State Veterans' Homes (SVH) Corrective Action Plan
(Idaho State Veterans Home – Lewiston survey: 7/9/24 – 7/11/24)

Important: Attestation by the SVH leadership, including the SVH nurse leader, of actions to assure timely completion of goals and establishment of oversight to assure continued improvement in areas identified for correction. The Corrective Action Plan (CAP) should include input from all levels of staff and affected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assessment and Assurance.

State the Issue **Identify the Regulation and Findings**	**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with Quality Assessment and Assurance fundamentals)	**Address how the SVH will identify other residents having the potential to be affected by the same deficient practice**	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**	**How does the SVH plan to monitor its performance to make sure that solutions are sustained** (Actions should align with Quality Assessment and Assurance)	**Proposed Completion Date** (i.e. when corrective action will be fully implemented and sustained)
CFR 51.120 (i) accidents Failure to implement effective and individualized interventions for the prevention of falls for 1 resident.	Education provided by facility staff development coordinator, for all nursing staff, identifying proper interventions available for prevention of falls and education provided for implementation and documentation of interventions following each fall. Resident affected had fall prevention interventions reviewed and care plan updated by the facility clinical team on 7/23/2024. Education for nursing staff will be completed by September 1, 2024.	Facility treatment team in review of the deficient practice reviewed the previous two months fall incidents to identify if proper interventions were implemented. No other falls reviewed failed to have immediate interventions included but it was determined that all residents have the potential to be affected by the same deficient practice.	Quarterly education, and upon all new hires for licensed nursing staff specifically for utilization of the list of fall interventions and the proper documentation of those fall interventions to be provided for by the Staff Development Coordinator. Education for utilization of tab on the incident report indicating immediate interventions implemented on each fall incident. Education provided will include the education materials provided on the original educations provided by September 1, 2024 but may include any updated guidance or specific items which may have been observed during prior education/facility audits.	Clinical team (administrator, Director of Nursing (DON), Minimum Data Set (MDS) coordinator, Social Services and Registered Nurse manager (RN) will audit all fall incidents weekly X4 weeks, then monthly for 3 months to ensure implementation of fall interventions occur with each fall incident. Any deficient audit will require 1:1 education for the Licensed Nurse involved. Results of these audits will be reported to monthly Quality Assurance Performance Improvement (QAPI) meeting with a threshold of 100% compliance. Audits will begin 9/3/2024 and will continue until proposed completion date of 1/6/2025.	1/6/2025

CFR 51.120 (j) nutrition Failure to implement and provide interventions as planned for the prevention of significant weight loss for 1 resident.	Resident affected had diet order reviewed and edited on 8/19/2024 to clarify fortified diet. Resident affected added to the facility Nutrition at Risk committee on 8/19/2024 to reviewed weekly for weight loss and diet concerns. Tray card meal tickets color coded on 7/12/2024 to highlight the required meal items for the fortified diet.	Facility Nutrition at Risk committee reviewed all other residents identified as high risk for weight loss. Two other residents identified required update in care plan regarding fortified diets with those care plans updated.	Electronic Medical Records program Point Click Care reviewed for proper notification protocols on 8/19/2024 for long term weight loss. Registered dietician clarification for fortified diets to include fortified fats, fortified sugars etc. on 8/19/2024. There are multiple fortified diets which are specific to a resident's dietary needs. For example, a resident with congestive heart failure may require a fortified diet addressing salt intake. Dietary staff are educated on the various fortified diets. Registered dietician to review and care plan any refusals/dislikes of nutritional interventions related to fortified diet plans during weekly nutrition at risk committee meeting beginning with meeting held on 8/19/2024. Quarterly care plan reviews to include review of all recorded weights to ensure automatic notifications from electronic medical records program have not missed any significant weight changes. This process began with care conference reviews conducted during the week of 8/19/2024. Color coded tray card	Registered dietician or designee to conduct weekly audits of tray line fortified diet serve out X4 weeks and then monthly X3 months. Registered dietician or designee to conduct weekly audits X4 months, of identified residents at risk for weight loss to ensure proper interventions in place. Dietary services manager to audit 2 resident nutritional care plans per week X4 months. All audits to be presented to monthly QAPI meeting with a 100% threshold. Any disparity or failed audit will require additional intervention and/or education. Audits will begin 9/3/2024 and will continue until proposed completion date of 1/6/2025.	1/6/2025

			meal tickets, which were implemented on 7/12/2024 after the finding of the original deficient practice to indicate and highlight various fortified meal items to be served out will continue.		
CFR 51.120 (n) Medication errors Failure to administer medications as ordered for 1 resident.	Education provided by facility staff development coordinator for the licensed nurse noted in the deficiency on 7/12/2024. All licensed nurses within the facility educated regarding proper medication administration of metered dose inhalers and administration of nasal sprays. Education provided also included proper administration of self-administered metered dose inhalers and nasal sprays. Education completed by September 1, 2024. Resident affected completed an updated self-administration assessment noted in nursing note on 7/25/2024 and was provided education on proper administration of self-administered metered dose inhalers and nasal sprays.	Facility clinical leadership, following original education of the noted deficiency reviewed the entire facility population for those residents who were assessed for self-administration of metered dose inhaler and nasal sprays. Re-assessment of each of those other residents were completed with one resident choosing not to move forward with self-administration and their care plan was updated to reflect that change in choice. No other issues identified.	Quarterly education, and upon all new hires for licensed nursing staff specifically for proper administration of metered dose inhalers and administration of nasal sprays to be provided by staff development coordinator. Residents assessed and educated for self-administration of metered dose inhalers and nasal sprays upon admission and each quarterly care conference to be provided for by RN manager or designee. Education provided will include the education materials provided on the original educations provided by September 1, 2024 but may include any updated guidance or specific items which may have been observed during prior education/facility audits.	RN Manager will conduct 3 random audits of administration of metered dose inhalers and nasal sprays per week X4 weeks then monthly X3 months. Results of audits to be presented to monthly QAPI with a threshold of 100% compliance. Any failed audits will result in 1:1 education for the licensed nurse responsible for failed audit. Audits will begin 9/3/2024 and will continue until proposed completion date of 1/6/2025.	1/6/2025
CFR 51.140 (h) Sanitary conditions Failure to ensure resident meals had been stored, prepared, and served in a sanitary condition to prevent cross-contamination and	Sanitation bucket changed from hot water solution to cold water at time of finding on 7/11/2024 to hold the proper ppm of sanitizer in the sanitization bucket. Education provided to all dietary staff on sanitation bucket solution conducted on 7/12/2024 regarding mixture, timely	Registered dietician and dietary manager conducted additional observations of the sanitation bucket following the change from hot to cold water. The proper ppm of sanitizer was identified on each observation.	Sanitization mixture changed from hot water to cold water on 7/11/2024. Hourly changing of the sanitizer along with testing with the proper testing strip to occur upon each bucket change updated on	Registered dietician will conduct weekly audits of the sanitization bucket X4 weeks and then monthly X3 months. Registered dietician will conduct random hand washing audit of dietary staff weekly X4 weeks	1/6/2025

potential illness.	changing and testing of the solution for the proper ppm of sanitizer. Education for cook and dietary manager identified in survey report on proper hand washing protocols provided on 7/12/2024. All other dietary staff re-educated on proper hand washing protocols by September 1, 2024.	All residents continue to have the potential to be affected by the deficient practice noted and the dietary manager observed all dietary staff following the re-education on proper hand washing with no other failures to perform the proper hand washing identified.	8/19/2024. Monthly hand washing/infection control education for all dietary staff and upon hire for new hires provided by infection control nurse or designee beginning on September 1, 2024. New hand washing educational placards placed on 7/15/2024 within high visibility areas of the kitchen.	and then monthly X3 months. All audits will be presented to monthly QAPI with a threshold of 100%. Any failed audits will result in 1:1 education for the team member responsible for the failed audit. Audits will begin 9/3/2024 and will continue until proposed completion date of 1/6/2025.	
CFR 51.190 (a) infection control Failure to provide urinary catheter care by using appropriate infection control technique to prevent the spread of infection for 1 resident.	Certified Nursing Assistant identified with deficient catheter care educated by Staff Development Coordinator on the proper urinary catheter care technique to prevent the spread of infection by September 1, 2024. Resident identified observed for signs/symptoms of infection per facility protocol with 3 days of alert charting. This took place from 7/12/2024 to 7/15/2024. All certified nursing staff re-educated with catheter care in-service provided by staff development coordinator by September 1, 2024.	Infection preventionist identified all other residents with catheter usage. Those identified residents catheter care was then observed by the infection preventionist and staff development coordinator with no other resident issues identified throughout those observations.	Bi-annual education, and upon all new hires for all facility certified nursing assistants specifically regarding proper urinary catheter care provided by staff development coordinator or their designee. Education provided will include the education materials provided on the original educations provided by September 1, 2024 but may include any updated guidance or specific items which may have been observed during prior education/facility audits.	Infection Preventionist will conduct 1 random audit of resident catheter care per week X4 weeks and then 2 random audits performed monthly X3 months. Results of audits to be presented to monthly QAPI with expected compliance threshold of 100%. Any failed audits will result in 1;1 re-education of facility personnel responsible for failed audit. Audits will begin 9/3/2024 and will continue until proposed completion date of 1/6/2025.	1/6/2025
CFR 51.200 (a) Life safety from fire. Failure to test and inspect the fire alarm in accordance with the code. Failure to properly maintain the smoke barriers. Failure to properly test and	Visual inspection and documentation of all facility smoke detectors completed by maintenance foreman and maintenance craftsmen seniors on 8/14/2024. Testing of facility alarm system battery charger, load voltage and discharge test for the back-up batteries conducted by Facility Maintenance director on August 20, 2024. .	The facility maintenance foreman and maintenance craftsmen seniors conducted a facility wide inspection of facility smoke barriers with no other failed penetrations identified. All facility smoke detectors inspected by facility craftsmen seniors with no further issues	Visual inspection of smoke detectors added to the monthly inspection schedule on 7/10/2024 within the TELS system. Inspections to be completed by maintenance craftsman senior. Testing of facility alarm system battery charger,	Maintenance foreman, or his designee will conduct monthly audit of visual inspection of facility smoke detectors. Audit findings will be reported in monthly QAPI with threshold of 100%. Maintenance foreman, or his designee will conduct monthly audit of smoke barrier	1/6/2025

inspect illuminated battery powered exit signs in accordance with the code.	Smoke barriers identified in survey report were all sealed in accordance with section 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code on the same day of the original finding 7/10/2024. Penetrations were sealed by facility maintenance personnel on July 10, 2024. In addition, visual inspection of entire building for possible penetrations in the various smoke barriers were conducted on July 23, 2024 with any irregularities corrected at time of finding. Battery operated exit signs tested and inspected by facility maintenance team on August 20, 2024.	identified. Facility alarm system tested by facility maintenance foreman with no further issues identified.	load voltage and discharge test for the back-up batteries added to the bi-annual inspection schedule on 7/10/2024 within the TELS system. Smoke barrier inspections added to the quarterly inspection schedule on the facility TELS system. Original deficient smoke barriers were corrected on 7/10/2024 ongoing inspections to be completed by maintenance craftsman senior. Battery operated emergency exit sign inspections added to the monthly inspection schedule on 7/10/2024 within the TELS system. Inspection to be completed by maintenance craftsman senior.	inspections with all audit findings reported in monthly QAPI meeting with a threshold of 100%. Any deficient audit will have immediate mending of smoke barrier penetration. Maintenance foreman, or his designee will conduct monthly audit of batter operated emergency exit signs with audit findings reported in monthly QAPI meeting with a threshold of 100%. Any failed audits will result in immediate mending and/or replacement of emergency exit sign and/or battery. Audits will begin 9/3/2024 and will continue until proposed completion date of 1/6/2025.	

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