State Veterans' Homes (SVH) Corrective Action Plan-LTC

Illinois Veterans' Home at Quincy 5/6/24-5/10/24

Updated 10/08/24

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)
§ 51.41 (c) (2) **Payments under State home care agreements** **The findings include:** Based on communications and record reviews, it was identified that the facility utilizes third-party providers for dental, mental health, radiology, and foot care services. Upon review of the written agreements between the facility and the third-party providers for each of the services, it was identified that the agreements did not specify that costs for services for Veterans for whom the facility receives the prevailing rate of VA Per Diem (Prevailing Rate Veterans) for nursing home care must be billed to the facility. Instead, each of the written agreements directed the third-party provider to invoice all residents' Medicare, Medicaid and/or private	Related to mental health, radiology and podiatry services IVHQ is working to amend contracts to indicate that 100% of cost for 70-100% service connected veterans will be billed to the Home. IVHQ is also working to establish a written contract with dental providers. Facility is reviewing invoices for these services which occurred in 2024 to determine amounts billed to insurance (mental health, radiology and podiatry) and residents (dental). Facility is discussing ability with vendors to process payment to vendors for amounts of insurance or private pay and have refunds issued to insurance/private pay	Related to mental health, radiology and podiatry services, IVHQ is working to amend contracts for mental health, radiology and podiatry to indicate that 100% of cost for 70-100% service connected veterans will be billed to the Home. IVHQ is also working to establish a written contract with dental providers and will indicate that 100% of cost for 70-100% service connected veterans will be billed to the Home. In turn, 100% will be billed back to the veteran by the Home.	Mental health, radiology and podiatry services contracts will be amended. Dental contract will be established. All medical invoices are reviewed by an employee of the Business Office. This employee already monitors therapy invoices to ensure we are billed 100% for prevailing rate veterans. This practice is being implemented for the other services that have been identified as needing to be covered 100% by the Home – mental health, radiology, and podiatry. IVHQ is also working to establish a written contract with dental providers and will indicate that 100% of cost for 70-100% service connected veterans will be billed to the Home and the Home will bill the veteran. Employee notifies vendor if	Bills for these mental health, radiology and podiatry services will be reviewed to ensure 70-100% service connected residents are fully billed to the Home. If found to be billed incorrectly, Home will notify vendor to correct. Home will notify dental office of 70-100% services connected residents needing to be billed to the Home and will follow same practice. This process is currently completed by an employee in the Business Department who reviews every medical invoice. This process has been in place for therapy services and is being implemented for the other services identified that should be covered 100% by the Home for prevailing rate veterans. Audit will be completed by Business Office – randomly selecting 5 invoices from related vendors. Frequency will be monthly for 3 months. Start date will be October 2024, end date December 2024. Results will be reported to Home Administrator. Goal for compliance is no errors – 100% of cost covered for these services for prevailing rate veterans.	Radiology contract amendment was completed 6/28/24. Podiatry contract amendment was completed 8/20/24. Mental health contract amendment is pending vendor signature since 7/25/24. IVHQ currently working to establish dental contracts, targeted completion date by 10/31/24. Facility review and refund of insurance/private payments targeted completion date: 10/31/24. Targeted completed of implementation

insurance for services provided. Further review identified that the facility does not currently have any responsibility towards payment of dental services for any residents. The written agreements for mental health, radiology, and foot care stipulate that all residents' insurance is billed first, with the facility only paying if there is a copay or other remaining balance. The facility leadership could not provide evidence to demonstrate that the facility had paid the costs for Prevailing Rate Veterans in receipt of the services identified above	parties.		invoiced for amount other than 100% and requires vendor correction and resubmission of invoice.		and 3 monthly audits: 12/31/2024.
§ 51.70 (c) (5) **Conveyance upon death.** **The findings include:** Review of the facility's undated policy titled, "Resident Trust Fund Policy Notification and Authorization," revealed: "Upon the death of a resident, the Home shall provide the executor or administrator of the resident's estate with a complete accounting of all of the funds in a resident's trust account. Within 30 days of a resident's death, the IVH must convey the resident's funds and a final accounting of those	Funds for the two 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 #25 on May 9, 2024. Letter and a copy of required documentation was sent to next of kin for R#26 via certified mail on May 9, 2024. Phone contact was made July 25, 2024, and documents were sent again via email. Two additional estates were identified being past 90 days during a complete review of	During admission new members will be asked to provide a copy of their Last Will and Testament and assign a designated person to collect funds upon death and have them complete a W9. The W9 that is filled out upon admission will be used to convey funds for all accounts of deceased residents.	Upon notification of death of a resident, the Adjutant's office will send out correspondence to the executor that will include a final accounting of funds and a copy of the completed W9 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	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 Adjutants office will keep track of open estates dates and when funds are set to the State of Illinois Unclaimed Property. The Adjutant will conduct an audit of all deceased estates weekly for four weeks beginning July 29, 2024 and ending August 26, 2024	October 4, 2024

funds to, in order of precedence: the executor or administrator of the estate; the attorney for the estate; or in the absence of a will or trust, the IVH may accept a small estate affidavit and disburse the deceased resident's trust accounts funds to the small estate affiant." Review of Resident #25's Electronic Health Record (EHR) revealed the resident expired on 9/29/23. Resident #25's Trust Fund Statement revealed an ending balance of $166.80. Review of Resident #26's EHR revealed the resident expired on 12/30/23. Resident #26's Trust Fund Statement revealed an ending balance of $157.37. An interview was conducted with the Business Manager (BM) on 5/8/24, at 10:03am. The BM revealed that the resident's trust fund accounts were not conveyed within 90 calendar days because the facility management did not have a will or trust for either resident. The BM revealed it was the facility's expectation to convey funds at least 30 days after a resident expires	all accounts. Contact was made via phone for one estate and attempted for the other. Certified letter was sent to both next of kins July 25, 2024.On October 2, 2024 funds were conveyed to one of the additional estates to the individual administering the residents estate, in addition verbal compliance was received to send the funds for the other estate to the State of Illinois Unclaimed Property.		payment. The Adjutant's office will track the date documents received for estate closeout, and date voucher sent to Business Office. Business Office will document the date the voucher was paid. Goal for compliance: 100%. The current outstanding estate will be released to the State of Illinois Unclaimed Property by Friday, October 4, 2024.		

§ 51.80 (b) (2) Bed-hold notice upon transfer. **The findings include:** The facility policy titled, "Bed Hold Policy Notification," not dated, stated: "It is the policy of the Illinois Department of Veterans' Affairs to hold a member's bed for them when the members leaves the facility for any of the following reasons: …2. An authorized medical leave of absence for any length of time…The member's belongings and bed will be maintained during their absence. The member is still responsible for all monthly maintenance charges, Aid and Attendance charges (if applicable), and cable TV charges." Review of Resident #24's medical record revealed the resident was readmitted to the facility on 12/21/22, and diagnoses included Congestive Heart Failure, Urinary Tract Infection, and Exacerbation of Chronic Obstructive Pulmonary Disease. Review of a Health Status Note, dated 6/28/23, at 4:15 p.m., revealed Resident #24 was transferred to the hospital via ambulance for Hypoxia. A subsequent Health Status Note, dated 6/28/23, at 6:10 p.m., stated Resident #24 was being released to return to the facility. There was nothing	IDVA is creating a PCC progress note template for all transfers and therapeutic leaves that verifies resident/POA was notified of Bed Hold notice. This will be completed by August 9, 2024.	All direct-care staff will be trained on PCC progress note template by August 9, 2024.	IDVA is creating a progress note template for transfers and therapeutic leaves that verifies the resident/POA was notified of Bed Hold notice. This will be completed by August 9, 2024. The Adjutant's Office will conduct an audit of all transfers and leave of absences to ensure the bed hold policy was given twice weekly starting August 9, 2024 for four weeks, ending September 6, 2024 (Goal is 80% compliance)	Quality Assurance and Improvement committee will review survey findings, the new progress note template, and the audit at the Quality of Assurance and Performance Improvement committee meeting held on August 14, 2024.	September 6, 2024

in the resident's electronic medical record to state the resident or his/her family member or legal representative was notified of the facility's Bed Hold Policy at the time of the resident's transfer to the hospital, or anytime thereafter. Review of Resident #28's medical record revealed the resident was admitted to the facility on 11/29/23, and diagnoses included Atrial Fibrillation, Gastrointestinal Hemorrhage, Atherosclerotic Heart Disease, and Benign Prostatic Hyperplasia. Review of a Health Status Note, dated 5/1/24, at 7:00 p.m., noted the resident was started on an antibiotic twice daily for seven (7) days for a Urinary Tract Infection. Review of a Physician's Progress Note, dated 5/2/24, at 10:43 a.m., revealed that Nursing voiced concern to the Provider that the resident was weaker, speech more difficult to understand, had worsening edema with weight gain, and little urinary output on the preceding night shift. The Provider contacted the resident's legal representative, and it was agreed that the resident would be transported to the Emergency Room via security and a stretcher for evaluation. There was nothing in the resident's electronic medical record to state the					

resident or his/her family member or legal representative was notified of the facility's Bed Hold Policy at the time of the resident's transfer to the hospital, or anytime thereafter. Review of Resident #30's medical record revealed the resident was readmitted to the facility on 11/16/23, and diagnoses include Unspecified Dementia and Personal History of Traumatic Brain Injury. According to a Progress Note, dated 5/5/24, at 6:45 p.m., Resident #30 fell while in the dining room, hitting his/her head. The resident was found to be unresponsive with no respiration or palpable pulse. Cardiopulmonary resuscitation was initiated with success, and the resident was transported to the hospital via ambulance. There was nothing in the resident's electronic medical record to state the resident or his/her family member or legal representative was notified of the facility's Bed Hold Policy at the time of the resident's transfer to the hospital or anytime thereafter. When asked for documentation that residents were provided a written copy of the facility's Bed Hold Notice upon transfer to the hospital, at approximately 11:00 a.m., on 5/9/24, the Business Manager provided a copy of the "Home Resident Contract Between					

Resident and Facility," which was signed at the time of admission. The Business Manager reported that, because the facility always held a resident's bed when a resident transferred to the hospital, the facility did not provide a written notice of the bed hold policy. The Business Manager also reported that nursing staff provided verbal notification to the resident / legal representative at the time of transfer that the resident's bed would be held for them, and that this verbal notification was recorded in the resident's Progress Notes. As of the time of the survey exit, at 9:15 a.m., on 5/10/24, the facility was unable to provide evidence that the resident or a family member or legal representative was provided a written notice at the time of transfer, informing them that the bed would be held and/or that the resident would be responsible for any applicable charges during their absence.					

§ 51.110 (c) Accuracy of assessments. **The findings include:** An observation during the initial tour, on 5/6/24, at 11:30 a.m., revealed Resident #8 wore weather appropriate clothing. The resident utilized a motorized wheelchair and had a contracture of the left hand. Continued observation revealed the resident had a pack of cigarettes located in his/her shirt pocket. An interview was conducted during the initial tour with Registered Nurse (RN) E, on 5/6/24, at 11:40 a.m., and revealed Resident #8 was assessed to be a safe smoker; therefore, the resident was allowed to smoke freely without supervision. During an observation, on 5/7/24, at 1:10 p.m., Resident #8 was observed in the smoking area with a lit cigarette and smoked without any safety concerns. After completion of smoking, the resident extinguished the cigarette butt into the designated receptacle. Review of the facility's "Resident Assessment Instrument/Minimum Data Set" policy, reviewed/revised 9/2020, revealed: "The Resident Assessment Instrument (RAI) assists staff to consistently and accurately	With regard to tobacco use not being accurately coded on a resident's MDS: - MDS coding was corrected to reflect tobacco use on Resident #8 - MDS employee was educated on the facility's "Resident Assessment Instrument/Minimum Data Set" policy on 7/2/24 All MDS nurses received training on the facility's "Resident Assessment Instrument/Minimum Data Set" policy on 7/2/24	-The MDS section for tobacco use was reviewed on all residents 5/17/2024 by MDS supervisor. -All tobacco users reviewed for smoking UDA by unit supervisors on 5/17/24	-MDS supervisor will audit MDS assessments of the MDS nurses of 2 audits a week x4 weeks from 7/14/24- 8/10/24 (Goal is 100% compliance) -All tobacco users to be reviewed for smoking UDA and MDS coding during quarterly care plan meetings	-Quality Assurance and Improvement committee will review the survey findings and audit sheets at next Quality of Assurance and Performance Improvement committee meeting held on August 14, 2024.	-Corrective Action will be fully implemented and sustained by October 04, 2024.

gather information regarding resident needs/strengths, preferences, and assess change in condition utilizing a standardized assessment tool (MDS 3.0) which provides the foundations for an individualized plan of care for each resident." Review of the Resident #8's clinical record revealed, on 5/25/23, the facility admitted the resident with diagnoses of Cerebral Infarction, Hemiplegia left non- dominant side, and Multiple Contractures. Review Resident #8's Annual MDS, with an Assessment Reference Date (ARD) of 4/25/24, revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Continued review of the MDS revealed the facility assessed the resident to not use tobacco. Review of Annual MDS, with an ARD date of 5/25/23, revealed the facility assessed the resident to have intact cognition. Further review of the MDS found it assessed Resident #8 to not use tobacco. An interview, on 5/8/24, at 10:45 a.m., with MDS RN D revealed he/she was aware of Resident #8's tobacco use. He/she revealed the purpose of having an accurate MDS assessment was to ensure the					

resident's care needs were individualized. MDS RN D revealed the failure to capture Resident #8's tobacco use on the MDS was an oversight. The lack of capturing Resident #8's smoking on the MDS lead the facility to not develop a Care Plan for smoking.					

§ 51.110 (e) (1) Comprehensive care plans. **The findings include:** Review of the facility's "Care Plan (Baseline/Comprehensive) – Care Plan Meeting" Policy No 3.5-C, with a revised/reviewed date of 9/2023, revealed the facility will utilize the Resident Assessment Instrument (RAI) to develop a Comprehensive Care Plan. The facility used various sources to obtain needed information for the RAI sources which included but were not limited to: 1. Identified resident's problems. 2. Identified resident's unique characteristics, strengths, weaknesses, needs and preferences. It further stated: "Readmissions and unit to unit transfers will require updating of the Comprehensive Care Plan in the EHR [Electronic Health Record] as indicated to guide appropriate resident centered care." Observation during the initial tour, on 5/6/24, at 11:30 a.m., revealed Resident #8 wore weather appropriate clothing. The resident utilized a motorized wheelchair and had a contracture to his/her left hand. Continued observation revealed the resident had a pack of cigarettes located in his/her shirt pocket.	With regard to tobacco use not being accurately care planned: -R#8's care plan was revised and individualized to include tobacco use on 5/9/2024	-All tobacco users' care plans reviewed for accuracy by unit supervisors on 5/17/24	-MDS supervisor will audit care plans of all tobacco users for 2 audits a week x4 weeks from 7/14/24-8/10/24. (Goal is 100% compliance) -All tobacco users to have care plans reviewed during quarterly care plan meetings by MDS nurses	-Quality Assurance and Improvement committee will review the survey findings and audit sheets at next Quality of Assurance and Performance Improvement committee meeting held on August 14, 2024.	-Corrective Action will be fully implemented and sustained by October 04, 2024.

An observation, on 5/7/24, at 1:10 p.m., revealed Resident #8 in a smoking area, with a lit cigarette, and they smoked without any safety concerns. After completion of smoking, the resident extinguished the cigarette butt into the designated receptacle. Review of Resident #8's clinical record revealed, on 5/25/23, the facility admitted the resident with diagnosis of Cerebral Infarction, Hemiplegia left non- dominant side, and Multiple Contractures. Review of Resident #8's comprehensive Care Plan, with a review date of 3/29/24, revealed no Care Plan for tobacco use was developed. An interview, on 5/8/24, at 10:45 a.m., with Minimum Data Set (MDS) Registered Nurse (RN) D revealed he/she was aware of Resident #8's tobacco use. He/she revealed the purpose of developing a Care Plan was to guide a resident's care needs. MDS RN D stated the lack of capturing Resident #8's smoking on the MDS lead the facility to not develop a person-centered Care Plan for smoking.					

§ 51.180 (d) Labeling of drugs and biologicals. **The findings include:** The facility policy titled, "PHARMACY POLICY AND PROCEDURES STORAGE OF MEDICATIONS AT THE NURSING UNITS," revised August, 2003, found: "PROCEDURE…6. Expired or discontinued medications shall be returned to the Pharmacy Department in a timely manner in accordance with policies and procedures in effect. The Emergency Medication Box and stock medications shall also be monitored in a similar manner on a routine basis." During a tour of the Medication Room on the Fort Shapland Neighborhood, at 9:25 a.m., on 5/6/24, observation found 19 Male End IV (Intravenous) Caps, which were kept past their expiration date of 4/1/24, and were available for patient use. These findings were verified with Nursing Supervisor A at 9:40 a.m., on 5/6/24. During a tour of the Medication Room on the West Wing of the Fifer Neighborhood, at 7:30 a.m., on 5/9/24, observation found one (1) opened, almost full, 100-count box of 30- gauge x 1/3-inch Novofine disposable	With regard to expired medications and treatment supplies: - Fort Shapland med room was reviewed for all expired items on 5/9/24 by Hammond Hall nursing unit supervisor – All Fifer med rooms and med carts were reviewed for all expired items on 5/9/24 by Fifer nursing unit supervisor	All medication carts and medication rooms were reviewed and audited for any expired items by unit supervisors on 5/17/24	-IVHQ is amending Unit Monthly Check sheets to standardize each unit to add specific list items to check for expired items in Medication Room and medication carts. - Unit supervisors will conduct 1 audit a week x4 weeks from 8/18/24-9/14/24 of each unit's medication room and each nurse's medication carts to ensure there are no expired items and to monitor charge nurses' compliance with checking for expired items as marked on the check sheets. (Goal is 100% compliance) -Unit supervisors will conduct random audits of medication carts of nurses and medication rooms for expired items no less than once per month (Goal is 100% compliance) -All nursing units to review at the next unit staff meeting that medication carts are to be checked weekly for expired items and when adding a new box of any supplies or medication that all items in the old box should be used first or discarded and not added to the new box.	Monthly check sheets will be turned in to unit supervisors and unit supervisors will audit 100% of all unit monthly check sheets for completion by conducting random audits of medication carts of nurses and medication rooms for expired items no less than once per month -Quality Assurance and Improvement committee will review the survey findings and revised monthly check sheets at next Quality of Assurance and Performance Improvement committee meeting held on August 14, 2024. - Random audits of medication carts and medication rooms will be reported to the Director of Nursing	Corrective Action will be fully implemented and sustained by October 04, 2024.

safety needles that had expired on 9/23/23, and were available for patient use. These findings were verified with Nursing Supervisor B at 7:40 a.m., on 5/9/24. During an observation of medication carts on the Fifer Neighborhood, on 5/9/24, the following items were found expired and available for use: At 7:32 a.m., on 5/9/24, an observation of Medication Cart B #2 found five (5) vials of sterile 0.9% saline with expiry dates of “FEB 24.” This observation was verified by Nursing Supervisor B at 7:38 a.m., on 5/9/24. At 7:50 a.m., on 5/9/24, an observation of Medication Cart A #2 found 19 individually packaged Bisacodyl rectal suppositories with expiry dates of “05/22,” and one (1) 30-ounce bottle of Nutricia Pro-Stat Concentrated Liquid Protein Medical Food with an expiry date of “21/MAR/2024.” This observation was verified by Nursing Supervisor B at 7:56 a.m., on 5/9/24. At 7:58 a.m., on 5/9/24, an observation of Medication Cart D #2 found the following: three (3) packages of Transparent Film Dressing with expiry dates of “2022-11-30;” two (2) packages of Xeroform Occlusive Gauze with expiry					

dates of “2023-04-30;” and one (1) VanishPoint 3 milliliter syringe with an expiry date of “2024-01.” These observations were verified by Nursing Supervisor B at 8:10 a.m., on 5/9/24. At 8:12 a.m., on 5/9/24, an observation of Medication Cart D #1 found the following: one (1) bottle of CoaguChek test strips with an expiry date of “2023-07-31;” and eight (8) vials of sterile 0.9% saline with expiry dates of “23-07.” These observations were verified by Nursing Supervisor B at 8:22 a.m., on 5/9/24. When interviewed at 3:12 p.m., on 5/9/24, the Director of Nursing stated his/her expectations were that medication rooms and carts were to be checked weekly on night shift for expired items; expired medications were to be placed in a box and returned to the pharmacy; and expired supplies were to be discarded.					

§ 51.190 (b) Preventing spread of infection. **The findings include:** Review of the facility policy titled, “Hand Hygiene,” with a revision date of 3/19/24, stated: “PROCEDURE: I. Who, what, when, where how – Staff	With regard to hand hygiene, glove changes, and sanitizing scissors during wound care treatment: - Deficiencies were reviewed with wound care nurse on day of observation on 5/7/24 with wound	-Annual skills lab education and check offs given to all nurses on hand hygiene, wound care, and dressing changes the week of April 8-12	-Wound care nurse to complete Relias in- service on “Wound Care: Treatment Considerations” -Wound Care Supervisor will perform observation and competency checklist on wound care dressing changes of the wound	Facility IP nurse will complete a monthly IC report to monitor for any patterns of clinical infections and audit findings. The Director of Nursing (DON) will be responsible for ensuring the IC report and audits and are submitted to the Quality of Assurance and Performance Improvement committee on -Quality Assurance and Improvement	Corrective Action will be fully implemented and sustained by October 04, 2024.

members should perform hand hygiene for the clinical indications list below…A. When to perform hand hygiene: 1. Immediately before touching a patient; 2. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; 3. Before moving from work on a soiled body site to a clean body site on the same patient; 4. After touching a patient or the patient's immediate environment; 5. After contact with blood, body fluids, or contaminated surfaces; 6. Immediately after glove removal; 7. Before eating and after using toilet." Record review revealed Resident #3 was admitted to the facility on 11/29/22, and diagnoses included Peripheral Vascular Disease and Lymphedema. Resident #3's Quarterly Minimum Data Set (MDS) Assessment, dated 2/13/24, contained a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also identified Resident #3 had a total of three (3) venous/arterial ulcers present.	care supervisor and 2 additional wound care treatments were observed by surveyor the following day with no deficiencies noted - Wound care supervisor reviewed all wound care policies with wound nurse on 7/2/24.		nurse 2x a week for 4 weeks from 7/14/24-8/10/24 (Goal is 100% compliance)	committee will review the survey findings and audit sheets at next Quality of Assurance and Performance Improvement committee meeting held on August 14, 2024.	

Resident #3's Provider Orders contained the following treatment orders: "RIGHT LATERAL AND MEDIAL LEG VENOUS WOUNDS: Cleanse with save-cleanse do not scrub, blot dry, Calmoseptine to peri wound areas, do not wipe old off, cut Aquacel cal alg [calcium alginate] to fit wound bed, [three] 3 non adhesive aquacell 4x4 to laterial wound, [three] 3 ABD pad around leg, and Kerlix. Double layer of tubagrip. every day shift for venous wound" [sic] (dated 4/5/24). "LEFT HEEL: Cleanse with save-cleanse do not scrub, blot dry, Calmoseptine to peri wound areas, do not wipe old off, cut Aquacel cal alg to fit wound bed, Aquacel heel dressing with Double layer of tubagrip. one time a day for venous wound" [sic] (dated 4/5/24). During an observation of wound care for Resident #3 that began at 10:28 a.m., on 5/7/24, Registered Nurse (RN) C entered the room carrying a clipboard with a storage compartment and two (2) cloth underpads ("chux"). Resident #3 was seated in a recliner at bedside with both legs elevated on the recliner's footrest. RN C placed one (1) chux on the top of Resident #3's bed, to create a clean					

field, and one (1) chux on the footrest under the resident's legs. RN C obtained wound care supplies from the resident's wardrobe cabinet, as well as several gloves from the glove dispenser by the door, and placed the items on the clean field. RN C also removed dressing supplies from the clipboard's storage compartment and placed those items on the clean field. After setting up the supplies on the clean field, and without first performing any hand hygiene, at 10:30 a.m., RN C donned a pair of gloves, opened a package of 4x4 gauze, removed the gauze from the package, and used the dry gauze to wipe dried drainage from the lateral wound on the resident's right lower extremity. After wiping the wound, and without changing gloves, RN C discarded the used gauze, opened a second package of 4x4 gauze, and held it open in one (1) gloved hand. RN C then obtained a spray can of Sterile Saline Wound Cleaser from the clean field with the other gloved hand, sprayed saline into the open package of gauze, and returned the spray can of saline to the clean field. RN C removed the moistened 4x4 gauze from the open package wearing a contaminated glove, cleansed the lateral wound on the					

resident's right lower extremity, and discarded the used gauze. Without changing gloves, RN C obtained another 4x4 gauze and patted the wound dry. RN C used the ruler printed on the edge of the gauze package to measure the dimensions of the lateral wound. RN C then removed gloves, retrieved a small bottle of hand sanitizer from his/her pocket, sanitized their hands, and placed the bottle of sanitizer on the clean field. RN C donned a new pair of gloves, examined the medial wound on the resident's right lower extremity, and used the ruler on the package from another 4x4 gauze to measure the dimensions of the medial wound. RN C then removed and discarded the gloves and donned another pair of gloves without performing hand hygiene. RN C retrieved a pair of bandage scissors from a pocket on his/her uniform top, picked up a length of Suprasorb dressing material from the clean field, trimmed the Suprasorb to a size to cover the lateral wound, and returned the cut piece of Suprasorb to the clean field. RN C opened additional supplies in preparation for dressing both wounds on the right lower extremity and					

placed them and the used bandage scissors on the clean field. RN C applied the trimmed piece of Suprasorb to the wound bed of the lateral wound, placed the foam cover dressings over both the lateral and medial wounds, applied ABD [Army Battle Dressing] pads over the foam dressings, and wrapped the right lower extremity with a roll of Kerlix. RN C cut the Kerlix, discarded the unused portion of the roll, and applied tape to secure the Kerlix. RN C then applied Tubigrip over the Kerlix on the right lower extremity. At 10:40 a.m., on 5/7/24, RN C removed and discarded their gloves, used hand sanitizer, and applied a new pair of gloves. RN C opened another package of 4x4 gauze, picked up the spray can of normal saline that had been handled while wearing contaminated gloves, sprayed the normal saline into the open package to moisten the gauze, and returned the spray can of normal saline to the clean field. Without changing gloves after handling the spray can, RN C removed the moistened gauze from the open package and cleansed the wound on the left heel. RN C discarded the used gauze, opened another package of 4x4 gauze, patted the wound dry, and used the					

package to measure the dimensions of the left heel wound. RN C discarded the package, removed and discarded their gloves, sanitized hands, and donned new gloves. RN C retrieved the previously used scissors from the clean field and, without sanitizing the scissors, trimmed another piece of Suprasorb for use on the left heel wound. RN C opened the package to a cover dressing for the heel, applied the Suprasorb to the wound, and applied the cover dressing to the heel. RN C applied Tubigrip to the left lower leg and doffed their gloves. RN C then discarded trash, placed the used scissors in their uniform pocket, collected supplies and both chux in his/her ungloved hands, and placed the unused supplies back in the resident's wardrobe cabinet. RN C carried the two (2) chux out of the resident's room, down hall, and placed them in a linen hamper in another room. When interviewed at 10:55 a.m., on 5/7/24, RN C reported having performed hand hygiene prior to entering the resident's room, but not immediately after touching surfaces in the environment (e.g., storage clipboard, items					

in wardrobe, etc.), and before donning gloves to cleanse the lateral wound on the right lower extremity. RN C acknowledged it was not his/her practice to wipe down the outside of the spray can of normal saline before storing it in the wardrobe for the next dressing change. Therefore, the spray can was not clean before it was placed on the clean field, and the exterior of the can was further contaminated when handled by contaminated gloves. RN C acknowledged he/she did not perform hand hygiene after each glove change during the dressing changes. RN C acknowledged he/she did not clean the bandage scissors before or after each use. During an interview at approximately 2:00 p.m., on 5/7/24, the Director of Nursing agreed that the bandage scissors should have been sanitized before and after each use; hand hygiene should have been performed prior to donning gloves and after removing gloves; and the nurse should not have handled the spray can of saline with contaminated gloves, or handled the gauze after it was moistened with the saline with the same gloves that handled the spray can.					

§ 51.200 (a) Life safety from fire. **The findings include:** Observation during the building inspection tour, on 5/9/24, at 5:51 p.m., revealed the wheeled, gas-fired four (4) burner range, the griddle, and the deep fat fryer located on the cooking line in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning, as required by section 12.1.2.3 and 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. An interview, on 5/9/24, at 5:51 p.m., with the Chief Engineer revealed that the facility was not aware an approved method should be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning. The census of 250 was verified by the Administrator on 5/9/23, at 8:40 a.m. The findings were acknowledged by the Administrator and verified by the Chief Engineer during the exit interview on 5/10/23, at 9:14 a.m.	With regard to the corrective action taken for residents impacted by wheeled, gas-fired four (4) burner range, the griddle, and the deep fat fryer located on the cooking line in the kitchen not having an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning of Hammond Building. Work request was submitted on 5/9/24 to anchor these 3 pieces of equipment as required. Work request completed anchoring these 3 pieces of equipment on 5/10/24.	All 74 residents residing in Hammond were impacted by this situation.	All equipment is now anchored in assigned spots. Maintenance Director will monitor equipment positioning for proper placement in the future.	At the quarterly facility Quality Assurance and Improvement committee, Maintenance Department will report on any issues relating to equipment positioning problems that might have been experience in the quarter.	Work request was immediately submitted on 5/9/24. New anchors were installed on 5/10/24.

§ 51.200 (b) Emergency power. **The findings include:** Observation during the building inspection tour, on 5/9/24, at 4:05 p.m., revealed the battery powered emergency lighting unit located in the generator room for the Schapers Building was not functional when the test button was pushed to simulate a power disruption to the unit. The facility failed to maintain the battery powered emergency lighting unit required to be installed in the generator room in accordance with section 7.3.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview, on 5/9/24, at 4:05 p.m., with the Chief Engineer revealed the facility was not aware the battery powered emergency lighting unit was not functional, and the preventative maintenance procedures were in place to have the battery powered emergency lighting unit tested on a monthly basis for 30-seconds and on an annual basis for 90-minutes. The census of 250 was verified by the Administrator on 5/9/23, at 8:40 a.m. The findings were acknowledged by the Administrator and verified by the Chief Engineer during the exit interview on 5/10/23, at	With regard to the corrective action taken for residents impacted by non-functioning emergency light in the generator room of Schapers Building: Work request was immediately completed on 5/9/24. New emergency light fixture was installed on 5/10/24.	All 25 residents residing in Schapers were impacted by this situation.	During required periodic generator testing, maintenance staff will monitor light operation on monthly generator inspection report and take action as needed to remedy the situation. Maintenance Director with monitor these monthly reports for needed action and follow-up.	At the quarterly facility Quality Assurance and Improvement committee, Maintenance Director will report on any issues relating to the operational condition of the emergency light and any problems that might have been experience in the quarter. Will also report any issues to facility Administrator at weekly Maintenance Review meeting.	Work request was immediately completed on 5/9/24**.** New emergency light fixture was installed on 5/10/24**.**

9:14 a.m.					

§ 51.210 (h) Use of outside resources. **The findings include:** During review of the facility's professional contracts, it was determined the facility did not have a contractual agreement with a dental provider. Further review revealed the facility staff provide a list of dental providers in the area for residents to choose from. On 5/8/24 at 11:30 a.m., the Business Manager (BM) confirmed the facility did not have a dental provider agreement. However, the facility did provide the residents with transportation to several local dentist providers in the area. The BM further revealed to his/her knowledge the facility had always done it that way and did not have a contract or written agreement with any dentist.	Upon admission, facility currently provides resident/family a listing of 8 local dental offices who are willing to see our residents. The listing includes information for each dental office including billing/estimated costs. Resident/ POA completes IVHQ form to indicate whether they would like IVHQ to schedule and provide transportation to dental appointments. If they would like IVHQ to schedule and transport, they can list their top three choices for dental office. This information is then used to schedule appointments and transportation for the resident. This current process ensures that all residents who desire assistance with scheduling and transportation for dental appointments are assisted. Home has become aware that VA requires a written contract is in place. Home will establish a contract with local dental providers in order to meet the VA requirements.	Current practice is in place to ensure needs of all residents are met regarding dental services: Upon admission, facility currently provides resident/family a listing of 8 local dental offices who are willing to see our residents. The listing includes information for each dental office including billing/estimated costs. Resident/ POA completes IVHQ form to indicate whether they would like IVHQ to schedule and provide transportation to dental appointments. If they would like IVHQ to schedule and transport, they can list their top three choices for dental office. This information is then used to schedule appointments and transportation for the resident. This current process ensures that all residents who desire assistance with scheduling and transportation for dental appointments are assisted. Facility is working to establish contracts with local dental providers in order to meet the VA requirements. Review of NH residents receiving dental services is underway to determine which of the 8 offices on the listing are being utilized, will continue to work towards establishing contracts with all providers being utilized to bring facility into compliance. Will	Facility is working to establish contracts with local dental providers in order to meet the VA requirements. Once contracts are in place, we will notify residents/families of the contracted providers. Resident/family will be required to switch to a contracted dental provider in the case that they are using a dental provider who is unwilling to establish a contract. Facility is currently working with multiple staff on review of dental services to determine which of the 8 offices on the listing are being utilized. Facility will update listing to include only those dental offices willing to contract with the facility. New form/listing will be sent to all resident's/families once contracts are established and information will be shared with pertinent staff along with updated listing of contracted providers.	Schedulers will be informed of contracted providers to be used when scheduling resident dental appointments. Tracker will be maintained by schedulers of dental appointments with resident name, date and dental provider/office. Tracker will be audited by Business Office to ensure dental offices are under contract. Frequency of audit will be monthly for 3 months. Start date will be upon execution of contracts, end date upon completion of 3 monthly audits. Results will be reported to the Home Administrator.	IVHQ currently working to establish dental contracts, targeted completion date: 1/31/25.

		update listing to include only those dental offices willing to contract with the facility.			

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