State Veterans' Homes (SVH) Corrective Action Plan
Oklahoma Veterans Home – Norman – 10/31/-11/3/2023

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)
§ 51.43 (d) Drugs and medicines for certain veterans VA may furnish a drug or medicine under this section and under §17.96 of this chapter by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means and packaged in a form that is mutually acceptable to the State home and to VA set forth in a written agreement. Rating: Not Met one (1) of seven (7) sampled Residents was ineligible to have medications furnished by the VA.	Resident was ineligible for Aide and Attendance based on excessive estate. A VA Form 10-0460 was filled out in error in April 2022 because it was thought the form had to be filled out for all residents. The form did not say she qualified for medication, rather "Excessive Estate" was written on the form. She was marked as ineligible for medications in the facility electronic medical records system, PCC. That list is sent monthly to the VA hospital. Facility attempted to use a spreadsheet to track eligibility, and the resident was marked as eligible by mistake on that spreadsheet. The spreadsheet was used twice but has been discontinued. The incorrect spreadsheet was also provided to the VA survey team. Resident remains ineligible for prescriptions on report from PCC that is sent to the VA hospital.	All current Resident records in PCC have been checked to ensure all residents have been properly identified for medication eligibility.	New residents will have eligibility checked and recorded upon admission. Residents who have a new Aide and Attendance or Service Connection claim decision will be reviewed by Patient Services to determine if their eligibility for medications changes.	Administrator of Designee will monitor all admissions to ensure eligibility has been recorded properly, weekly x 4, monthly x 3 then quarterly. Veteran Services Representative to report in quarterly QA meeting on changes in Service Connection and Aide and Attendance. Report will be compared with PCC to ensure eligibility status in PCC is correct.	Mar 31, 2024

	The veteran is a WWII veteran. A new 10-10 SH has been submitted based on expanded health care availability through the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (Cleland-Dole Act). Facility has not been informed if that will allow resident to be eligible for medications through the VA. Meanwhile, she remains marked as ineligible on report to VAMC. Patient Services staff to be on requirements for medication eligibility.				
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility**.** Rating – Not Met The facility failed to provide evidence that a surety bond or other assurance was secured for the security of all personal funds of residents deposited with the facility.	The facility has a current Certificate of Liability Insurance that covers the facility for acts of crime up to $1,000,000. Oklahoma Department of Veterans Affairs will work with the VA to complete a packet of all necessary documents which will be submitted to the Under Secretary of Health for review.	This has the potential to affect all residents if the trust fund is somehow compromised.	The business office will run a trust fund balance report that includes the sum of all residents' accounts on the first business day of each month. The Administrator or designee will review the balance monthly to ensure it is under $1,000,000. If the balance of the trust account is over $900,000, any resident that has over $50,000 in their trust account will be identified. The facility will contact the USDVA or resident's financial designee and request a new payee to be named for the resident VA monies, Social Security or any other financial entitlements.	Resident fund totals compared to policy limit to be monitored monthly and reported quarterly to QI committee by the Administrator or designee. Administrator will quarterly request an update from the ODVA Director of Homes until approval has been obtained from the Under Secretary of Health.	Dec 31, 2024

§ 51.70 (n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe. Rating – Not Met The facility failed to assess a resident for self-administration of medication for safe practice for one (1) out of 46 sampled residents (Resident #19).	Resident involved had not been assessed and had not been approved for self-administration of medication. He had purchased over the counter medications from Walmart. Medications were removed when discovered. He was assessed for self-administration and could not meet requirements.	All residents' records were reviewed, and 15 residents were identified to have orders for the self-administration of medication. All residents were assessed using an assessment tool in PCC. No resident was able to satisfactorily meet the requirements of the assessment, and none were approved for self-administration. All medications were removed from resident rooms.	Residents already sign an agreement on admission to not have over the counter medication or medications from other providers without approval from the care team. This is also included in the resident handbook. All residents will be reminded by letter of this requirement. Residents who desire to self-administer medication will be assessed and reviewed by the care team. With mail order available and Walmart nearby, residents purchasing over the counter medications is an ongoing problem. Additionally, some families will bring medications to their resident. Direct care staff will be educated that medications should not be in residents' rooms and instructed to report any medications discovered in resident rooms to Nursing Administration or facility Administration so it can	Any issues will be reported to Administration. List of residents with self- administered medications will be reviewed in quarterly QA meeting to ensure all have had assessments completed with a goal of 95% compliance.	Mar 31, 2024

			be removed and address with the resident if they are not approved for self- administration. Weekly environmental rounds that are performed by Administration, Director of Nursing, Housekeeping, Maintenance and RN Unit Manager, Social Services and other departments will include checking for over the medications in resident rooms.		
§ 51.120 (n) Medication Errors. The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented Rating – Not Met The facility failed to ensure that medications/ supplements were given as ordered for one (1) resident resulting in one (1) error out of 33 opportunities observed (Resident #47).	An observation and interview, on 11/1/23, revealed that for one resident Prosource was supplied in a 45 ml packet while the Physician Order was for 60 ml twice per day. When this was pointed out the Nurse Practitioner was notified, and the order was changed to reflect what was available.	All resident records were reviewed, and 17 residents currently have orders for dietary supplements. Long term there are many residents who may need dietary supplements.	Dietary Manager provided an updated list of what supplements were available. Providers and Nursing compared list to orders for all residents to ensure orders were correct. Staff being trained on reading orders to verify quantities for supplements. List of supplements available to be updated and distributed as availability changes and quarterly.	Director of Nursing or designee will randomly monitor supplements being administered to ensure the correct dosage is being given with a goal of 95% compliance. This will be done weekly x 4, monthly x3 then quarterly any issues will be reported to QA.	Mar 31, 2024

§ 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 The facility failed to ensure food served to residents was stored and served under sanitary conditions. 1. Observations revealed there was a large accumulation of ice buildup located behind the fans in the walk-in freezer. In addition, four (4) boxes of frozen chicken were stored directly underneath the ice buildup.	1. Accumulated ice was removed. Walk in freezer had missing and torn insulation on some lines. Insulation was replaced.	All residents could potentially be impacted. All other walk ins were inspected for ice accumulation with none found.	Dietary Manager and Supervisors to inspect walk-ins weekly and submit work orders as necessary. Updated daily mechanical rounds to include visual inspections of walk-in units inside and outside. Weekly maintenance workorders issued to check for ice, remove any ice found, verify the integrity of the refrigerator piping and door seals. Repair as needed. Dietary workers to be retrained on stocking refrigerators in accordance with the first in, first out principle.	Weekly inspections will be annotated in a log for reach walk-in. Assistant Administrator to check log for staff compliance. Maintenance supervisor to check weekly work orders for compliance by staff. Compliance goal is 90%. Logs and work orders to be reviewed in quarterly QA meeting.	Mar 31, 2024
	2. Expired milk was removed from refrigerator and disposed of.	Refrigerators on all other units were checked for expired items. Expired items were disposed of.	Dietary Manager, Supervisors and dietary staff will check refrigerators daily.	Dietary staff will record their daily checks to ensure compliance with a goal of 90%. Assistant Administrators, Administrator, and Nursing Administration will conduct spot checks and report issues to Dietary Manager for correction.	Mar 31, 2024
	3. Dietary workers involved received immediate retraining on washing and sanitizing hands before and while serving food, as well as other proper infection control procedures (such as not touching the tops of the plates).	All residents have the potential to be impacted by improper hand washing by dietary staff.	All dietary staff to be retrained on washing and sanitizing hands before and while serving.	The Dietary Manager and Supervisors will monitor staff for proper hand washing and sanitizing while serving food. This will be done weekly x 4, monthly x 3 then quarterly with a goal of 90%.	Mar 31, 2024

2. On 10/31/23, observations of a nourishment refrigerator on a unit of the facility revealed five (5) single serving containers of 2% milk and five (5) single serving containers of skim milk which were dated 10/30/23. The containers of milk were behind newer containers of milk dated 11/7/23. 3. Dietary Worker did not wash or sanitize their hands before serving food on unit and did not wear gloves. 4. Dietary worker did not take and record temperatures for food before serving.	4. Dietary workers involved received immediate retraining.	All residents have the potential to be affected when food temperatures are not properly taken and recorded.	All dietary staff to be retrained on taking food temperatures and recording temperatures prior to serving.	Dietary Manager, Supervisors, and Nutrition Assistant will conduct daily observations on units to ensure food temperatures are taken and logged correctly. This will be done weekly x4, monthly x3 then quarterly with a goal of 90% compliance.	Mar 31, 2024
§ 51.190 Infection control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Rating – Not Met 1.The SVH failed to ensure	1. All nurses and ACMAs were retrained on the proper cleaning and sanitizing of glucometers between uses.	There are currently 70 residents who are required to have their blood sugar checked with a glucometer.	The cleaning and disinfection of glucometers was added to the annual skills fair. This task will be trained quarterly x4. As an additional precaution, residents with a blood borne pathogen have each been assigned their own glucometer.	Director of Nursing or designee will monitor the cleaning of glucometer between residents. This will be done weekly x4, monthly x3 then quarterly with a goal of 95% compliance. Any issues will be reported to QA.	Mar 31, 2024

staff appropriately cleaned and disinfected glucometers between residents, 2.SVH failed to ensure that licensed staff removed gloves after performing catheter care and pressure ulcer treatment on one (1) of five (5) halls. 3. Staff failed to clean and sanitize scissors before and after using for resident care.	2. All nursing staff were trained on the proper donning and removal of gloves while providing catheter and wound care. 3. Nursing staff be trained on the proper cleaning and disinfection of equipment between uses for resident care.	There are currently 32 residents requiring catheter care. All residents have the potential to be affected by this practice.	This task to be trained quarterly x4. This task to be trained quarterly x4.	Director of Nursing or designee will monitor the proper use of gloves when providing catheter care and wound care to residents. This will be done weekly x4, monthly x3 then quarterly with a goal of 90% compliance. Any issues will be reported to QA. Director of Nursing or designee will monitor the cleaning of equipment before and after using for resident care. This will be done weekly x4, monthly x3 then quarterly with a goal of 90% compliance. Any issues will be reported to QA.	Mar 31, 2024 Mar 31, 2024
§ 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. **Rating** – Not Met 1.The facility failed to maintain the kitchen cooking hood ventilation systems in accordance with the code.	1a. Grease Baffles - All damaged grease baffles were replaced 1b. Kitchen Hood Seams – All seams were cleaned and recalked with high temp RTV silicone.	All residents have the potential to be affected. All residents have the potential to be affected.	Kitchen Staff to receive training on proper installation. Replacements ordered for use as needed. Monthly inspections have been generated for maintenance to inspect all kitchen vent hoods to verify integrity and repair as required.	Dietary Manager and supervisors to monitor equipment. Maintenance supervisor to review inspection reports to ensure completed and repairs performed. Maintenance supervisor to review inspection reports to ensure completed and repairs performed.	Mar 31,2024 Mar 31, 2024

2. The facility failed to properly maintain the sprinkler system.	2. Staff removed and rerouted the cabling that had been wrapped around and zip tied to the sprinkler pipe.	All residents have the potential to be affected.	Monthly electrical room inspections were changed to include Verify that no wiring, cabling, conduit, etc. is attached to or interferes with the sprinkler pipe or sprinkler head.	All work performed by staff or contractors will be monitored to ensure it is done in a manner to not impact sprinkler system. Maintenance supervisor to review inspection reports to ensure completed and repairs performed.	Mar 31, 2024
3. The facility failed to maintain the doors located within fire barrier walls to resist the passage of smoke.	3. Doors have been repaired. E2 main entry doors, fire rated sweeps have been replaced. F1 main entry doors, doors have been adjusted and working properly. F2 doors leading to dining area, doors adjusted and not dragging, will close without extra force.	All residents have the potential to be affected.	In addition to the required annual fire / smoke door inspections Maintenance will perform a semiannual function test on all smoke and fire doors. Fire and Safety staff will be trained to conduct monthly visual inspections of fire / smoke doors.	In addition to the required annual fire / smoke door inspections Maintenance will perform a semiannual function test on all smoke and fire doors. Fire and Safety staff will be trained to conduct monthly visual inspections of fire / smoke doors.	Jun 30, 2024
4. The facility failed to conduct all required fire drills.	4. Residents on units that did not conduct all fire drills have the potential to be affected, as well as all other residents. SVH will revise procedures for scheduling and conduct of fire drills to ensure no monthly fire drills are missed.	All residents have the potential to be affected.	SVH will revise procedures for scheduling and conduct of fire drills to ensure no monthly fire drills are not missed.	Copies of sign off sheets that a fire drill has been completed will be provided to the Assistant Administrator upon completion of the drill monthly.	Mar 31, 2024

5.The facility failed to prohibit the use of portable space heaters that did not meet the requirements of the code.	Fire and Safety staff educated on the importance of and the procedure for completing fire drills monthly. 5. Portable space heaters were immediately moved at the time of the survey.	All residents have the potential to be affected.	Staff will be educated on uses of portable space heaters. Fire and Safety will include checks in offices during their rounds.	Fire and Safety will include checks in offices during their rounds. This will be done weekly. Any issues will be brought to Administration.	Mar 31, 2024
§ 51.210 (h) Use of outside resources. Not Met 1. The facility failed to ensure there was a sharing agreement for mental health services provided by the VA Medical Center,	1. Oklahoma Department of Veterans Affairs-Central Office is currently working with the VAMC in OKC to obtain a mental health sharing agreement.	There are currently 76 residents who receive Mental Health services through telehealth or in-person through the VAMC. Additional veterans are identified as they are admitted, or as consults are submitted and accepted by the VAMC. Social Services Director keeps record of all residents receiving mental health services through the VAMC.	Mental Health: Once sharing agreement is in place it will remain in effect to cover current residents, and any residents requiring these same services in the future, who receive telehealth for (mental health and psychotherapy) and in person mental health visits at the VAMC in OKC and psychiatric hospital stays at the VAMC in OKC.	Administrator or designee will monitor progress quarterly until a sharing agreement with VAMC in OKC has been obtained. Status will be reported quarterly in QAPI meeting.	Dec 31, 2024
2. and failed to provide a written agreement between the facility and outside agencies for the	2. Facility does have a written agreement with a local dental office.	There are currently 93 residents who receive dental services outside of the VA healthcare system.	Dental sharing agreement remains in place for residents requiring dental services	All agreements and contracts are reviewed annually at the start of the Fiscal Year to determine if they need to be	Oct 17, 2023

provision of dental services to the residents of the facility.			in the community. Agreement expires and will need renewal 2/1/2025.	renewed. Dental sharing agreement will be reviewed along with other agreements.	

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