the Daily AM Meeting form. This is an ongoing process, with no end date. Beginning 1/23/24, Nursing leadership, Administrators, Social Services staff, Providers and Therapy staff will be educated, demonstrating competency via written test on 51.90 VA regs and ODVA Nursing SOP-Restraint policy, to be completed by 1/31/24. Topic and purpose of education addressed resident rights concerning use of a restraint, recognizing what a physical and chemical restraint is and using the least restrictive option. Annual education on Restraints, with demonstration of competency/understanding via written test will be held during our Annual Skills Fair for all staff beginning February 8-12, 2024. Topic and purpose of education addressed resident rights concerning use of a restraint,		

			recognizing what a physical and chemical restraint is and using the least restrictive option Nursing New Hire Checklist was revised 1/22/24, to include education on ODVA policy: Nursing SOP, Restraints. Nursing Annual Proficiency Checklist was revised 1/22/24 to include education of ODVA policy: Nursing SOP, Restraints. Beginning 1/24/24, Nursing Grand Rounds Audits were revised to include direct observation for the presence of physical restraints and order review for potential restraints. Nursing Grand Rounds are conducted weekly, and are an ongoing process, with no end date. A Root Cause Analysis was completed 11/29/23. Deficient practice concerning restraints occurred due to a lack of education (what constitutes a restraint) and communication (nursing receiving timely information concerning therapy assessments) for both nursing and therapy staff. Deficient practices have both been addressed via staff competencies, annual educations, audits, and an update to PCC software so all therapy notes, including assessments, will auto-trigger to show on the 24-Hour Report, a report nursing reviews daily. Beginning 11/30/23, Assistant		

			Administrator or Designee will monthly, provide additional oversight of audits- validating audits are being conducted as outlined, with all appropriate actions and interventions implemented as needed utilizing the *Audit Logs Nov 2023 For Cause Survey* to ensure: 1. audits are being managed effectively. 2. adverse trends/patterns, and/or adverse process/system failures are identified. 3. corrective measures, where indicated, are implemented based on results of use of the "Just Culture Decision Tree" and "Just Culture Decision Support Tool".		
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)
§ 51.90 (c) (3) Staff treatment of residents. The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. Rating – Not Met Scope and Severity – G Residents Affected – Few	Staff involved with care of resident #18 were immediately educated on ODVA policy regarding reporting and investigating injuries of unknown origin 11/30/23. A skin assessment with treatment was completed for resident #18, 11/29/23.	A one-month look-back audit was completed for the month of November, 2023, utilizing key words such as "bruise, purple, and skin tear" to identify any instances where an incident report and investigation should have been completed for an injury of unknown origin. One incident was identified in progress note 11/29/23 for Resident #30. Incident investigated 12/13/23 and report completed 12/15/23; nursing staff involved in incident were educated. The look back	Beginning 1/23/24, the DON or designee will audit from the 24-Hour Report, during morning meetings, addressing issues the same day, utilizing key words such as "bruise, purple, and skin tear" to identify instances where an incident report should be completed utilizing the *Audit Logs Nov 2023 For Cause* Survey for instances of injury. An Incident Report and investigation will be completed as needed for those missing as to prevent further potential abuse/neglect. Audits will be	Audits will continue, until a compliance rate equal to or better than 90% is sustained for a minimum of three consecutive months (or ongoing if required). Results will be presented at quarterly QAPI meetings, beginning 1/17/24. Immediately upon completion of current audit (*Audit Logs Nov 2023 For Cause* Survey, Wound team Nursing staff, via weekly skin assessments for potential injuries of unknown origin, will continue to randomly review patient charts for key words such as "bruise, purple, and	5/30/24

		audit is included on *Audit Logs Nov 2023 For Cause Survey*.	completed a minimum of twice weekly. Beginning 12/4/23, the DON or designee will complete a random, weekly chart audit utilizing key words such as “bruise, purple, and skin tear” to identify instances where an incident report and investigation should have been completed utilizing the *Audit Logs Nov 2023 For Cause* Survey for instances of injury of unknown origin. An Incident Report, investigation, and on-time staff education will be completed for those missing to prevent further potential abuse. All nursing Staff will be educated, demonstrating competency via written test, on VA 51.90 regs and ODVA Nursing SOP for reporting and investigating injuries of unknown origin starting 12/5/23. Knowledge of VA and ODVA regs., with supporting education will help staff Additional education will be provided at facility’s Annual Skills Fair, with demonstration of competency via written test, concerning reporting/investigating an injury of unknown origin, February 8-12, 2024. Beginning 12/1/23 Administrator or Designee will review all Injury of Unknown Cause type incidents in PointClickCare (PCC) facility’s healthcare software, to identify and	skin tear” to ensure all findings have been acted upon per 51.90(c)(3) VA regs., with correction as indicated utilizing audit log Staff Treatment of Residents (Injury of Unknown Cause). This is an ongoing process with no end date.	

			address those warranting investigation, complete with Administrator Note, with subsequent reporting as required per VA, State and Federal law. Any issues noted will be addressed immediately with on-time education conducted as needed. Nursing Annual Proficiency Checklist was revised 1/22/24 to include education on ODVA Nursing SOP for reporting and investigating injuries. Nursing New Hire Checklist was revised 1/22/24, to include education on ODVA Nursing SOP for reporting and investigating injuries.		
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§51.100 (h) (1) Social Services (1) The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident; Rating – Not Met Scope and Severity – G Residents Affected – Few	A Mood Assessment was completed 11/29/2023, 6:30pm for Resident #8. Based on results of that mood assessment, current risk level, and hospital discharge plan (11/7/23), facility developed and completed a Safety Plan 11/29/23, 8:40pm, that included line of sight supervision, completion of PHQ2-9 (mood assessment), provision of additional mental health resources (988 VA Crisis hotline	A review to ensure all residents with mental health/psychosocial concerns such as suicidal ideation, signs/symptoms of depression, maladjustment to long term care, etc., obtain medically related social services, i.e safety plan, interventions, etc., was conducted beginning 11/29/23 via PCC Mood Assessment (MDS3.), PHQ9-V2 Report and PCC Progress Notes. Through	As of 11/29/23, all residents with mental health/psychosocial concerns such as suicidal ideation, signs/symptoms of depression, indicators of maladjustment to long term care such as social withdrawal, new onset or sudden increase in behaviors, etc. are being monitored and reviewed during daily AM meeting, to ensure the resident receives appropriate treatment and services, in alignment with this facility's Suicide	Audit results will be brought to QAPI meeting beginning 1/17/24, and will continue until 100% compliance has been reached for 3 consecutive months. As of 11/29/23, all instances of suicidal ideation, signs/symptoms of depression, indicators of maladjustment to long term care such as social withdrawal, new onset or sudden increase in behaviors etc., are being monitored and reviewed via	6/30/24

	and list of local mental health providers) and care planned. Coping strategies were identified 11/30/23 to help manage resident depression and were initiated 11/30/23. All parts of this Safety Plan were completed and implemented. Safety plan was communicated to staff via Kardex and the Patient Information Worksheet and the 24-Hour Shift Report. As part of Resident #8's Safety Plan, resident's previous social worker was reassigned per resident request and preference. Resident was notified of this change 11/29/23 at 8:00pm and a meeting with resident and social worker was set for 12/1/23 of which both attended. Purpose was to confirm reassignment of SW with resident and to discuss Safety Plan. To date, resident continues with current Social Worker per their preference. Social Worker met with resident 12/1/23 to review Safety Plan, and assist with consult for mental health services. A mental health tele-visit was scheduled for 12/5/24 and resident attended. On 12/29/23 resident declined to attend same day mental health appointment stating it was not necessary at that time. To date, Social Services staff and interdisciplinary team continue to assist resident with mental health and psychosocial needs, and additionally encourage	this process two additional veterans were identified (#31 and #32). Safety Plans and interventions were created and care planned 11/29/23. Residents were placed on IDT Watchlist Huddle. IDT team assessed residents; interventions were implemented; meds were reviewed and adjusted by the provider. Beginning 11/30/23, the Social Services (SS) Manager or designee will complete weekly direct observation and chart audits, utilizing the *Audit Logs Nov 2023 For Cause* log to ensure all recently admitted residents, residents with mental health/psychosocial concerns such as loss of a loved one, suicidal ideation, signs/symptoms of depression, maladjustment to long term care, etc., and new admissions, receive appropriate care and treatment, medically related social services, i.e. assessments, safety plan, interventions, per facility's suicide protocol and VA regs 51.120. Audits will continue until 100% compliance is met for 3 consecutive months. Beginning 11/30/23, Assistant Administrator or Designee will monthly, provide additional oversight of audits- validating audits are being conducted as	Protocol as needed, and per VA 51.120 regs. This process will be ongoing, with no end date. All Social Services staff were educated on facility's <u>new</u> CVC Suicide Protocol 12/12/23 and 12/11/23, which also includes use of the Safety Template and Columbia Suicide Severity Rating Scale (C-SSRS) demonstrating competency via written test. This will be an annual training required of all SS staff, with no end date. New suicide protocol was also added to ODVA Relias training 12/11/23 and is now required for all staff to complete with written competency. New protocol will be assessed for effectiveness by Administrators via GAP Analysis beginning February 2024. Education on new facility suicide protocol (CVC Suicide Protocol), with competency via written test, will be held during our Annual Skills Fair for Social Services staff beginning February 8-12, 2024. Nursing leadership, Administrators, and Social Services (SS) staff completed a two-hour training 2/15/24 led by the EOVACHS SS team on use of the Columbia Suicide Severity Rating Scale Screener (C-SSRS) and use of Safety Plan template. Weekly training continues. C-SSRS ID badges will be issued to all Nursing Managers, House Supervisors, and Social Services	daily AM meeting, utilizing the 24-Hour Report, with follow up by SS to ensure resident receives appropriate treatment and services, in alignment with this facility's Suicide Protocol, as needed, and per VA 51.120 regs. Reviews will be documented beginning 1/24/24 using the Daily AM Meeting form. This process will be ongoing, with no end date. Any relevant issues will be brought to QAPI meetings and addressed as needed.	

	participation in onsite therapy. As of January, 2024, resident continues to work with therapy on a regular basis. Efforts continue to ensure resident #8 receives appropriate mental health and psychosocial services. A review of all residents with psychosocial/mental health concerns was conducted on 11/29/23 via PCC Mood Assessment (MDS3.) PHQ9-V2 Report and PCC Progress Notes. Through this process two additional veterans were identified (#31 and #32). Interventions and Safety Plans were implemented and care planned 11/29/23. Residents were placed on IDT Watchlist Huddle. IDT team assessed residents; interventions were implemented.	outlined, with all appropriate actions and interventions implemented as needed utilizing the *Audit Logs Nov 2023 For Cause Survey* to ensure: 1. audits are being managed effectively. 2. adverse trends/patterns, and/or adverse process/system failures are identified. 3. corrective measures, where indicated, are implemented based on results of use of the "Just Culture Decision Tree" and "Just Culture Decision Support Tool". Beginning February 2024 question #6 from the Columbia-Suicide Severity Rating Scale (C-SSRS) will be added to SS new admissions form to assess resident's history of suicidal ideation, to assist in identifying those who might be at a higher risk for in the future and discuss any necessary additional mental health services.	staff by March, 2024 (ID badge is a quick reference tool for staff to use in the event a resident expresses suicidal ideation). A Root Cause Analysis was completed 11/29/23. Deficient practice concerning Social Services failing to seek/obtain/provide further ongoing services that address mental health/psychosocial concerns such as suicidal ideation, signs/symptoms of depression, maladjustment to long term care, etc., occurred due to inadequate facility policy that lacked guidance (Nursing Services Policy and Procedures Manual-Suicide Threats) and communications breakdown by Social Services staff (staff failed to follow-up with IDT team and resident to ensure needed psychosocial/mental health services were provided). Deficient practices have been addressed via staff competencies, annual educations, audits, and review at daily Morning meeting. As of 3/12/24, all residents are re-assessed using the PHQ2-9 Mood Assessment, completing within the first 4 weeks after an event, and or as needed, and thereafter quarterly to help monitor and avoid recurrence of mental health and/or psychosocial concerns including, but not limited to depression, suicidal ideation, maladjustment to long term care, functional decline, etc.		

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§ 51.110 (c) Accuracy of assessments. (1) Coordination— (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. (2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Rating – Not Met Scope and Severity – D Residents Affected – Few	Resident #6 Care Plan was updated 12/29/23 to reflect desired weight loss. Dietician was notified 12/28/23 to review resident's plan for desired weight loss. Facility is currently auditing MDS for capturing weights accurately via *Audit Logs Nov 2023 For Cause Survey*. Residents #18 and #19 CAAs (care area assessments) were modified to contain relevant documentation describing causes and contributing factors, including fractures related to falls 12/28/23.	The 2023 Incident Report log was reviewed by MDS for major injuries, with a 90-day lookback period (Sept. Oct., Nov 2023). No major injuries were found needing to be claimed in the MDS. Beginning 11/30/23, the DON or designee will complete a weekly chart audit of 5 residents utilizing the *Audit Logs Nov 2023 For Cause* log to identify instances of Minimum Data Set (MDS) documentation errors concerning weight loss/gain, and falls with major injury, correcting MDS assessments as needed. Audits will continue until 90% compliance is met for 3 consecutive months. The *Audit Logs Nov 2023 For Cause* log was revised12/28/23 to include monitoring for falls CAA. A MDS review that included <u>ALL</u> sections was completed 2/12/24 for a random sample of 10 residents utilizing the MDS Monitoring tool. No errors were	Nursing MDS staff was educated, demonstrating competency, on VA regs. 51.110, Claremore Veterans Center MDS and IDCP policy, and RAI manual, of which included the following: - Section K, weights are accurately claimed - Section V:11, CAA contains fractures related to falls - Section J, Coding MDS instrument is accurate for falls and falls with major injury. Competencies demonstrating staff knowledge of VA regs, ODVA policy, concerning how to conduct an accurate MDS Assessment were validated via written test. Immediately upon successful completion of weekly chart audits (90% compliance met for 3 consecutive months), facility will begin monthly random chart audits of 5 residents, to be completed by the MDS supervisor, verifying weights, falls, and falls with major injury are accurately claimed and that the CAA contains fractures related to falls utilizing MDS section K0300, K0310, J1800, J1900, and V11 Falls CAA Audit Logs. Issues discovered during	Audit results will be brought to QAPI meeting beginning 1/17/24 and will continue until 90% compliance has been reached for 3 consecutive months. Immediately upon successful completion of weekly chart audits (90% compliance met for 3 consecutive months), facility will begin monthly random chart audits, to be completed by the MDS supervisor, verifying weights are accurately claimed and that the CAA contains fractures related to falls utilizing MDS section J, K and V11 Falls CAA Audit Logs. This will be an ongoing process with no end date.	4/30/24

		identified. Beginning 11/30/23, Assistant Administrator or Designee will monthly, provide additional oversight of audits- validating audits are being conducted as outlined, with all appropriate actions and interventions implemented as needed utilizing the *Audit Logs Nov 2023 For Cause Survey* to ensure: 1. audits are being managed effectively. 2. adverse trends/patterns, and/or adverse process/system failures are identified. 3. corrective measures, where indicated, are implemented based on results of use of the "Just Culture Decision Tree" and "Just Culture Decision Support Tool".	audits will be brought to QAPI meetings as needed. A Root Cause Analysis was completed 11/29/24. Deficient practice regarding accuracy of assessments occurred due to a lack of education on RAI sections J, K and V:11 Fall CAA for MDS nursing staff. Deficient practices are currently being addressed via staff competencies, annual educations, and ongoing audits.		
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§ 51.120 (g) Mental and Psychosocial functioning Based on the comprehensive assessment of a resident, the facility management must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate	On 11/29/23, the following corrective actions were completed for Resident #8- • To ensure resident safety, line of sight supervision was started 8:00pm, 11/29/23, and continued until resident met with a mental health provider.	A review of all residents with mental health and/or psychosocial concerns, including, but not limited to, signs/symptoms of depression including loss of a loved one, suicidal ideation, maladjustment to long term care, etc., new admissions, and functional decline, was conducted	As of 12/6/23, all residents are re-assessed using the PHQ2-9 Mood Assessment, completing within the first 4 weeks after an event, and or as needed, and thereafter quarterly to help avoid recurrence of mental health and/or psychosocial concerns including, but not limited to depression, suicidal ideation, maladjustment to long term care,	Audit results will be brought to QAPI meeting beginning 1/17/24 and will continue until 100% compliance has been reached for 3 consecutive months in accordance with VA 51.120 reg. and facility Suicide Protocol. Any relevant issues discovered during daily AM meetings will be brought to QAPI meetings and addressed as	4/30/24

treatment and services to correct the assessed problem. Rating – Not Met Scope and Severity – J Residents Affected – Few	• PHQ2-9 (mood assessment) was completed 6:30pm, 11/29/23, to assess current risk level with results of mild depression (8.0). • Based on the results of the mood assessment, the facility developed a safety plan based on discharge plan and current risk level 11/29/23, 8:40pm. • Care plan was updated to include safety plan. Safety plan was communicated to staff via Kardex and the Patient Information Worksheet, and 24-hour shift report. • Upon completion of Electric Wheelchair evaluation, EWC was returned to resident 12/1/23. • The facility monitored resident via line of site supervision starting 8pm 11/29/23, based on his mood assessment 11/29/23, and upcoming psyche evaluation 12/1/23. • The facility will conduct a refresher in-service for 2B direct care staff on recognition of signs and symptoms with response appropriate to mental health concerns. This will be started 11/29/23 and completed by 12/6/23. • Facility reached out on 11/30/23 to contracted Mental Health providers for	11/29/23 via PCC Mood Assessment (MDS3.), PHQ9-V2 Report, and PCC Progress Notes. Through this process two additional veterans were identified. Interventions and Safety Plans were implemented, and care planned 11/29/23. IDT team assessed residents and interventions were implemented. Additionally, residents were placed on IDT Watchlist Huddle (WLH). Residents from the 24Hour Report, Incident Report, or who triggered for Quality Measures predominantly determine which residents are placed on WLH's. WLH's are daily huddles that provide opportunity for staff to discuss those residents using a whole team approach for quality improvement intended to result in timely, concrete action steps to prevent or decrease resident decline. Beginning 11/30/23, the DON or designee will complete weekly direct observation and chart audits, utilizing the *Audit Logs Nov 2023 For Cause* log for mental health and/or psychosocial concerns, including, but not limited to, signs/symptoms of depression including loss of a loved one, suicidal ideation, maladjustment to long term care, etc., new admissions, and functional decline, verifying the resident	functional decline, etc. <u>All</u> residents, regardless of mental health status/events are assessed regularly using the PHQ2-9 Mood Assessment, quarterly and as needed. As of 11/29/23, all reports of mental health and/or psychosocial concerns, including, but not limited to, difficulty adjusting to LTC, functional decline, signs/symptoms of depression or suicidal threat are being reviewed during daily AM meeting, to ensure residents receive appropriate treatment and services, and in alignment with this facility's new Suicide Protocol, as needed, and per VA 51.120 regs. Reviews will be documented using the Daily AM Meeting form. This process will be ongoing, with no end date. All staff are being educated annually, and as needed, demonstrating competency via written test, beginning 12/11/23, via ODVA Relias training platform, on new facility Suicide Protocol. Education addressed who was responsible for reporting threat of suicide, how it was to be addressed, how the Safety Plan should be used before and during crisis. All Social Services, Administrators, and APRNs will receive annual training on facility new Suicide Protocol, demonstrating	needed.	

	appointment quicker than current appointment scheduled on 12/1/23. • Coping strategies were identified to manage resident depression symptoms; completed by nursing and social worker, beginning 11/30/23. • Previous social worker was reassigned to resident and meeting was set for 12/1/23, notifying resident of change 11/29/23 at 8:00pm. • Resident #8 was included on watchlist huddles for mood behavior changes beginning 11/29/23, by 9pm. This will be ongoing with weekly reevaluation by IDT. • 988 Suicide & Crisis Lifeline contact information was provided to Resident #8, 11/29/23 at 8:10 pm. Efforts continue to ensure resident #8 receives appropriate mental health and psychosocial services. On 12/1/23 resident's mental health needs were assessed by a mental health nurse, and an appointment was scheduled 12/5/23 which resident attended. On 12/29/23 resident declined to attend same day mental health appointment stating it was not necessary at that time. Resident will be assessed on a weekly basis for potential s being assessed every 2 weeks(how	received appropriate care, supervision, and treatment per facility's suicide protocol and VA regs 51.120. Audits will continue until 100% compliance is met for 3 consecutive months. Thereafter, monthly audits will be performed to validate continued compliance. The number of records reviewed will be 10% of said population or 100% if less than 30. The expected benchmark will be 98%. Beginning 11/30/23, Assistant Administrator or Designee will monthly, provide additional oversight of audits- validating audits are being conducted as outlined, with all appropriate actions and interventions implemented as needed utilizing the *Audit Logs Nov 2023 For Cause Survey* ensure: 1. audits are being managed effectively. 2. adverse trends/patterns, and/or adverse process/system failures are identified. 3. corrective measures, where indicated, are implemented based on results of use of the "Just Culture Decision Tree" and "Just Culture Decision Support Tool".	competency via written test, during our Annual Skills Fair, February 8-12, 2024. Nursing leadership, Admin., and Social Services (SS) staff completed a two-hour training 2/15/24 by the EOVACHS SS team on use of the Columbia Suicide Severity Rating Scale Screener (C-SSRS) and use of Safety Plan template. Weekly education by EOVACHS SS team continues. C-SSRS ID badges will be issued to all Nursing Managers, House Supervisors, and SS staff by March, 2024 (ID badge is a quick reference tool for staff to use in the event a resident expresses suicidal ideation). A Root Cause Analysis was completed 11/30/23. Deficient practice concerning residents receiving appropriate mental health services occurred due to staff lack of knowledge and failed communications. Deficiencies are currently being addressed via staff competencies (verification of knowledge of protocol), annual educations, ongoing audits (verification of staff adhering to facility protocol), and daily review of the 24 Hours Report (verification of communications between IDT members, and verification mental health services were provided as indicated).		

	often) for 8 weeks, thereafter monthly, returning to quarterly To date, interdisciplinary team continues to assist resident with mental health and psychosocial needs, and additionally encourages participation in onsite therapy. As of January, 2024 resident continues to work with therapy on a regular basis. Efforts continue to ensure resident #8 receives appropriate mental health and psychosocial services. As of 12/6/23, resident #8 is being re re-assessed using the PHQ2-9 Mood Assessment, completing within the first 4 weeks after an event, and or as needed, and thereafter quarterly to help avoid recurrence of mental health and/or psychosocial concerns including, but not limited to, difficulty adjusting to LTC, functional decline, suicidal ideation, depression, etc. As with all other residents, resident #8, regardless of mental health status/events is being assessed regularly using the PHQ2-9 Mood Assessment, quarterly and as needed.				

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)
§ 51.140 (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 Board of the National Research Council, National Academy of Sciences; (2) Be prepared in advance; and (3) Be followed. Rating – Not Met Scope and Severity – E Residents Affected – Some	All residents have the potential to be affected by the deficient practice. During Nov. 2023 VA For Cause Survey, pureed bread for 1D residents was placed high on the food cart. Because it was out of line-of-sight, staff failed to provide pureed bread to 1D residents. Building from our last survey, facility implemented a new process change, in which staff will utilize the Menu Item Checkoff Log form to further ensure all food items for the meal they are serving are present for service. This form will be used on ALL units beginning 2/9/24. Beginning 2/12/24, and improving from our 2023 Annual Survey CAP, audits have been expanded to include residents on ALL units, to identify those who may have been impacted by this deficient practice.	Beginning 12/13/23, Dietary Manager or Designee will conduct direct observation audits, completing a minimum of five each week, utilizing the *Audit Logs Nov 2023 For Cause Survey.* to ensure the following: - 1D residents with orders for pureed, minced/moist, and/or soft/bite sized diets receive the same food items as regular diets including bread. Beginning 2/12/24 Dietary Manager of Designee will also conduct direct observation audits of ALL units, completing a minimum of five each week, utilizing the *Audit Logs Nov 2023 For Cause Survey* to ensure the following: - residents with orders for pureed, minced/moist, and/or soft/bite sized diets receive the same food items as regular diets including bread. Staff are completing the Menu Item Checkoff Log to ensure all menu items are available for service. This is an ongoing process with no end date. Beginning 1/8/24 Dietary Manager of Designee will complete weekly direct observation audits to ensure	Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning 1/17/24, for further evaluation and to ensure compliance with 51.140 (c). As of 12/13/23, the following audits have been added to our Dietary Grand Rounds. This process has no end date: - verifying residents with orders for pureed, minced/moist, and/or soft/bite sized diets receive the same food items as regular diets - proper serving tools are being used - the Menu Item Checkoff Log is being completed - menu extensions are available to the cooks. Dietary staff will be re-educated, demonstrating competency via written test by 1/5/24 on using proper measuring tools to ensure residents receive proper portions; correctly using the Menu Item Checkoff Log; and ensuring cooks are provided with the menu extensions for the meals they are preparing. Both Dietary and all Nursing staff received training concerning proper	Audits will continue, for three consecutive months, with results presented at quarterly QAPI meetings, beginning 1/17/24 until 90% compliance is met per VA 51.140 regs. As of 12/13/23, and improving from our 2023 Annual Survey CAP, the following have been added to Dietary Grand Rounds (an ongoing log with no end date, is completed rotationally weekly for all units) to ensure systemic improvement: - direct observation audits verifying residents with orders for pureed diets are actually served those food items per the *Menu Item Checkoff Log.* - direct observation audits verifying proper measuring tools are used during service. - direct observation that menu extensions are available for the meal being prepared.	5/30/24

		the following: - menu extensions are provided to the cooks for the meal they are preparing - potatoes are served using proper measuring tools for pureed diets Beginning 12/13/23, Assistant Admin. or Designee will complete direct observations each month to ensure all residents receive food according to the written menus utilizing the *Audit Logs Nov 2023 For Cause Survey*. Beginning 11/30/23, Assistant Administrator or Designee will monthly, provide additional oversight of audits- validating audits are being conducted as outlined, with all appropriate actions and interventions implemented as needed utilizing the *Audit Logs Nov 2023 For Cause Survey* to ensure: 1. audits are being managed effectively. 2. adverse trends/patterns, and/or adverse process/system failures are identified. 3. corrective measures, where indicated, are implemented based on results of use of the "Just Culture Decision Tree" and "Just Culture Decision Support Tool".	procedures for residents with pureed, minced/moist, and/or soft/bite sized diets and their receiving the same food items as regular diets during our Annual Skills Fair, February 8-12, 2024. This is an annual training with no end date. Additionally, beginning 1/9/24, Assistant Admin. or Designee will complete a minimum of five random direct observations each month to ensure residents receive food according to the written menus and/or food on the salad bar in the Dining Room is kept at appropriate temperatures (temp) utilizing the *Audit Logs Nov 2023 For Cause Survey*, continuing for a period of 3 months. Audit results presented at QAPI beginning 1/17/24. Staff are completing the Menu Item Checkoff Log to ensure all menu items are available for service. This is an ongoing process with no end date. Nursing staff will receive annual training, demonstrating competency, concerning residents with orders for pureed, minced/moist, and/or soft/bite sized diets, and their receiving the same food items as regular diets during our Annual Skills Fair February 8-12, 2024. A Root Cause Analysis was completed 12/14/23. Deficient practice concerning		

			residents not receiving bread as listed on the menu (puree) on the 1D unit occurred due to staff error and lack of knowledge and skills. Deficiencies are currently being addressed via staff educations and competencies, annual educations, ongoing audits, direct observations by Assistant Administrator, Dietary Grand Rounds, and Menu Item Checkoff Log, and consultations and observations from the Dietician.		
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)
§ 51.140 (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. Rating-Not Met Scope and Severity – E Residents Affected – Some	Building from our last survey, facility has revised current temperature log to include supervisory approval signature indicating that all food items were served at the correct temp. The salad bar in the Dining Room was immediately closed 11/29/23 upon discovery of the deficiency, with all food items removed at the time; salad bar was put back into service with appropriately temped food items the same day. All dietary staff were re-educated 12/12/23 on food serving under sanitary conditions, and action to be taken when food is not kept at the correct temperature. Salad bar - is currently being	Dietician was consulted, provided feedback and helped develop the new salad bar process and audits, 12/6/23 to ensure process improvements. New process will be assessed for effectiveness by Administrators via GAP Analysis beginning February 2024. Beginning 12/13/23, Dietary Manager or Designee will complete weekly, a minimum of five direct observation audits, utilizing the *Audit Logs Nov 2023 For Cause Survey* to ensure the following: the salad bar temp log is completed; any salad bar food items found to be out of safe temp range are	Dietary staff will be re-educated on food serving under sanitary conditions, and action to be taken when food is not kept at the correct temperature, demonstrating competency by 1/5/24. Content of education and competencies will be reviewed by Administration, Dietary Manager, and Dietician, and revised dependent upon results of Dietary Grand Rounds audits, and annual Skills Fair competencies, to ensure effectiveness of education. Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning 1/17/24 for further evaluation and to ensure compliance with 51.140 (h).	Audits will continue for three consecutive months and until a minimal of 90% compliance is achieved with results presented at quarterly QAPI meetings, beginning 1/17/24 for further evaluation and to ensure compliance with 51.140 (h). As of 12/13/23, Dietary Grand Rounds have been revised to include ongoing audits to ensure food is served under sanitary conditions specific to food temps, with staff educated accordingly. This is an ongoing process with no end date. Ongoing results will be reviewed with Dietician with recommendations implemented accordingly. The Dietician is also increasing her time at the building and will be spending more hands-on time auditing and training staff.	5/30/24

	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. Additionally, the Dietary Shift Supervisor will confirm food temperatures are appropriate prior to food being served per VA 51.140 regs. .	identified and discarded and the <u>new salad bar process</u> is being followed. Beginning 2/14/24 audit results will be shared with Dietician, to gain and implement guidance/feedback accordingly. <u>These audits will be revised 2/26/24, increasing the minimum number of audits to ten weekly.</u> Beginning 12/13/23, Assistant Admin or Designee will complete two direct observations each week to ensure food is distributed and served under sanitary conditions utilizing the *Audit Logs Nov 2023 For Cause Survey*. Beginning 11/30/23, Assistant Administrator or Designee will monthly, provide additional oversight of audits- validating audits are being conducted as outlined, with all appropriate actions and interventions implemented as needed utilizing the *Audit Logs Nov 2023 For Cause Survey* to ensure: 1. audits are being managed effectively. 2. adverse trends/patterns, and/or adverse process/system failures are identified. 3. corrective measures, where indicated, are implemented based on results of use of the "Just Culture Decision Tree" and "Just Culture Decision	As of 12/13/23, Dietary Grand Rounds have been revised to include ongoing audits to ensure food is served under sanitary conditions specific to food temps, and the new salad bar process is being followed, with staff educated accordingly. This is an ongoing process with no end date. New salad bar processes include a change to smaller pan size, preparing one salad bar item at a time, adding ice to the salad bar cooler, and ensuring the pans are cold prior to placement on the salad bar. A Root Cause Analysis was completed 12/14/23. The deficient practice of ensuring food was distributed and served under sanitary conditions occurred due to staff error, lack of communication with supervisor and lack of skills and knowledge. Deficiencies are currently being addressed via a new salad bar process, a new temperature log that includes a supervisor to check the salad bar prior to service, staff educations and competencies, annual educations, ongoing audits, direct observations by Assistant Administrator, Dietary Grand Rounds, and consultations and observations from the Dietician.	Dietary staff received additional, annual training concerning salad bar food temps, during our Annual Skills Fair, February 8-12, 2024.	

		Support Tool".			
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)
§ 51.210 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. Rating – Not Met Scope and Severity – J Residents Affected – Few	A GAP analysis which includes an Action Plan that is specific, measurable, achievable, relevant and timebound (SMART format) will be performed to identify contributing factors allowing operations and management system deficiencies. Date of completion will be March 18, 2024. Administrators are responsible for completing GAP analyses. <u>Assurance of Financial Security</u> - All residents have the potential to be affected by the deficient practice until ODVA financial plan, assuring the security of all personal funds of residents, is approved by the VA Under Secretary of Health. <u>Restraints</u> – Resident # 8 was identified during survey. <u>Social Services</u> – Resident #8 resident was identified survey. <u>Accuracy of Assessments</u> – Residents #6, #18, and #19 were identified during survey.	All residents, operations and management systems had the potential to be impacted by system deficiencies. Operations and management system deficiencies that are identified thru the GAP analysis will be corrected as per the Gap Analysis Performance Improvement Plan (PIP). Date of completion by April 18, 2024 and to be discussed in next scheduled QAPI meeting April, 2024.	Beginning April 19, 2024, Administrator and Assistant Administrators will meet weekly to review progress of PIP implementation. In addition, implementation of the "Just Culture Decision Tree" and "Just Culture Decision Support Tool" will be utilized to help sustain system improvement. This new process is part of our shift to an outcomes-based and ongoing learning culture, helping to provide additional oversight of facility processes and systems. This new process beginning January, 2024, will be ongoing, with no end date. Just Culture monthly meetings will consist of reviewing the 8 deficiencies cited from 51.210 findings; any systems identified from the GAP analysis; data from *Audit Logs Nov 2023 For Cause Survey*, to ensure: 1. audits are being managed effectively. 2. adverse trends/patterns, and/or adverse process/system failures are identified. 3. corrective measures, where indicated, are implemented based	Administrator will present audit findings from GAP analysis and "Just Culture" meetings at QAPI, starting April, 2024. Data to be reviewed, with resulting action plans and remedies implemented to prevent further recurrence of deficient practices in alliance with facility QAPI protocol. Thereafter, monthly audits from "Just Culture" meetings will be performed to validate continued compliance for six (6) months.	10/31/24

	Mental and Psychosocial Functioning – Resident #8 was identified during survey. Residents #31 and #32 were identified thru facility's internal audit. Menus and Nutritional Adequacy – All residents have the potential to be affected by the deficient practice until the facility ensures all residents receive food according to the written menus. Sanitary Conditions – All residents have the potential to be affected by the deficient practice until facility ensures all food is distributed and served under sanitary conditions. Use of Outside Resources – Residents #27, #28, and #29 were identified during survey. Upon completion of the GAP analysis, it will be reviewed in QAPI Committee meeting April, 2024.		on results of use of the "Just Culture Decision Tree" and "Just Culture Decision Support Tool". Findings will be logged on the *Audit Logs Nov 2023 For Cause Survey*. Upon completion of these audits Just Culture meetings will continue for an additional 6 months to validate continued compliance. Additionally, the following actions will be implemented: Staff Treatment of Residents - Beginning 12/1/23 Administrator or Designee will review all Injury of Unknown Cause type incidents in PCC to identify and address those warranting investigation, complete with Administrator Note. This is an ongoing process, with no end date. Menus and Nutritional Adequacy – Beginning 12/13/23, Assistant Admin. or Designee will complete direct observations each month to ensure residents receive food according to the written menus utilizing the *Audit Logs Nov 2023 For Cause Survey*. Sanitary Conditions – Beginning 12/13/23, Assistant Admin or Designee will complete direct observations each month to ensure food is distributed and served under sanitary conditions utilizing the *Audit Logs Nov 2023 For Cause Survey*.		

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)
§ 51.210 (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 outside	This facility is currently in communications with Eastern Oklahoma VA Healthcare System (EOVAHCS) to establish a sharing agreement for mental health services received thru EOVAHCS. This facility has numerous veterans who prefer to receive such services thru the VA despite lacking a sharing agreement and their preference is respected. As of 2/19/24, facility's Admissions team will continue to advise all potential admits of our status, recommending they use providers this facility has a written agreement with for mental health services. An update was last received 2/13/24 from EOVAHCS Chief of Quality, who indicated the sharing agreement for mental health services submitted to VISN for review and approval, was denied. The submitted "packet" was deemed incomplete and EOVAHCS Chief of Quality is following up for further guidance.	All residents requesting mental health services through the EOVAHCS have the potential to be affected by the same alleged deficient practice. As of 1/12/24, twelve residents were receiving mental health care services and all have been advised of our lack of a sharing agreement with our VAMC. Of the twelve: - three are utilizing services with providers this facility has written agreements with (residents #43, #44, and #33). - nine are utilizing services with our VAMC who we do not have a sharing agreement with (residents #34, #35, #36. #37, #38, #39, #40, #41, and #42). These residents have declined to change providers to those we do have a written agreement with.	To ensure the deficient practice will not recur, this facility will perform the following beginning 1/5/24: - Admission team will continue to inform potential residents that the facility does not have a sharing agreement with the VAMC at this time for mental health services. For new residents seeking mental health services, facility will recommend they utilize providers the facility has a written agreement with. This practice will continue until we are in full compliance per 51.210 VA regs. *Audit Logs Nov 2023 For Cause Survey* will be utilized to track and verify those efforts. As of 2/19/24, Administrator or Designee will continue to complete monthly audits documenting communication efforts to secure a sharing agreement for mental health services per 51.210(h) regs. for a period of 3 consecutive months beginning Dec., 2023 and ending after a sharing agreement is in place for mental services with EOVAHCS utilizing the *Audit Logs Nov 2023 For Cause Survey.*	Survey audits will continue until 100% compliance is met, for three consecutive months, with results presented at quarterly QAPI meetings beginning 1/17/24, for further evaluation and to ensure compliance with VA regs. 51.210 (h). 100% compliance is defined as this facility having a written or sharing agreement (as applicable) with all persons or agencies for all residents receiving mental health services outside this facility. Once a sharing agreement with EOVAHCS is reached, the *Contracts Agreements* log will be used to monitor the status of the agreement, including expiration of, with no end date, to ensure compliance with 51.210(h) is sustained.	12/31/24

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. Rating – Not Met Scope and Severity – D Residents Affected – Few					

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