State Veterans' Homes (SVH) Corrective Action Plan
Alfredo Gonzalez Texas State Vet Home 3-19 to 3-22-24

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)
§ 51.120 (i) Accidents	The Director of Nursing services completed the accident investigation for resident #1. The Regional nurse & Vice President of Ops re-educated administrator and Director of Nursing Service on importance of accident investigations. An event notification email will be sent to Vice President of Ops and Regional nurse by Administrator or Director of Nursing services for review of any accident that meets criteria of unwitnessed fall with injury.	We will identify accidents that warrant more thorough investigation by daily review of via the 24-hour report, team member notifications via phone, daily morning clinical start-up and daily review of risk management.	The Director of Nursing services or designee will review the 24-hour reports and incidents to ensure that all accidents are investigated timely, and interviews and statements from team members will be obtained timely.	Administrator will audit all event notifications regarding accidents daily x 4 weeks, and weekly x 8 weeks thereafter, to ensure the Administrator or designee obtained proper statements and that the investigation was completed. The results of the audits will be presented to Quality Assurance Process Improvement (QAPI) committee monthly x 2 months. Any changes in the plan, if needed, will be made, and reported to the administrator. The audits began on 3-25-24 and will continue until 6-24-24. Our goal for compliance is 90%.	07-01-2024
§ 51.120 (m) (1) Unnecessary drugs	For the resident # 12 and resident #14 the behavior tracking order and Medication Administration record sheets for behavioral tracking were immediately put in place. The Director of Nursing services re-educated the nurses to check the orders and Medication Administration record sheets for behavior tracking on current residents on psychotropics, new admissions, and readmissions.	We will identify residents who need orders and Medication Administration record sheets for behavioral tracking of psychotropics meds by reviewing those orders on new admissions, readmissions, and in clinical start-up will review any new or changed psychotropic orders on current residents.	The Assistant Director of Nursing or designee will review orders and Medication Administration record behavioral tracking sheets of psychotropic meds during clinical start-up on new admissions, readmissions, and new or	The Assistant Director of Nursing or designee will audit medication orders and Medication Administration record behavioral tracking sheets for psychotropic meds on new admissions, readmissions, and for all current residents who receive or may be prescribed psychotropic medications daily x	07-01-2024

			changed psychotropic orders on current residents to ensure the orders for behavior tracking are in place and the behavioral tracking sheet is being used.	4 weeks and twice a week x 8 weeks. The results of the audits will be presented to QAPI committee monthly x 2 months. Any changes in the plan, if needed, will be made and reported to the administrator. The audits began on 3-25-24 and will continue until 6-24-24. Our goal for compliance is 90%.	
§ 51.140 (h) Sanitary conditions	All items in the kitchen were properly washed, cleaned, and dried. Re-education provided by Food Service Director to dietary team members to ensure proper drying of dishes/blender, proper cleaning of appliances, juice gun, and proper cleaning and sanitizing of kitchen surfaces, cookware and appliances.	All residents who receive beverages and meals from the kitchen are potentially at risk for the alleged deficient practice	Food Service Director or designee will be do a cleaning schedule and implement proper dish/blender drying procedures to be followed by dietary team members. Upon hiring new dietary team members, their orientation will include proper cleaning tasks and dish/blender drying procedures. Audits will be conducted to ensure procedures are in place.	The food service director or designee will be conducting audits on dish/blender proper drying, and cleaning of juice gun, bins, and kitchen appliances 3 days per week x 4 weeks and once a week x 8 weeks. The results of the audits will be presented to QAPI committee monthly x 2 months. Any changes in the plan, if needed, will be made and reported to the administrator. The audits began on 3-25-24 and will continue until 6-24-24. Our goal for compliance is 95%.	07-01-2024
§ 51.200 (a) Life safety from fire	The Director of Maintenance immediately inspected all storage areas to ensure there were not issues, and in the identified areas maintenance team members immediately placed all storage items below the 18-inch clearance from ceiling to allow for proper sprinkler performance if activated. Maintenance Director re-educated central supply, maintenance, housekeeping, and dietary team members on the 18-inch threshold.	All residents are potentially affected by this alleged deficient practice.	The Maintenance Director will schedule maintenance team members to check the 18-inch clearance on a daily basis. Posters will be added in addition to the red tape that marks the 18-inch threshold to remind individuals where to place items in storage.	The Maintenance Director or designee will audit the storage rooms 5 x per week for 4 weeks and 3 x per week x 8 weeks, thereafter. The results of the audits will be presented to QAPI committee monthly x 2 months. Any changes in the plan, if needed, will be made and reported to the administrator. The audits began on 3-25-24 and will continue until 6-24-24. Our goal for compliance is 100%.	07-01-2024

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