# *State Veterans' Homes (SVH) Corrective Action Plan*
## *(Georgia War Veterans Nursing Home – 9/5/2023 – 9/8/2023)*

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**<br><br>**Identify the Regulation and Findings** | **Address how corrective action will be accomplished for those residents found to be affected by the deficient practice**<br>(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**<br>(Actions should align with Quality Assessment and Assurance) | **Proposed Completion Date** (i.e. when corrective action will be fully implemented and sustained) |
|---|---|---|---|---|---|
| **§ 51.70 (e) (1) – (3) Privacy and confidentiality.**<br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br>(1) Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. | Re-educated the employee involved with the direct care of resident with emphasis on exposing only the area that required nursing care. The re-education involved direct observation by the Nurse Educator. | Identified all residents with supra pubic or Foley catheters in the facility. There are seven (7) residents with indwelling catheters identified. | Reviewed the residents' Bill of Rights with staff emphasizing dignity, respect, and privacy when providing care.<br>Amended the nursing policy titled "Privacy" to include minimal exposure when providing care.<br>Amended the nursing skills checklist to include direct observation or verbalization of supra pubic catheter site care annually.<br><br>Skills checklist completed on orientation and annually for all nursing staff. | The CNA's assigned to residents with indwelling catheters were spot checked by the nurse managers for minimal exposure and to ensure privacy was maintained.<br><br>Each nurse manager will randomly select five employees weekly to directly observe and document the maintenance of privacy during care with a target of 90-100% compliance. The audit tool will be used for three months. | 1/10/24 |

| | | | | | |
|---|---|---|---|---|---|
| (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;<br>(3) The resident's right to refuse release of personal and clinical records does not apply when—<br>(i) The resident is transferred to another health care institution; or<br>(ii) Record release is required by law. | | | | | |
| **§ 51.100 (a) Dignity.**<br>(a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. | Re-educated the employee involved with the direct care of resident with emphasis on dignity by completing documentation on the dressing prior to adhering to the resident. The re-education involved direct observation by the Infection Preventionist and wound nurse. | Identified all residents with wounds that required dressing changes in the facility. There are ten (10) residents identified by the wound nurse. | 1.) Updated the wound care procedure to include writing the date, time and nurse's initials on the label/tape prior to applying the new dressing.<br><br>2.) All licensed staff re-educated on the emphasis of dignity by completing documentation on the dressing prior to adhering to the resident. The re-education involved direct observation by the Infection Preventionist and Wound Nurse. | The licensed staff assigned to residents with dressing changes were spot checked by the Infection prevention for appropriate completion of documentation on the dressing prior to adhering to the resident.<br><br>The audit tool was created to ensure that the resident's dignity is upheld while receiving wound care. The infection preventionist will spot check the licensed staff performing wound care on 5 residents weekly for 10 weeks and document the maintenance of dignity throughout the dressing change process with 100% compliance. | 12/29/23 |
| **§ 51.110 (c) Accuracy of assessments.**<br>(1) Coordination— | Coordinate with the appropriate participants of the (IDT) interdisciplinary team to assess residents ADL's, Falls, Falls intervention, and Wound care. | The MDS Coordinators will review the data from the 802 and 672 for accuracy.<br>The Wound Team Coordinator | The MDS Coordinators will review the data from the 802 and 672 for accuracy. | The MDS Coordinators will continue to complete sections J and P and the Wound Team Coordinator will complete | 01/10/24 |

| | | | | | |
|---|---|---|---|---|---|
| (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.<br>(ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment.<br>(2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. | Resident #6 – After comparing previous CNA documentation in the chart to Plan Of Care documentation; resident changed from independent to requiring supervision during meals. Supervision during meals requires cueing and encouragement. Care plan reflects the status of the resident.<br><br>Resident #9 – The MDS Assessment corrected to reflect the correct number of wounds.<br><br>Resident #10 – The MDS assessment corrected to reflect the correct number of falls and the correct number of injuries.<br><br>Resident #11- The incorrect intervention removed from the MDS assessment. | was educated on completing section M (skin) weekly and MDS Coordinator will review for accuracy.<br><br>The MDS Coordinator will participate in the weekly Fall Committee Meeting and review falls.<br><br>The MDS Coordinator will participate in weekly wound rounds and coordinate with the Wound Team Coordinator regarding the Wound Report.<br><br>Education was provided to the MDS Coordinators via the MDS RAI 3.0 Manual – (Section – P0200) on fall prevention measures and equipment. | The Wound Team Coordinator will complete section M weekly and MDS Coordinator will review for accuracy.<br><br>The MDS Coordinators will utilize the new (EHR) Electronic Health Record risk management tool and review with IDT weekly during Resident Care Conference.<br><br>The MDS Coordinator will participate in weekly wound rounds and coordinate with the Wound Team Coordinator regarding accuracy of the Wound Report. | section M.<br>The Nurse Managers will review sections J (falls), M (skins), and P (restraints and fall interventions) for accuracy quarterly.<br><br>Prior to the care plan conference, the MDS coordinator and each nurse manager will review each resident assessment to ensure accuracy prior to the weekly care plan conference. The MDS coordinator and each nurse manager developed an ongoing tool to assist in monitoring assessment inaccuracies. The tool is incorporated weekly during the care plan conference. This will become standard operating procedure going forward. | |
| **§ 51.110 (e) (1) Comprehensive care plans.**<br>(1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and | Resident # 10 care plan corrected to reflect oxygen usage. | The MDS Coordinators reviewed the resident's physician orders, the 802, and the 672 with the care plans for accuracy. No other negative findings noted. | The MDS Coordinators will review new orders in Electronic Health Records and update the care plan as indicated. | The MDS Coordinators will monitor the physician orders daily in EHR.<br><br>The MDS Coordinators will monitor the 802 and the 672 bi-monthly in the EHR for accuracy concerning oxygen use.<br><br>The Nurse Managers will review care plans PRN, quarterly, and annually.<br><br>During the care plan conference, the MDS coordinator and interdisciplinary team will review each resident's orders to ensure care plan accuracy. The MDS coordinator and interdisciplinary team developed an ongoing tool to confirm | 01/10/24 |

| | | | | | |
|---|---|---|---|---|---|
| (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part. | | | | accuracy of the care plan. Using the care plan conference schedule, the MDS coordinator along with the interdisciplinary team will discuss the resident's care plan. The weekly incorporation of the tool will document agreement with or needed amendments to the resident's care plan. This will be ongoing as part of standard operating procedures. | |
| **§ 51.120 (b) (3) Activities of daily living.**<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination. | Resident #4 received toenail care on 09/06/2023. | Amended the nail trimming procedure to include toenail care.<br><br>Amended the "Skin-Care-Preventative" Procedure to include observation of toenails and fingernails during routine ADL care.<br><br>Amended the "Bathing a Resident- Bed Bath" Procedure to include observation of toenails and fingernails during routine ADL care. | Per M.D. orders due to diagnosis of osteomyelitis and poor vascular history, resident #4 seen by Podiatry for further consultation and nail trimming.<br><br>Educate staff to report difficulty with performing nail trimming to the Charge Nurse or Nurse Manager for assessment by the Medical staff or Podiatrist.<br><br>Utilize a nail audit tool for compliance with nail care. | The Charge Nurse and CNA's observed Residents toenails on all residents on each nursing unit to ensure nail care compliance.<br><br>The Nurse manager performed random toenail audits weekly to ensure nail care compliance. Perform 20 random weekly audits for eleven weeks for a compliance of 90-100%. The completion date for the audit is 12/29/2023. | 12/29/2023 |
| **§ 51.120 (i) Accidents.**<br>The facility management must ensure that—<br>(1) The resident environment remains as free of accident hazards as is possible; and<br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents. | Resident #11 was discussed in Fall Committee Meeting and the following fall interventions were implemented: Helmet, treaded socks, hipsters, bed alarm and floor mats.<br><br>Resident #11 care plan revised to include appropriate fall interventions.<br><br>Resident #11 re-evaluated by PT, placed in a Juditta wheelchair for safe sitting posture. | Fall prevention strategies and interventions audited on all residents in the facility.<br><br>Fall interventions cross-referenced with plan of care for accuracy. Care plans revised and updated as indicated. | Reviewed, updated and provided resident roster of safety intervention in use weekly to the Falls Committee Chair, DON, ADON, Nurse Managers and MDS Coordinators. The Senior Nursing Assistant uses the resident safety interventions checklist for each resident on an assigned nursing unit weekly for accuracy. | During the weekly Fall Committee meeting, the quarterly resident care plan reviews for that week that have Morse score >10 will prompt the Nurse Manager to collaborate with the Senior Nursing Assistant and Restorative Technician to evaluate any safety measures.<br><br>Perform 10 random weekly audits for 8 weeks using the | 12/28/2023 |

| | | | | | |
|---|---|---|---|---|---|
| | | | The safety intervention checklist is used as an audit tool to ensure the most current interventions are utilized.<br><br>A MDS Coordinator participates in the weekly Falls Committee meeting and documents falls and interventions on care plans as discussed. | resident safety intervention checklist as an audit tool. Target rate of 95-100% compliance of accurate safety interventions and documentation on care plans.<br><br>The completion date for audits is 12/28/2023. | |
| **§ 51.120 (l) Special needs.**<br>The facility management must ensure that residents receive proper treatment and care for the following special services:<br>(1) Injections;<br>(2) Parenteral and enteral fluids;<br>(3) Colostomy, ureterostomy, or ileostomy care;<br>(4) Tracheostomy care;<br>(5) Tracheal suctioning;<br>(6) Respiratory care;<br>(7) Foot care; and<br>(8) Prostheses. | Resident #10 oxygen tubing changed and labeled on 09/07/2023. Documented in the Electronic Health Record (HER). | Reviewed resident's orders.<br><br>Five (5) residents identified in the facility requiring oxygen therapy. | Nurse Managers added oxygen-tubing changes to the EHR treatment administration record monthly and as needed. All oxygen tubing is to be changed on the 1st of every month and documented in EHR treatment administration record. Nurse managers directly observed tubing for appropriate labeling with 100% compliance. | Amended the oxygen therapy procedure to address the following:<br><br>1.) Documenting monthly tubing changes in the EHR treatment administration record.<br><br>2.) Labeling the new tubing with date, time and nurse's initial with each change.<br><br>Weekly visual inspections by the nurse manager for 4 weeks. Nurse manager or supervisor will visualize tubing and check documentation for tubing changes and labeling monthly. | 9/29/2023 |
| **§ 51.120 (n) Medication Errors.**<br>The facility management must ensure that—<br>(1) Medication errors are identified and reviewed on a timely basis; and<br>(2) strategies for preventing medication errors and adverse reactions are implemented | Staff member involved with resident #15 was re-educated on how to administer eye drops as per nursing procedure, titled Medication Administration-Eye Drops. The nurse involved was re-educated to have the resident blink; then close the eye while the nurse applies gentle pressure against the inner aspect of the eye for about 20-30 seconds. Repeat in the other eye if ordered. | Reviewed residents EHR and identified those residents requiring eye drops and nasal sprays in addition to routine oral medications. | Re-educated licensed nursing staff on the rights of medication administration. | Incorporated the facility pharmacist to perform direct observation of medication administration on each nursing unit monthly and provide real time feedback as appropriate.<br><br>The observation of medication administration is a permanent part of the monthly pharmacy inspections including the | 10/27/2023 |

| | | | | | |
|---|---|---|---|---|---|
| | Staff member involved with resident #16 was re-educated on how to reconcile oral medications prior to administration. Check EHR and obtain the correct medication. Read the label carefully, checking the name and dosage of the specified medication at the time of removing and before administering said medication.<br><br>Staff member involved with resident #16 was re-educated on how to administer nasal sprays. Hand hygiene with soap and water. Don gloves. Have resident blow their nose gently before spraying. Gently insert bottle tip into one nostril and press on the other side of your nose with one finger to close off the other nostril. Keep your head upright. Breathe in slowly while squeezing the bottle. Wipe the nozzle with a tissue and replace the cap. Doff gloves and perform hand hygiene. | | | quarterly pharmacy and performance improvement committee meetings. Monthly observations are conducted with an expected compliance rate of 97%-100% for medication administration.<br><br>The consultant pharmacist will observe/audit one medication pass per floor per month. This will be standard operating procedure ongoing. | |
| **§ 51.140 (h) Sanitary conditions.**<br>The facility must:<br>(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;<br>(2) Store, prepare, distribute, and serve food under sanitary conditions; and<br>(3) Dispose of garbage and refuse properly.<br>the bags of food belonged to the residents or the staff. | Staff lunches no longer kept in the nourishment refrigerator located in the pantry.<br><br>Re-educated nursing staff to place personal lunches into clear zip lock bags, with their name and date on the bag.<br><br>Added thermometers to the freezer of the resident's nourishment refrigerator in the pantry. | In reviewing our diet order's approximately, 116 residents use the nourishment refrigerators. There is a nourishment refrigerator located on each nursing unit in the pantry. | To avoid storing food under unsanitary conditions nourishment refrigerators used for resident nourishments only.<br><br>New refrigerators purchased for staff use only and placed in staff break room.<br><br>Re-educated nursing staff to place personal lunches into clear zip lock bags, with their name and date on the bag.<br><br>Added freezer thermometers to the nourishment freezers. | Nurse managers and nursing supervisors check for documentation of refrigerator and freezer temperatures daily.<br><br>Monitor staff refrigerator for proper packaging of lunches with name and date. | 10/24/2023 |

| | | | | | |
|---|---|---|---|---|---|
| | | | Amended refrigerator and freezer temperature and cleaning record to include documentation of freezer temperature. | | |
| **§ 51.190 (a) Infection control program.**<br>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.<br>(a) Infection control program. The facility management must establish an infection control program under which it—<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections. | Staff involved with Resident #4 educated on the process of rinsing the components of the piston syringe and allowing them to air dry after administering eternal feeding.<br><br>Piston syringe and storage bag for Resident #4 discarded.<br><br>Staff involved with Resident #9 re-educated on the wound care procedure with emphasis on performing hand hygiene between donning/doffing gloves. | The MDS Coordinator utilized the 802 and the 672 to identify all residents with feeding tubes and/or receiving wound care.<br>Identified ten (10) residents with feeding tubes.<br>Identified ten (10) residents with wounds and receive wound care. | Provided education to nursing staff on the appropriate use of hand hygiene between donning and doffing gloves when providing wound care to residents.<br><br>1.) Revision of Wound Care Policy and Procedure to include doff/don and perform hand hygiene between each phase of the dressing change.<br><br>2.) Amended the nursing skills checklist to include hand hygiene between donning gloves during wound care.<br><br>Skills checklist completed on orientation and annually for all nursing staff.<br><br>3.) Amended the Tube feeding policy and procedure to reflect the process of one time use components of the piston syringe and allowing them to air dry after administering eternal feeding and medication. | The Infection Preventionist performs audits on the process of rinsing the components of the piston syringe, and monitors the piston syringe components for moisture and no visible droplets in the syringe with 100% compliance for three months.<br><br>The Infection Preventionist performs random wound care audits to ensure staff don/doff gloves in addition to performing hand hygiene during each phase of wound care with 100% compliance. | 1/10/2024 |

| | | | | | |
|---|---|---|---|---|---|
| **§ 51.190 (b) Preventing spread of infection**<br>(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident.<br>(2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease.<br>(3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | Staff involved with Resident #5 re-educated on suprapubic catheter care procedure with emphasis on performing hand hygiene between donning/doffing gloves.<br><br>Staff involved with Resident #6 re-educated on the wound care procedure with emphasis on performing hand hygiene between donning/doffing gloves. | The MDS Coordinator and Infection Preventionist utilized the 802 and the 672 to identify all residents receiving wound care and indwelling catheter care.<br><br>Identified seven (7) residents with indwelling catheters.<br>Identified ten (10) residents with wounds. | Provided education to nursing staff on the appropriate use of hand hygiene between donning/doffing gloves when providing wound care and catheter care for the resident(s).<br><br>The Importance of Hand Hygiene in Infection Prevention in-service provided to nursing staff.<br><br>The Infection Prevention quiz amended to reinforce staff's competency on performing hand hygiene between glove changes.<br><br>Nursing Staff are required to take the Infection Control quiz via onboarding and annually.<br><br>Nursing Staff must pass the quiz with 80% or better.<br>Provided education to nursing staff on the following:<br><br>1) Revision of Wound Care Policy Procedure.<br><br>2) The Importance of Hand Hygiene in Infection Prevention and Control.<br><br>3) Amended the nursing skills checklist to include hand hygiene between donning/doffing gloves during care. | Nursing Staff are required to take the Infection Prevention quiz via onboarding and annually.<br><br>Nursing Staff pass the quiz with 80% or better.<br><br>The Infection Preventionist and charge nurses will use the hand hygiene audit to perform 5 random hand hygiene observations per floor per week to ensure hand hygiene occurs at appropriate times during the shift and with resident interactions with 95-100% compliance for three months. | 1/10/2024 |

| | | | | | |
|---|---|---|---|---|---|
| | | | Skills checklist completed on orientation and annually for all nursing staff. | | |
| **§ 51.200 (a) Life safety from fire.**<br>(a) Life safety from fire. The facility must meet the applicable provisions of NFPA<br>101, Life Safety Code and NFPA 99,<br>Health Care Facilities Code. | 1. The Director of Maintenance and Safety contacted Dixie Communications to modify the fire alarm equipment inspections and back-up batteries inspection and testing for the fire alarm system from annually to semiannually. | 1. The Director of Maintenance and Safety determined as outlined in the survey report that all residents and staff are affected by the deficient practice. | 1. The Director of Maintenance and Safety has confirmed that Dixie Communications will now inspect the fire alarm system and back-up batteries on a semiannual basis each October and April and provide a comprehensive report after each inspection.<br><br>The Director of Maintenance and Safety will report the completion of each semiannual inspection in Safety Committee and Performance Improvement Committee reports. | 1. The last fire alarm equipment inspection including back-up batteries inspection conducted October 24, 2023 and the next semiannual inspection was pre-scheduled for the week of April 15, 2024.<br><br>The Director of Maintenance and Safety will report the completion of each semiannual inspection in Safety Committee and Performance Improvement Committee reports including a copy of the semiannual inspection report. As future semiannual inspections are completed, the details reported in the monthly Safety Committee and Quarterly Performance Improvement committee reports for the month and quarter following actual completion. | 1. 10/25/2023 |
| | 2. The Director of Maintenance and Safety contacted Fire Tech to quote for parts and labor and schedule the installation of a new sprinkler head in the Elevator Machine room in the basement. | 2. The Director of Maintenance and Safety determined as outlined in the survey report that only staff are affected by the deficient practice, as this is a controlled access elevator for staff use only. | 2. Fire Tech will install a new sprinkler head tied into the existing system in the Elevator Machine room. This deficient practice will be resolved upon installation of the new sprinkler head. | 2. Visual inspection of all sprinkler heads are performed quarterly by Fire Tech.<br><br>The Director of Maintenance and Safety will report the installation of the new sprinkler head in the Elevator Machine room at the November 2023 Safety Committee and January 2024 Performance Improvement Committee reports to assure sustainment and closure. | 2. 1/24/2024 |

| | | | | | |
|---|---|---|---|---|---|
| | 3. The Director of Maintenance and Safety obtained specifics to incorporate into a new and improved Annual Fire Door Inspections form based on discussion with the Ascellon surveyor during the virtual survey. | 3. The Director of Maintenance and Safety determined as outlined in the survey report that all residents and staff are affected by the deficient practice. | 3. A revised more detailed Annual Fire Door Inspections form was created to include a detailed list of the 14 items to be inspected for each fire door. The revised form will be used annually for the fire door inspections. Another annual inspection will be completed in October 2023 using the new form as part of the corrective action plan. | 3. Visual inspection of all 14 items on the new Annual Fire Door Inspections form will be completed for all fire doors by the Georgia War maintenance team.<br><br>The Director of Maintenance and Safety will report the completion of the annual inspection of the fire doors using the revised form in the November 2023 Safety Committee and January 2024 Performance Improvement Committee reports following completion. | 3. 10/24/2023 |
| | 4. The Nursing department contacted the vendor who inspects Patient-Care Related Electrical Equipment (PCREE) to add the electric, resident beds in the facility to the inspection list and schedule an initial inspection. | 4. The Director of Maintenance and Safety determined as outlined in the survey report that all electric, resident beds are affected by the deficient practice. There are 179 beds in the facility with 123 occupied at this time. | 4. The Director of Maintenance and Safety in conjunction with the Nursing department contacted CE Technologies who inspects PCREE to add the electric, resident beds to the equipment list for each annual inspection. In addition, a quote was requested for an initial inspection to be completed as soon as possible. | 4. The Nursing department received a quote from CE Technologies to conduct an initial inspection for all electric, resident beds. The beds were added to the overall equipment inventory list for all subsequent annual electrical, resident equipment inspections.<br><br>Once the inspection is completed, the Director of Maintenance and Safety will report the initial inspection of the electric, resident beds in the November 2023 Safety Committee and January 2024 Performance Improvement Committee reports following completion. As future annual inspections are completed, the details will be reported in the monthly Safety Committee and Quarterly Performance Improvement committee reports | 4. 1/24/2024 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | for the month and quarter following actual completion to assure sustainment and closure. | |
| **§51.200 (b) Emergency power.** (1) An emergency electrical power system must be provided to supply power adequate for | The Director of Maintenance and Safety will update the Weekly Generator Service/Operation Log Sheet to include specific gravity testing on a monthly basis. A hydrometer was ordered to complete the specific gravity testing on the batteries. | The Director of Maintenance and Safety determined as outlined in the survey report that all residents and staff are affected by the deficient practice. | The Director of Maintenance and Safety updated the Weekly Generator Service/Operation Log Sheet incorporating an additional monthly specific gravity testing | The revised Weekly Generator Services/Operation Log Sheet will be used for all future weekly inspections. The revisions to the form and subsequent service log/operation sheets will be reported at the November 2023 | 1/24/2024 |

| | | | | | |
|---|---|---|---|---|---|
| illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination.<br>(2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br>(3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code.<br>(4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. | | | referenced in the survey findings. The revised form will be used for weekly inspections beginning October 2023. After the initial log sheet is completed as part of the corrective action plan, the monthly specific gravity test will be conducted the first week of every month. | Safety Committee meeting and the January 2024 Performance Improvement Committee meeting to assure sustainment and closure. | |

| | | | | | |
|---|---|---|---|---|---|
| **§ 51.210 (h) Use of outside resources.**<br>(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section.<br>(2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for—<br>(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and<br>(ii) The timeliness of the services.<br>(3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health | The Associate Director select a Behavioral Health/Mental Health Services with a third-party provider in lieu of a sharing agreement with the VA. | The Associate Director in conjunction with the Medical Director determined as outlined in the survey report that 5 residents affected by the deficient practice. | The Associate Director obtained an agreement from Christopher Dennis MD PLLC to provide Behavioral Health/Mental Health services to the facility in partnership with the Georgia War Medical Director.<br><br>All residents who need mental health services or medication review and management oversite will be referred to the new third party provider. | The agreement for services maintained in Administration and renewal added to the tracking system for timely future renewals. | 10/27/2023 |

| | | | | | |
|---|---|---|---|---|---|
| Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran. | | | | | |

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