State Veterans' Homes (SVH) Corrective Action Plan
Alfredo Gonzalez Texas State Veterans Home, 3/21/23-3/24/23

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)
51.90 (c) (2)	Administrator and DNS were in-serviced on the timely reporting of incidents found to meet criteria. An event notification email will be sent to at VP and DCO for review of an incident meets criteria. Audits will be conducted.	We will identify residents 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.	DNS or designee will review the 24-hour reports and incidents to ensure that all incidents that meet criteria will be identified and reported timely.	Administrator will audit all event notifications daily x 4 weeks, and weekly x 4 weeks thereafter to ensure self-reports were identified and sent in timely. The results of the audits will be reported to QAPI x 2 months.	7-19-23
51.110 (b) (1)	For residents #1, #2, #3, and #4 the care plans for the CAA's have been completed.	These Veterans were reviewed and had their MDS accurately reflect identified triggers. The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide specific guidance on how to understand or interpret the triggered areas. The RAI states that written documentation may appear elsewhere in a resident's record, for example, flow sheets, progress notes, MARS, TARS, and ADL documentation.	Two MDS were hired. Both MDS were re-educated regarding the RAI process to include: MDS 3.0, RAI Manual Chapter 4: Care Area Assessment (CAA) Process and Care Planning by Regional Clinical Reimbursement RN.	DNS or designee will review 2 veterans per day x 4 weeks in the Daily Clinical Start Up Meeting to validate the accuracy of the MDS 3.0 assessments and the completion of CAA Trigger Summary. DNS/designee will then audit 2 veterans per weeks x 4 weeks thereafter to ensure completion of CAA Trigger Summary. The results of the audits will be reported to QAPI x 2 months. Any identified issues will be addressed immediately.	7-19-23
51.110 (e) (1)	For resident #1 the care plan was corrected to include non-pharmacological interventions for sleep.	DNS or designee will identify residents by reviewing the orders to find residents on hypnotics and an attempt of non-	Two MDS were hired. Both MDS were given training by Regional Clinical Reimbursement	DNS or designee will review all hypnotic orders for non-pharmacologic interventions and update care plan as appropriate	7-19-23

		pharmacologic interventions will be done and will be updated in the care plan.	RN. DNS ordesignee will review hypnotics to ensure non-pharmacologic attempts were made and care plan updated.	for each veteran on hypnotic medication. DNS/designee will review new orders daily in the Clinical Start Up meeting to ensure nonpharmacological interventions are added to the care plan for hypnotic medications as appropriate for the veteran. Audit will include identified non-pharmacologic interventions done and an audit of the care plan will be completed. The results of the audits will be reported to QAPI x 2 months. Any identified issues will be addressed immediately.	
51.110 (e) (2)	For Resident #7, #23, and #24 the family members were invited to care plan and they participated. All residents are potentially affected.	MDS or designee will identify residents by review of PCC to create list of residents to be scheduled a care plan meeting based on their admission/quarterly/annual or significant change careplan due They will give a list weekly to LSW for the invitations to be done and sent out.	Two MDS were hired. MDS nurses were given training by Regional Clinical Reimbursement RN on scheduling care plan meetings as indicated. MDS Coordinators will ensure the invitations are sent out and care plans held weekly.	MDS or designee will review the list of those scheduled and those that attended care plan meetings weekly x 4 weeks for 2 months. The results of the audits will be reported to QAPI x 2 months. Any identified issues will be addressed immediately.	7-19-23

51.120	For resident #5 the enteral nutrition bag was dated when identifiedas not dated. The nurses will adhere to the G-tube pump manufacturers recommendations and care plans are now updated to include the recommendedtimes the formula and water flush bags should be changed. All residents with G-tube are potentially affected.	Nurses will date the formula and bag with water flush when they are added to the pump for the G-tube. MDS or designee will have care plans include the recommendedtimes forthe bags to be changed.	All nurses and the two MDS were in serviced on the importance of dating all formula bags and bags forthe waterflush. Audits of the G-tube bags placed on the pump will be conducted by DNS or designee. MDS coordinators will ensure the care plans are updated to include the recommended times for changing the bags.	DNS or designee will audit 3 to 5 residents with G-tube daily x 2 weeks and will audit 3-5 residents weekly x 4 weeks. The results of the audits will be reported to QAPI x 2 months. Any identified issues will be addressed immediately.	7-19-23

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

51.120 (j)	All team members were immediately re-educated on the importance of following the RD recommendations and new orders in place in a timely manner. Weight loss committee meets weekly to review residents identified as having weight loss. The RD is part of the committee. The team reviews residents with weight loss and interventions implemented.	All residents that are at risk for weight loss will be identified as potential to be affected.	RD will add ADNs to email when sending out dietary recommendations. DNS and ADNS were re-educated ontimely follow up on recommendations.	Monitoring tool will be completed weekly x 4 weeks, and monthly x 2 months to ensure sure recommendations were signed and new orders completed. The results of audits will be reported to QAPI monthly x 2 months. Any identified issues will be addressed immediately.	7-19-23
51.140 (h)	All team members were immediately re-educated to not touch the glasses and coffee mugs by the rim. The team members were also re-educated to sanitize/wash hands in between touching residents. Sanitizers are available to team members as well as the wall mounted ones. All residents that go to communal dining are potentially affected.	Residents who go to the dining room for communal dining will be identified as potential to be affected. Nurses and CNAs will be distributing glasses and coffee mugs without touching the rim. Nurses and CNAs will sanitize hands in the dining room before touching a resident after feeding or touching another resident.	Dining rooms will be monitored by DNS/designee to ensure that nurses and CNAs are properly serving drinks in a sanitary manner and sanitizing/washing hands in between residents.	DNS or designee will audit dining rooms 3 x week for 2 months. The results of the audits will be reported to QAPI x 2 months. Any identified issues will be addressed immediately.	7-19-23
51.190 (b)	All nurses and nurse managers were re-educated on the importance of placing signage on door as needed for controlling the spread of infection when resident is placed on isolation precautions. All residents are potentially affected.	DNS will identify those needing contact precautions and/or isolation precautions by reviewing the 24-hour report, via telephone call from nurses or physician, and review of labs in the daily Clinical Start Up meeting.	Doors of residents will contain the necessary signs once the resident is identified as needing to be on isolation precautions and/or have contact precautions.	DNS or designee will identify those on isolation precautions and ensure signage is posted throughout their duration of isolation. Those on isolation precautions will be audited daily to ensure signage is posted. The results of the audits will be reported to QAPI x 2 months. Any identified issues will be addressed immediately.	7-19-23
51.200 (a)	All kitchen equipment is in working order and the metal between the deep fat fryer and gas range is in place and in good condition. The metal plate was attachment was completed immediately upon notification. The Director of Dietary and Maintenance Director will ensure the plate is in place. All residents that go to the dining area are potentially affected.	The residents identified as at risk for being affected by the removal of the metal place would be those who go to the dining room near the kitchen. The Director of Maintenance and Director of Dietary will monitor the kitchen during rounds to ensure the plate is in place and in good condition	Safety rounds will be conducted in the kitchen by Director of Maintenance and Dietary Director.	The Director of Maintenance will audit the metal place daily x 4 weeks and weekly x 4 weeks thereafter. The results of the audits will be reported to QAPI x 2 months. Any identified issues will be addressed immediately.	7-19-23