State Veterans' Homes (SVH) Corrective Action Plan
Illinois Veterans' Home at Manteno – September 24 - 27, 2024

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. Please reference VA GEC's CAP Standard Operating Procedure for detailed guidance on completing this CAP template.

State the Issue Identify the Regulation Number and language only	Address how corrective action will be accomplished for those residents found to be affected by the deficient practice	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 & what benchmarks will be used to determine sustainment	Proposed Completion Date
§ 51.40 (a) Basic rate. Except as provided in §51.41, VA will pay per diem for care provided to an eligible veteran at a State home at the lesser of the following rates: (1) One-half of the daily cost of the care for each day the veteran is in the State home, as calculated under paragraph (b) of this section. (2) The basic per diem rate for each day the veteran is in the State home. The basic per diem rate is	The Agency (IDVA) has access to High-performance Analytic Appliance reporting, also known as HANA. This report itemizes the facility's cost by service dates to support the actual cost for July services. The State of Illinois' fiscal year runs July 1 – June 30.	All residents have the potential to be affected by this deficient practice. IVHM will generate the HANA expenditure report by date of service, and total by month, to calculate the eligibility of the correct basic rate of per diem.	IVHM has generated the HANA report by date of service to support the correct full basic rate amount for the month of July 2024. This report will be added to the monthly reconciliation the IVHM completes and will be available upon site survey each year.	IVHM Business Administrator will monitor this practice each month, beginning 11/20/24 and ending 3/31/25, and monthly going forward for the purpose of itemizing the cost by service date. This monitor will be added to the monthly reconciliation efforts established at the SVH. The goal is to be 100% compliant in the generation of the HANA support detail. Monitoring results will be reported at the quarterly QAPI meeting on 4/10/25.	04/10/2025

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established by VA for each fiscal year in accordance with 38 U.S.C. 1741(a) and (c).				**IVHM has provided additional documentation to the SHPD program, who has determined that the expenditures figure provided in our spreadsheet does justify the correct per diem cost of care for July 2024.**	
§ 51.41 (c) (2) 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).	The Illinois Veterans Home at Manteno (IVHM) has amended contracts to indicate that 100% of cost for 70-100% service-connected veterans will be billed to the Home. Facility is reviewing all medical claims and medical claim statement invoices for these services which occurred in FY2024 that were billed to insurance for radiology, podiatry, therapy and physician services. IVHM has reached out to those medical providers to discuss ability with provider to bill IVHM for full amount of medical claim. Payment to provider will equal amounts of insurance or private pay and have refunds issued to insurance/private pay parties.	Any IVHM Veteran who is 70 – 100% service connected, as well as those Veterans who are adjudicated at the prevailing rate who are not 70 – 100% service connected, has had their medical billing claims reviewed.	All medical invoices are reviewed by an employee of the IVHM's Fiscal Department. The Fiscal Department employee already monitors therapy invoices to ensure we are billed 100% for prevailing rate Veterans. This practice has been implemented for the other services that have been identified as needing to be covered 100% by the Home – physician services, therapy, radiology, and podiatry. The Fiscal Department employee notifies the vendor if the facility is invoiced for an amount other than 100%, and requires vendor correction and resubmission of invoice.	IVHM Business Administrator is responsible for these measures. Billing claims audits began 10/01/2024, and will conclude 3/31/2025. Audits will be completed weekly x4, and monthly x5. Medical billing claims will continue to be audited by IVHM's Business Administrator as they are received. Audit results will be reported at the 4/10/25 quarterly Quality Assurance Process Improvement (QAPI) meeting. Business Administrator will document and report progress updates to quarterly QAPI. Goal for compliance is 100%.	4/10/2025

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§ 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.	A final accounting of funds for the 12 identified residents has been sent to the responsible party. The Conveyance of Funds policy has been updated to reflect that within 90 days, unclaimed funds will be moved to the Illinois Unclaimed Property division of the Illinois State Treasurer.	During admission, new residents will be asked to provide a copy of their Last Will and Testament, and to assign a designated person to collect funds upon death and have them complete a form W-9. The form W-9 that is filled out upon admission will be used to convey funds for all accounts of deceased residents.	Upon notification of the death of a resident, the Adjutant's Office will send out correspondence to the Executor that will include a final accounting of funds, a copy of the completed form W-9 for any corrections, and a Small Estate Affidavit to close the account. If needed, follow up phone calls and reminder letters will be sent. When documents are approved or corrected and received, a voucher payable request and supporting documents will be sent to the Business Office to process the payment. IVHM policy has been updated to reflect that on the 30th day, or the business day before if the 30th day falls on a weekend or holiday, if documents necessary to release the deceased resident's funds have not been received, the Reimbursement Officer will request a check for the remaining resident trust fund balance, made payable to Illinois State Treasurer, and these funds will be sent to the Illinois Unclaimed Property division of the Illinois State Treasurer. The Adjutant's Office will track the date documents received for estate closeout, and the date the voucher was sent to the Business Office. The Business Office will document the date the voucher was paid.	The Adjutant's Office will be responsible for tracking receipts of 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 keep track of open estates dates and when funds are sent to the State of Illinois Unclaimed Property. The Adjutant will conduct an audit of all deceased estates weekly x25 beginning 10/01/24 and ending 3/31/25. The Adjutant will report the results of the audit at the 4/10/25 quarterly QAPI meeting. The goal for compliance is 100%.	4/10/2025

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			At the 30th day, all outstanding estates will be released to the State of Illinois Unclaimed Property.		
§ 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	Resident #2 and Resident #37 have been evaluated by Occupational Therapy (OT) and recommendations have been implemented and Care Plans updated.	All facility residents (22 total) currently using a Broda tilt chair for seating and positioning will have a seating evaluation completed by OT. OT will evaluate to determine if Broda seating is appropriate. They (OT) will recommend if the resident, while in a Broda tilt chair, is to be upright, semi-reclined or fully reclined. If a resident is in a Broda tilt chair and on skilled services, OT will complete seating evaluation prior to discharge from skilled services.	IVHM put into place the following systemic changes: 1) Seating evaluations completed by Occupational Therapist (OT) to determine if a Broda chair is indicated. 2) If a Broda chair is ordered, OT will indicate if it should it be upright, fully reclined, or semi-reclined, and this will be documented in the Veteran's Care Plan. 3) Seating and positioning will be reviewed at the quarterly Care Plan Team meetings, and with changes in condition for appropriate use. All direct care staff are educated annually on: 1) What constitutes a restraint, including therapeutic devices; and 2) Measures to avoid the use of restraints. It is the policy of IVHM to place all residents in the least-restrictive environment to ensure safety and promote independence.	Weekly for 11 weeks, the Restorative staff will monitor each resident in a Broda chair to ensure that seating and positioning recommendations are being followed. Beginning January 13, 2025 and ending on March 28, 2025, and will be reported at the April 10, 2025 quarterly QAPI meeting. The goal for compliance is 100%.	4/10/2025

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restraint-free environment. (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.					
§ 51.90 (b) (1) – (5) Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. (1) Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. (2) Physical abuse includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment. (3) Sexual abuse includes sexual harassment, sexual coercion, and sexual assault.	One (1) resident was affected by this deficient practice. Residents on the secured unit have been identified to have exit-seeking behaviors and cognitive impairments that do not support them leaving the secured area without supervision. Camera surveillance of all exit doors is in place as of 1/6/25. Exit doors are alarmed and staff respond immediately to an exit alarm. All direct care staff have been retrained on elopement prevention measures and procedures for the secured unit; resident location checks are conducted every one hour; and weekly door inspections are the systemic changes made to ensure this does not re-occur. IVHM was not able to conclude how the elopement occurred. A	This has the potential to affect all residents. All residents are assessed for exit-seeking behaviors. Residents identified to be cognitively impaired and exhibiting exit-seeking behaviors are placed on the secured unit for safety and supervision. Location monitoring of each resident is completed hourly, and all exits are surveilled continuously from both nurses' stations. All door closures on the secure unit are checked to ensure they are latching securely. Nine (9) video surveillance cameras were installed, are operational, and are focused on all exit doors of the secure unit, whether the door exits to the outdoors or to an interior hall. All surveillance cameras have a feed to video monitors located in both (5N and 5S) nurses' stations.	All exits will be monitored via the video surveillance cameras. Weekly inspections of the closing and latching mechanisms of all exit doors on the secured unit will take place, and that they can only be opened with a secure access code, known only to staff assigned to work the secure unit. Results of door inspections of the secured unit will be reported at the April quarterly QAPI meeting. After the April QAPI meeting, this will be a standing agenda item at the monthly Safety Committee meetings. Additionally, door inspections will continue monthly in concurrence with the fire drills for the secured unit. Any deficiency in closing/latching of exit doors from the secured unit will be repaired immediately. Camera surveillance of all alarmed exit doors, staff retraining, resident	Every eight (8) hours, a member of the Clinical team will monitor the operation and viewing of the video surveillance cameras, starting 1/6/25 and ending 3/31/25. The goal for compliance is 100%, and results will be reported at the April 10, 2025 QAPI meeting. The Fire/Safety Officer will conduct weekly audits of closing and latching mechanisms of all exit doors from the secured unit. Audits will begin 11/1/24, and end on 3/28/25. The audits will be completed weekly x4, monthly x4. Audit results will be reported at the April 10, 2025 QAPI meeting. Camera surveillance of all alarmed exit doors, staff retraining, resident location checks every one hour and weekly door inspections are the systemic changes made to ensure this does not re-occur.	4/10/2025

(4) Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions. (5) Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative.	thorough investigation was completed and found to be inconclusive as to the method of elopement. The single resident affected by this deficient practice continues to live on the secured locked unit. The clinical interventions that have been implemented to ensure the resident's right to be free from mental, physical, sexual and verbal abuse or neglect, corporal punishment, and involuntary seclusion, are: increased monitoring, increased documented Q30min location checks, and the implementation of a specialized individual activity program to decrease exit-seeking behaviors, all of which have been updated in this resident's Care Plan. No other elopements have occurred from this unit since the systemic changes were initiated.	All exit doors for the secure unit require that a secure access code be entered. Only staff assigned to work the secure unit are given the code. It is not shared with visitors or families. Facility staff have been retrained on elopement prevention measures and procedures for the secure unit. Additionally, all staff receive annual abuse/neglect training to ensure the residents' right to be free from mental, physical, sexual and verbal abuse or neglect, corporal punishment, and involuntary seclusion.	location checks every one hour and door inspections are the systemic changes made to ensure this does not re-occur. Should an exit door sound an alarm, staff respond immediately. No other elopements have occurred from this unit since the systemic changes were initiated. Any future occurrence will be thoroughly investigated. Camera/video will be reviewed as part of the investigation.		
§ 51.90 (c) (3) Staff Treatment of Residents. The facility management must have evidence that	One resident was affected by this deficient practice.	All residents on the secured unit have the potential to be affected by this deficient practice. All house supervisors have been	The Illinois Veterans' Home at Manteno (IVHM) will conduct prompt and thorough investigations of a resident who, on the hourly check, is not accounted for by: immediately	Should an elopement instance arise between 1/2/25 and 3/31/25, the facility's Administrator will be responsible for ensuring that investigations are conducted promptly	4/10/2025

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all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.		reeducated on reporting and investigating elopements.	notifying the appropriate regulatory agencies; holding an After-Action Review meeting the next business day after the breach/elopement to determine the cause; immediately address and provide a remedy for the breach/elopement; and completing an Investigations Report.	and thoroughly; the appropriate regulating agencies are notified immediately of the elopement; an After-Action Review meeting is held the next business day following the elopement; and completion of an Investigations Report. Results of any elopement instance(s) between the timeframe of 1/2/25 and 3/31/25 will be reported at the 4/10/25 quarterly QAPI meeting. The goal of compliance is 100%.	
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	Three (3) residents were identified to be affected by this deficient practice. This was corrected by the unit supervisor immediately when observed during survey. Immediately following the survey, training and observation of meal service was done by Leadership staff.	Observation of dining areas on all residential units will occur. Person-directed dining will be completed in October 2025 as part of direct care staff's annual training, and will continue to be an annual training for all direct care staff.	All Leadership staff and Nursing Supervisors are assigned to do a meal review. They will dine on the unit, and complete a review of the food and observation of staff interacting with residents. Comments and meal review ratings are shared with Dietary Managers and staff. All residents will be assisted to dine in a manner that promotes dignity and respect, and enhances their quality of life. Breeches in dining service will be corrected with staff at the time they are observed, and documentation of the occurrence will be sent to the Supervisor of the unit. Dining observation and evaluation by	Leadership and Nursing Supervisors will make unannounced rounds on unit dining rooms weekly x21 weeks, starting on 10/30/24 through 3/31/25. Copies of Meal Reviews and comments from observations of dining service will be presented and reviewed at the quarterly QAPI meeting on 4/10/25. Evaluation forms rating the food and staff interaction with the residents is an ongoing measure that will be reported quarterly. The goal of compliance is 100%.	4/10/2025

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			IVHM Leadership staff will continue with weekly evaluations of the food served to the residents, as well as observation of staff interaction with the residents.		
§ 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.	An immediate audit of logs for the dish machine and all refrigerators, freezers and coolers was completed. A certified Dietary Manager was hired through a staffing company and started 10/22/24. A policy (#15.02, effective 10/24) was drafted and approved. The policy details responsibility for labeling, storing and disposing of residents' food in the living area refrigerators.	All residents have food prepared and served from the central kitchen and all have the potential to be affected by this deficient practice.	Temperature logs of all equipment, i.e. dish machine, coolers, refrigerators, freezers will be monitored daily by the Dietary Supervisor, and checked weekly by the Dietary Manager 2. The comprehensive sanitation policy/checklist includes a daily equipment cleaning schedule. The Dietary Supervisor and the Dietary Manager 2 are responsible to ensure daily completion. The Adjutant is responsible for the Dietary department. A policy (#15.02, effective 10/24) was drafted and approved. The policy details responsibility for labeling, storing and disposing of residents' food in the living area refrigerators.	The Dietary Manager 2 and the Adjutant are responsible for auditing the percentage of completion of daily logs and compliance with the cleaning schedule data. For food storage in the living area refrigerators, the Nursing Supervisor for each living area is responsible for auditing their refrigerator once weekly (at a minimum) for twelve (12) weeks, for proper food storage, per policy #15.02, taking action where needed, and immediately reporting any action taken to the Director of Nursing. Audits will begin 10/1/24, and end on 3/28/25, and results will be reported at the 4/10/25 quarterly QAPI meeting. 100% compliance is expected.	4/10/25
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	A metal container with a self-closing lid has been replaced in the identified area.	All designated smoking areas in the courtyard area will be monitored weekly for four (4) weeks, then every two (2) weeks times 3, for a total monitoring period of 10 weeks, to ensure that the area is equipped with a metal container with a self-closing cover. This will continue monthly until 100% compliance is	An additional metal self-closing container has been procured. When the container in the area is being emptied, the replacement container will be in place.	Fire/Safety Officer will monitor all containers in all designated smoking areas in the courtyards every week for four (4) weeks beginning 10/28/2024; every two (2) weeks times 3, for a total monitoring period of 10 weeks; then monthly thereafter. Monthly results will be reported at the	1/9/2025

		achieved and sustained.		quarterly QAPI meeting on 1/9/25. The Fire/Safety Officer is responsible for this measure. 100% compliance is expected.	
§ 51.210 (o) (1) Clinical records. (1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.	Resident #37 was rescreened to determine if a Broda chair is an appropriate fit for him/her. Based on the evaluation by Physical Therapy (PT) and Occupational Therapy (OT), a Broda chair is appropriate due to insufficient trunk strength to maintain an upright seated position.	All Veterans in Broda chairs (22 total) have been re-evaluated by OT and PT for seating and positioning. An interface between Therapy's clinical documentation program and the facility's Point Click Care (PCC) Electronic Medical Record (EMR) has been established, which allows for licensed staff to have immediate access to current and historical therapy data, including the seating evaluation. This information is also immediately available to all providers within the Therapy tab located in PCC. All licensed staff have been educated on how to access information on the Therapy tab located in PCC.	An interface between Therapy's clinical documentation program and the facility's PCC program was established. Therapy documentation will be reviewed at each residents' quarterly Care Plan Team meeting, and updated with any change in condition. Restorative staff will audit the clinical record of all residents placed in Broda chairs for a seating evaluation upon initial order, at the quarterly Care Plan Meeting, and with Change of Condition.	Restorative staff will audit the clinical record of all residents placed in Broda chairs for a seating evaluation, 1) upon initial order; 2) at the quarterly Care Plan Meeting; and 3) with Change of Condition. Audits will begin 1/9/2025 and will end on 3/31/25. Restorative staff will report results of the audits at the 4/10/2025 quarterly QAPI meeting. The goal for compliance is 100%.	4/10/2025

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