State Veterans' Homes (SVH) Corrective Action Plan
(Arizona State Veterans Home – Tucson, 8/1/23-8/4/23)

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)
§ 51.43(a)(1)-(2) Drugs and medicines for certain veterans In addition to the per diem payments under § 51.40 of this part, the Secretary will furnish drugs and medicines to a State home as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for a veteran receiving nursing home care in a State home if - (1) The veteran: (i) Has a singular or combined rating of less than 50 percent based on one or more service-connected disabilities and needs the drugs and medicines for a service-connected disability; and	The one Veteran who is 100% service-connected and paid by VA at the prevailing rate of per diem, who was receiving a medication through the VA will now receive all of his medications through the pharmacy contracted with the Arizona State Veteran Home – Tucson	The facility completed an audit of all residents of the Arizona State Veteran Home – Tucson. No other residents were identified as receiving medication through the VA that did not meet criterion and review by VA.	The Business Office Team along with the Administrator will review information received by the VA on who is eligible to receive medications through the VA and were able to ask questions to clarify any miss-conception they might have on 8-28-23.	A Business Office Teammember or the Administrator will review all referrals to the Arizona State Veteran Home – Tucson before accepting or receiving medications through the VA.	9-20-23

(ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability; or (2) The veteran: (i) Has a singular or combined rating of 50 or 60 percent based on one or more service-connected disabilities and needs the drugs and medicines; and (ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service- connected disability. Rating: Not Met Scope and Severity - B Residents Affected – Some					
§ 51.100 (h) (2) Social Services (2) For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than 120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing	Arizona State Veteran Home – Tucson began recruitment upon receiving notice from prior Social Services Supervisor. A qualified Social Worker was recruited and signed an acceptance letter on July 13, 2023 and started work on August 19, 2023. Prior to the new Social Worker starting the facility employed a licensed social worker who only worked part- time (20 hours per week). The facility had a census of 95 residents and had a licensed capacity for 120 residents. In addition the Facility employed a	No residents were adversely affected by this practice.	ADVS has increased the Social Service Director salary to be competitive with the SAVAHIC		8-19-23

home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE Based on record review and staff interview, the facility failed to ensure a qualified social worker was employed. The findings include: Review of facility's staffing and personnel documents revealed no evidence of a qualified social worker included for the staff of the social services department for the 120 licensed beds. In an interview on 7/27/22 at 10:00 a.m., the Administrator confirmed that the facility had not had a licensed social worker on staff since 6/3/22	non-licensed Social Worker full time to assure all resident needs were met				
§ 51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	The Wound Nurse, ADON (s), and DON reviewed the one Veteran, who was the only facility acquired pressure ulcer at the time of the survey on **8/24/2023.** The EHR review included the Wound Management Form, Braden Scale, Treatment Order, Care Plan, and adaptive equipment in use. The EHR review resulted in: 1. Weekly Wound Management form with the current measurements of the healing Pressure Ulcer had already been updated and completed on **8/2/2023** during the survey. The one missing previous weekly measurement was due to the Wound Nurse's absence. The Weekly Measurements per policy & procedure have continued forward. 2. The previous physician treatment order was discontinued and the Wound Nurse obtained a treatment order to reflect the current one in place from the physician.	The Interdisciplinary Team will continue to identify and audit the EHR of all Veterans with facility acquired or admit pressure ulcer during clinical meeting. The Wound Nurse and/or designated trained RN/House Supervisor or the ADON's will open the Wound Management Form, confirm appropriate treatment order is current by ensuring any previous one if present is discontinued. The Wound Nurse will continue to coordinate weekly measurements of all Veterans with admit or facility acquired pressure ulcers. The Care Plan and POC will be updated to ensure all Nurses and CNA's implement consistently.	The IDT and Wound Nurse will review all treatment orders during clinical meeting to ensure correct physician orders are in place and ensure to discontinue previous ones Wound Care In-service by DON, **8/24/23.** The Wound Nurse and/or Designee (ADON's) in the absence of Wound Nurse will continue to ensure that accurate consistent weekly Wound Measurements are completed. The Wound Nurse provided In-service on **9/7/23** to House Supervisor and ADON's	The Wound Nurse and/or Medical Records Designee will complete Weekly Audits of all Wound Management Forms, Weekly Progress Notes, Physician Treatment Order, Adaptive Equipment, Care Plan and POC for all Pressure Ulcers. Weekly Audit will be Submitted to DON for review for at least ***three (3) months thru 11/29/2023.*** Rehab Director will continue to complete and submit monthly Adaptive Equipment list to DON. Wound Nurse and ADON's will ensure compliance during rounds. Wound Care Management report by Wound Care Nurse will continue to be presented at	In-Services: DON: **8/4/23** DON; **8/24/23** Wound Nurse - **9/7/23** Mandatory In-services on: **Sept, 12, 14, 19, and 21st., 2023** Staff training will be ongoing as needed. Weekly Wound Management Audits **for (3) months until 11/29//2023** Monthly QAPI meeting: starting

	3. The adaptive equipment review resulted in a new physician order, for a rolled washcloth for use in contracted hand and hand splint on other hand. The ineffective handcarrot because of the Veteran pushing it out was discontinued. The washcloth has proven to be very effective and Pressure Ulcer is healing nicely.	The Wound Nurse will continue to complete and submit Weekly Wound Reports to the DON for review and Monthly Wound Care report to Quality Assurance Committee for a t least ***3 months*** *from* ***9/27/2023 to 11/29/2023****, to ensure compliance.*	on requirement for completion of Weekly Wound Management Form. Staff Development provided Mandatory In-service **on 9/12, 9/14, 9/20, and 9/21** to all licensed staff (Nurses & CNA's) on Wound Care Management Program to include Pressure Ulcer Prevention with correctly fitting Adaptive Equipment and Physician Orders (entering, DC, & clarification)	monthly QAPI meeting *for at least* ***three (3) months from 9/27/2023 – 11/29/2023*** *to ensure compliance*	**9/27/2023 to 11/29/2023**
§ 51.120 (i) Accidents. The facility management must ensure that—) The resident environment remains as free of accident hazards a s is possible; and) Each resident receives adequate supervision and assistance devices to prevent accidents.	The one alert and oriented times (4) four Veteran who uses Oxygen on PRN basis via his concentrator in his room had his cigarette lighter found in his room removed immediately upon notification by the surveyor. Education provided to the Veteran by ADON and Charge Nurse regarding Smoking Policy and use of Oxygen. Veteran agreed to room check and turned over his lighter which was given to Charge Nurse to lock up in the medication cart for its safe keeping and easy access by the Veteran when needed on **8/2/2023** Smoking Assessment also completed and Veteran's Care Plan and POC updated. Policy updated to reflect clarification of privileges for keeping smoking items to include lighters for independent smokers and those who use oxygen. No one who uses oxygen will be permitted to keep their lighters in their room and nursing will keep for safe keeping secured in designated place.	Correction made immediately by nursing staff upon notification by surveyor on **8/2/23.** The MDS and ADON's completed review of All identified smokers to determine if able to keep lighter in their possession. No one else found to be in need of removing lighters or smoking items. No one else had current orders for oxygen use in room or up in wheelchair. All other Veterans already identified correctly as supervised or non-supervised smokers based on completed smoking assessments. In-service provided by DON to all Leadership on **8/2/2023** regarding Smoking Policy and Oxygen use. Admissions will inform a ll new admits who identify a s smokers during the admission process of the facility Smoking Policy and obtain their acknowledgement.	All new admits will have Smoking Assessment completed by Charge Nurse to determine cognition, Oxygen use, & ability to smoke safely. If found to need/use Oxygen and be unsafe to smoke unsupervised, the lighter & smoking items will not be allowed to be kept in the Veteran's possession or in their room. Nursing will secure the lighter and smoking items in designated place. IDT: MDS and/or ADON's will review completed Smoking Assessments to ensure accurate and update Care Plan and POC. Charge Nurses, ADON's, DON, & Leadership will ensure compliance during rounds and report any non-compliance to the Administrator	ADON's will complete audit of Smoking Assessment during post admission audit & report during IDT clinical team meeting. MDS to complete ***monthly*** audit during the completion of MDS's for Smoking Assessment accuracy, updated Care Plan & Veteran compliance for a t ***least three (3) months thru 11/29/2023 at the Monthly QAPI meeting.*** The Charge Nurse, ADON's, DON's and/or Designee and Leadership Team will identify and monitor supervised smokers during daily rounds. DON provided In-Service to all Leadership on **8/2/23** regarding facility Smoking Policy and safe keeping of lighters for Veterans with Oxygen and those deemed to be unsafe and in need of supervision during smoking. The facility has since updated the Smoking Policy, **Sept. 2023,**	Leadership In-service: **8/2/23** Mandatory In-services on: **Sept, 12, 14, 19, and 21st., 2023** Monthly QAPI meeting: **9/27/2023 (initial audit), until 11/29/2023 to** ensure ongoing compliance**.**

		.		to reflect clarification of securing lighters and smoking items for Smokers who use Oxygen and those needing supervision.	
§ 51.120 (n) Medication Errors. The facility management must ensure that—) Medication errors are identified and reviewed on a timely basis; and) strategies for preventing medication errors and adverse reactions are implemented.	. Clarification physician orders were obtained on **8/3/23** by the Charge Nurses from the attending provider for: 1. Treatment order of all additional specific locations in need of the Voltaren topical medication as identified by the surveyor for the one Veteran who drives care. 2. The clarification order was received to continue crushing of all medications and administration together via g-tube for the one (1) Veteran identified by the surveyor This was an established practice based on Veteran's preference, request and his Plan of Care. No changes made by physician when called. Veteran in agreement.	All Veterans with orders for topical ointments were updated as needed to reflect all locations being applied to as needed and identified by the Veteran. All G-tube Veterans, total of three, were reviewed and no one else was identified for need to clarify any orders as their meds were ordered to be given separately. Audit completed by ADON's on **8/4/23** The facility will continue to follow physician orders and get clarification orders as needed to ensure proper care and Veteran driven Person Centered Care services are provided.	The ADON's will continue to review all new admits and complete post admit audits as well as all new orders for current Veterans during IDT to ensure accurate Physician Orders are in place for all orders. All new nursing staff members will continue to receive training during orientation by Staff Development Designee. All current Nursing staff will complete Mandatory In-service on Medication Management and Physician Orders. **9/2023**	ADONS and/or Medical Records/ Designee will complete review of orders for accuracy during IDT meeting. Any needed corrections will be done timely and any nurse needing additional training will be provided with additional training as needed. Weekly random audit of new physician orders to ensure they are complete; to include all locations for topical medications specific orders for med delivery via G-Tube and reflect Veteran driven care choices, will be submitted to the DON by Medical Records for review thru ***11/29/2023*.** Monthly Report for Medication Management/Physician Orders audit will completed and presented by Medical Records during QAPI for at least ***three (3) months until 11/29/23*..**	Leadership In-service: **8/4/23** Mandatory In-services on: **Sept, 12, 14, 19, and 21st., 2023** Weekly Random audits of medication orders until **11/29/2023** Monthly QAPI meeting: **9/27/2023 until 11/29/2023**
§ 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.**	**<u>Means of Egress</u>** 1. The facility installed required exit and directional signage in Buildings #2, #3, #4, and #5. Addressing the corridor double doors in Buildings #2, #3, #4, and #5. The A and B units were changed to marked by an approved sign that was readily visible from any direction of exit access as required by section **<u>Smoke Barriers and Sprinklers</u>** 2. The semi-annual visual inspection of the smoke detectors, as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code. semiannual testing of the battery charger, load	1. Vendor has come to the facility to access scope of work for Exit Signs. New maps are posted to replace the Maps that were developed and posted by the architect of the facility. 2. Smoke detectors 3. Maintenance has marked the approved designated locations for all cooking appliances that need to	1 New Maps with corrected information have been posted on the units identified in the survey. The exit signs are in process. 2 Calendar reminder to be use along vendor Metro Fire has added it to their system. 3 Marking complete for proper location for cooking appliances in place 4 Calendar reminder to be use along vendor Metro	1 New Maps with corrected information have been posted on the units identified in the survey The exit signs are in process. 2 Calendar reminder to be use along vendor Metro Fire has added it to their system. 3 Marking complete for proper location for cooking appliances in place 4 Calendar reminder to be use along vendor Metro Fire has added it to their system. 5 Weekly audits will be completed to assure that all cooking appliances secured as	1) Maps completed 9-15-23 Exit signs in progress, expected completions date is 10-20-23 2) completed 9-15-23 3) Completed 8-2-23 4) Completed 9-15-23 5) Completion of Audit on 12-2-23

	voltage, or discharge test for the back-up batteries, as required by table 14.4.5 of NFPA 72, National Fire Alarm and Signaling Code. 3. revealed that the facility was not aware that an approved method should be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning, and they were looking into solutions. 4. Revealed the facility was not aware of the smoke detectors' sensitivity testing requirement, as required by section 14.4.5.3.2 of NFPA 72, National Fire Alarm and Signaling Code **Services Building (Elevators, Escalators, Laundry Chutes, etc.)** 5. The restraint system to limit the movement of the appliance was not connected, as required by section 10.12.6 of NFPA 54, National Fuel Gas Code.	be moved for either cleaning or repair. 4. Sensitivity testing scheduled for 5. If a cooking appliance requires to be moved in order to provide maintenance or cleaning it will be returned to its designated location once completed and secured by the clips as designed in original installation. Prior to using the equipment, dietary staff will ensure the equipment is within the designated location and the clips are secured. If there is an issue or concern, dietary staff is to notify the Maintenance Department prior to usage.	Fire has added it to their system. 5 Weekly audits will be completed for 3 months and reported to QAPI for review and further action as needed	designed and all cooking appliances are in proper position related to sprinkler. Audits will be completed for 3 months and reported to QAPI for review and further action as needed starting September 27, 2023 and ending 12-1-23 if compliance is met.	

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