State Veterans' Homes (SVH) Corrective Action Plan

Illinois Veterans' Home at Manteno – 10/17/23-10/20/23

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) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Rating:** Not Met **Scope and Severity** - D **Residents Affected** – Few	Funds for two (2) of the five (5) sampled residents have had a final accounting of funds and the funds have been conveyed to the individuals administering the resident's estate. Funds were conveyed for resident #26 on 10/20/23 and for resident #27 on 11/29/23.	100% of the accounts of deceased residents since 7/1/23 were audited and all residents have had their funds conveyed. The SVH has mad every effort to be in complete compliance with this standard; however, as an agency of the State of Illinois, our accounting practices are bound by the Illinois State Accounting Manual (SAMS) which prohibits us from releasing funds to the estate without a W-9, valid Last Will and Testament or a small estate affidavit for estates less than $100,000 or letters of office for accounts with greater than $100,000.	Upon Admission, and annually thereafter, the Adjutant will request a copy of the Veteran's Will. Upon notification of death of a resident, the Adjutant's office will send out correspondence to the POA that will include a final accounting of funds and state required documents to close the account with instructions to return documents withing 45 days. The SVH Adjutant will track this information, and if information is not received from the family in a timely manner, will send reminders to the POA weekly. When the documents are received, the funds will be returned to the POA or executor withing five (5) business days. The Adjutant's office will track the date deceased, date of POA notification, date documents received for estate closeout, and date voucher sent to the Business Office. Business Office will issue the funds withing five (5) business days. If funds	The Adjutant's office will be responsible for tracking the receipts of the state required documents to close the account and release the funds. The Adjutant's office will be responsible to notify the Business Office when the voucher can be released. The Adjutant's office will be responsible for reporting this information quarterly to the QAPI committee.	The goal for compliance is 100% of funds will be conveyed within the 90 calendar days as required by § 51.70. This process was implemented 11/23 and will be monitored monthly and reported quarterly. This will be fully implemented by June 30, 2024. The Adjutant is responsible for this quality measure.

			remain unclaimed after 90 days, they will be released to the unclaimed funds account held by the Secretary of Treasury for the State of Illinois.		
§ 51.100 (a) Dignity. 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. **Rating:** Not Met **Scope and Severity** - D **Residents Affected** – Few	One resident was identified to be affected by this deficient practice. All staff on the unit where this incident occurred were updated on the care plan related to dining for resident #1. Unit Supervisors and Leadership staff observed dining in each dining room on time per week to determine if other residents were affected. Based on observation all residents were assisted with dignity and respect.	The DON and the Unit Supervisors will review the Care Plans for members requiring assistance with dining on all residential units. The Unit Supervisor and the DON will ensure that the Care Plans on the unit are updated and reviewed by staff. Information on the residents' dining preferences will be added to the VNAC Care Sheet. At unit "Town Hall" meetings, Resident Council meetings and Food Service meetings, residents will be asked for feedback on dining service. This feedback will be reviewed by the Unit Supervisors and Leadership team, and used to improve meal quality and service.	All direct care staff, supervisors and executive team staff were re-trained on the module "Dining with Dignity". All Unit Supervisors and members of the Leadership staff are assigned a day to sample the Dietary meal and evaluate meal service to residents. They are assigned to dine on a residential unit and observe staff interaction with residents. After completing the meal and observing the dining service, they will complete an evaluation form. Observation and comments regarding the staff assisting the residents with dining is returned to the DON for follow up.	Unit Supervisors and members of the Leadership team will randomly join a unit to share a meal, and observe and evaluate the dining service. The goal of compliance is all residents will be assisted to dine in a manner that promotes dignity and respect and enhances their quality of life. Breaches in dining service will be addressed with staff at the time they are observed, and documentation of the occurrence will be sent to the supervisor of the unit. This corrective action will occur weekly through June 2024.	This quality measure was implemented in November 2023 and will be ongoing thru 6/30/24. The DON is responsible for this quality initiative.
§ 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	One resident was identified to be affected by this deficient practice. The MDS updates for this resident were completed when the deficiency was identified at the time of the survey.	All fall reports for the previous 60 days from the date survey findings were received (11/17/23) were audited and checked with each resident's MDS to ensure accurate coding. The MDS of all residents receiving hospice services were audited for accuracy of documentation of hospice services. No other residents were identified to be affected by this deficient practice.	Five (5%) percent of the SVH census will have their MDS assessments audited for accuracy by the DON each month.	5% of IVHM's total census will be audited monthly by the DON for MDS updates to ensure that they accurately reflect updates for changes of condition related to falls and hospice care. Results of audits will be reported at the quarterly QAPI meeting. The goal for this measure is 100% compliance. The Director of Nursing is responsible for this quality measure.	This quality measure was fully implemented in November 2023 and will continue through June 2024. The Director of Nursing is responsible for this quality measure.

certify the accuracy of that portion of the assessment. **Rating:** Not Met **Scope and Severity** - D **Residents Affected** – Few					
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Rating:** Not Met **Scope and Severity** - D **Residents Affected** – Few	One resident (#12) was identified to have been affected by this deficient practice. Resident #12 was administered the Shingrix vaccine, Dose 1, on 10/20/23. His 2nd dose of Shingrix is scheduled for 12/20/23. The second dose of Shingrix was administered 12/21/23.	All immunizations are tracked by the Infection Prevention nurse. An audit of the electronic medical record for immunizations was completed and no other residents were identified as having been affected by this deficient practice.	The Infection Prevention nurse will monitor resident immunizations and report the immunization rate for each vaccine at the monthly infection prevention meeting. The Infection Prevention nurse also report the results at the quarterly QAPI meeting.	Immunization orders are entered into the electronic medical record. The Infection Prevention nurse will monitor the immunization reports each month to ensure that all immunizations are given as ordered and according to the immunization schedule. The Infection Prevention nurse is responsible for this quality measure.	Implemented in November 2023, and will be sustained through June 2024. The goal for compliance is 100% with vaccination schedules.
§ 51.120 (m) (1) Unnecessary drugs (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. **Rating:** Not Met **Scope and Severity** - D	For two (2) of the five (5) residents identified, Resident #13 and Resident #16, the Pharmacist collaborated with the Physician and the Psych NP to determine if there were appropriate indications for prescribed medications. After consultation with the clinical team, it was determined that the medications were indicated for these residents.	A retrospective audit of the previous 3 months was completed by the Pharmacist to monitor for unnecessary drugs. Documentation was reviewed for adequate indications for use and that appropriate monitoring was in place. No other residents were identified to be affected by the same deficient practice.	The Pharmacist addressed the finding of unnecessary drugs and inaccurate indications and monitoring with a medication audit. Pharmacy had updated the drug indications for accuracy and made the appropriate recommendation to the medical providers.	The goal for compliance is that each quarter the Pharmacy Director and staff pharmacist will conduct medication reviews to ensure that the appropriate indications and monitors are present for the prescribed medications. The Pharmacy Director is responsible for this quality measure.	This has been implemented starting November 2023, and will be fully sustained through June 30, 2024. The Pharmacy Director is responsible for this quality measure.

Residents Affected – Few					
§ 51.120 (m) (2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility management must ensure that— (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. **Rating:** Not Met **Scope and Severity** - D **Residents Affected** – Few	For two (20 of the four (4) residents identified, Resident #14 and Resident #16, the Pharmacist collaborated with the Physician and the Psych NP. It was decided that no medication change was warranted and would be re-evaluated in the next quarter when the psychotropic/antipsychotic medications are scheduled to be reviewed. The electronic medical record was updated.	A retrospective audit of the previous 3 months was completed by the Pharmacist for all residents receiving psychotropic medication. No other residents were identified to be affected by this practice.	The Pharmacist will conduct a quarterly review of the psychotropic/antipsychotic medications ordered for residents. The Pharmacist recommendations for gradual dose reductions will be placed in the Pharmacy Progress Notes in the electronic medical record. Pharmacy will notify the MD and the Psych NP via email that Pharmacy recommendations have been made. The MD and the Psych NP will consider the pharmacist recommendations and enter a Progress Note in the electronic medical record, indicating whether they accept or decline the recommendation by the Pharmacist, and their rationale.	The goal for compliance is that each quarter, the Pharmacist will track: - The number of recommendations for gradual dose reductions (GDR) made by the Pharmacist. - The response rate by percentage of the Physicians/Psych NP to those recommendations. - The percentage of GDRs that were implemented from their recommendations.	This corrective action has been implemented. Initial results for November/December 2023 will be reported at the January 2024 QAI meeting. It will be sustained through June 30, 2024. The Pharmacy Director is responsible for this measure.
§ 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	An immediate audit of all food storage areas, both dry and cold storage, was completed. All opened, unsealed, undated and outdated food items were disposed. All food storage areas were cleaned, sanitized and organized. A comprehensive dietary checklist that identifies tasks to be completed and assigned to specific staff members has been	All residents have food prepared and served from the central kitchen and have the potential to be affected by this deficient practice.	All Dietary staff have been retrained on policies for Labeling and Dating Foods, Refrigerated Potentially Hazardous Food, Storage of Frozen Foods, use of the temperature testing equipment for the dish machine, how to take the temperatures and record the findings, and how to reports temperatures that are out of range. The Dietary Manager has the daily responsibility to monitor compliance with the assignments. The Adjutant will make unscheduled and	A quality improvement plan for the Dietary department has been implemented. A comprehensive checklist for food storage in dry and cold areas was developed and implemented. This checklist includes monitoring of temperature logs for the dish machine and cleaning of food preparation equipment. Tasks are assigned daily, and compliance is audited daily by the Dietary Manager. Results are	Comprehensive Dietary checklist implemented November 2023 and to be sustained through June 2024.

Scope and Severity - F **Residents Affected** – Many	implemented. All Dietary staff was educated on the importance of maintaining and documenting temperatures of the dish washing machine. This task is included on the comprehensive dietary checklist.		unannounced rounds to check if tasks are completed and documented. The Adjutant will inspect all food storage areas for opened, unsealed, undated and outdated food items.	reported monthly by the Dietary Manager to the supervisor (Adjutant). Quarterly, the Adjutant will report these results to the QAPI team wit a goal of 100%. This performance improvement plan will continue through June 2024. The Dietary Manager and Adjutant are responsible for completing and reporting these results to the Administrator and the QAPI committee.	
§ 51.170 (a)-(c) Dental services. A facility must provide or obtain from an outside resource, in accordance with §51.210(h) of this part, routine and emergency dental services to meet the needs of each resident; (b) A facility may charge a resident an additional amount for routine and emergency dental services; and (c) A facility must, if necessary, assist the resident— (1) In making appointments; (2) By arranging for transportation to and from the dental services; and (3) Promptly refer residents with lost or damaged dentures to a dentist. **Rating** - Not Met **Scope and Severity** - D **Residents Affected** – Few	For the one resident (3#) identified, he was assisted to make a dental appointment and the POA provided transportation. This resident has had dental service.	All residents will receive an annual dental screening by a local dentist. The local dentist will provide the screening exam at the facility. The screening dentist can refer for additional services as needed. The facility Physician also can generate a dental referral, if needed.	When additional dental services are required by the resident, or requested by the facility physician, the unit Social Worker will assist the resident to make an appointment and to arrange transportation.	A spreadsheet will be placed on the facility shared drive. The Social Worker will document the resident who requires dental services beyond a screening exam and the date the request/order was sent. They will track the dates the POA was notified, the date transportation was arranged, and the date that the resident went to the appointment. All residents referred for outside dental services will be seen within 60 days. Access to the shared drive file will be restricted to the Social Workers and the Transportation Coordinator.	Social Services Director will track and report the number of residents referred to outside dental providers and the length of time between the order/referral and the appointment. The goal of compliance is 100% of residents requiring outside dental services will be scheduled to see a dentist within 60 days of their referral. Social Services will assist the resident/POA to arrange

					transportation to and from the dental appointment. The Director of Social Services is responsible for this quality measure. This measure was implemented November 2023 and is ongoing. The results are being tracked by the Social Services Director and will be report to QAPI team for two consecutive quarters, ending June 2024. This quality improvement measure has a goal of 100%.

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