State Veterans' Homes (SVH) Corrective Action Plan
Georgia War Veterans Home, Milledgeville
July 11-14, 2023

Important: Attestation by the SVH leadership, including the SVH nurse leader, of actions to assure timely completion of goals and establishment of oversight to assure continued improvement in areas identified for correction. The Corrective Action Plan (CAP) should include input from all levels of staff and affected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assessment and Assurance.

State the Issue **Identify the Regulation and Findings**	**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice.** (Actions should align with Quality Assessment and Assurance fundamentals)	**Address how the SVH will identify other residents having the potential to be affected by the same deficient practice**	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**	**How does the SVH plan to monitor its performance to make sure that solutions are sustained?** (Actions should align with Quality Assessment and Assurance)	**Proposed Completion Date** (i.e. when corrective action will be fully implemented and sustained)
51.110 (e) Comprehensive Care Plan Based on observation, record review, and staff interviews, the facility failed to revise the Care Plan for two (2) of 29 sampled residents, who began to have behaviors related to anxiety (Resident #6) and catheter placement (Resident #9)	Residents #6 and #9 had their care plans updated with the missing information identified.	Case Mix Director (CMD) and members of behavior team reviewed residents care plans of all residents on the behavior program.	The CMD Director/Director of Health Services (DHS)/designee will educate Nurses and Behavior Management Team on the policy regarding care-plans. Case Mix Directors will be completing the audit tool as directed. DHS will monitor compliance via audit tool submitted by Case Mix Directors. ED and QAPI will monitor compliance via the QAPI process. An audit tool was created to ensure that the residents care-plan was **updated with**	Audits of the care-plan will be completed daily by one week, via the unit manager. (Then) Audits of the care-plan will be completed three times a week, by one week via the unit manager. (Then) Audits of the care-plan will be completed two times a week, by one week via the unit manager. (Then) Audits of the care-plan will be completed once a week, by one week via the unit manager. (Then) Audits of the care-plan will be completed monthly, via the unit manager for three months or until substantial	9/30/23

			current behaviors according to policy. **Care-plans will be reviewed quarterly with the interdisciplinary teams and changes made as needed.**	compliance is achieved	
51.120 (b) Activities of Daily Living Based on observations, interviews, and record review, the facility failed to provide necessary services to maintain good. grooming, personal hygiene, and mobility to a resident unable to carry out activities of daily living (ADLs) independently. This deficient practice affected one (1) of three (3) residents. reviewed for ADLs from a total of 29 residents sampled.	Resident #15 was provided with bath and shave immediately.	All currents residents were audited for signs of grooming or bathing. Any found needing shaving or bathing were completed on that shift.	The Director of Health Services/designee will educate Nurses/CNA's on the policy regarding ADL care. An audit tool was created to ensure that residents ADL care is provided.	Audits of the ADL care will be completed daily by one week, via the unit manager. (Then) Audits of the ADL care will be completed three times a week, by one week via the unit manager. (Then) Audits of the ADL care will be completed two times a week, by one week via the unit manager. (Then) Audits of the ADL care will be completed once a week, by one week via the unit manager. (Then) Audits of the ADL care will be completed monthly, via the unit manager for three months or until substantial compliance is achieved	9/30/23

51.120 (d) Pressure Sores Based on observations, interviews, and record review, the facility failed to provide necessary services to promote healing of pressure injuries by failing to ensure therapeutic support surfaces were properly functioning for one (1) of three (3) residents reviewed for pressure injuries from a total of 29 residents sampled.	Resident #15- had air flow mattress replaced.	All air mattresses currently in use were audited to ensure they were functioning correctly. There were no negative outcomes identified.	The Director of Health Services/designee will educate nurses on monitoring air mattress controls to ensure that it is working properly. Unit managers will be completing the audit tool as directed. DHS will monitor compliance via audit tool submitted by Unit managers. ED and QAPI will monitor compliance via through the QAPI process.	An audit tool was created to ensure that air mattress controls are working. Audits of the air mattress controls will be completed daily by one week, via the unit manager. (Then) Audits of the air mattress controls will be completed three times a week, by one week via the unit manager. (Then) Audits of the air mattress controls will be completed two times a week, by one week via the unit manager. (Then) Audits of the air mattress controls will be completed once a week, by one week via the unit manager. (Then) Audits of the air mattress controls will be completed monthly, via the unit manager for three months or until substantial compliance is achieved.	9/30/23

51.140 (d) Food Based on observations, interviews, record review, and review of the facility policy, the dietary staff failed to maintain the recommended temperatures for hot and cold foods. Additionally, the facility failed to store, label, and date potentially hazardous foods appropriately. This failure placed all residents in the facility at risk for foodborne illness, as well as decreased food intake by the residents when food was not served at the proper temperatures and was not palatable.	Residents #8, #5 and #10 were interviewed and had their food heated. Explained to residents to request reheating of food if needed.	All residents who are on a diet supplied from the facility kitchen are at risk of being affected by this deficient practice. There were no negative outcomes identified. Hobart industries came to complete maintenance on steam table immediately (7/14/23). Replaced non-functioning warmer with one that was properly functioning (7/14/23)	The Dietitian will educate dietary staff on maintaining the temperatures of food per policy. Training completed July 17, 2023. The warmer was changed out in the Wood kitchen. Hobart completed routine maintenance on steamer on 7/14/2023. An audit tool was created to ensure that all food temperatures and warmer temperatures are maintained at proper degrees according to policy	Audits of the temperatures of food at mealtimes and warmer temperatures will be completed daily by one week, via the CDM/Dietary partners. (Then) Audits of the temperatures of food at mealtimes and warmer temperatures will be completed three times a week, by one week via the CDM/Dietary partners. (Then) Audits of the temperatures of food at mealtimes and warmer temperatures will be completed two times a week, by one week via the CDM/Dietary partners. (Then) Audits of the temperatures of food at mealtimes and warmer temperatures will be completed one time a week, by one week via the CDM/Dietary partners. (Then) Audits of the temperatures of food at mealtimes and warmer temperatures will be completed monthly, via the CDM/Dietary partners for three months or until substantial compliance is achieved	9/30/23

51.140 (h) Sanitary Conditions Based on observations, interviews, and review of the facility policy, the dietary staff failed to store foods in a sanitary manner. This failure placed all residents who received food from the kitchen at risk for foodborne illnesses.	No residents were directly affected by this deficient practice	All residents who are on a diet supplied from the facility kitchen are at risk of being affected by this deficient practice. There were no negative outcomes identified.	The Dietitian will educate dietary staff on labeling/storage of food per policy. Inservice completed 7/14/2023. An audit tool was created to ensure that all food is labeled/stored according to policy.	Audits of the labeled/storage food will be completed daily by one week, via the Cook Manager. (Then) Audits of the labeled/storage food will be completed three times a week, by one week via the Cook Manager. (Then) Audits of the labeled/storage food will be completed two times a week, by one week via the Cook Manager. (Then) Audits of the labeled/storage food will be completed one-time a week, by one week via the Cook Manager. (Then) Audits of the labeled/storage food will be completed monthly, via the Cook Manager for three months or until substantial compliance is achieved	9/30/23
51.190 Infection Control Based on observation, interviews, and record review, the facility failed to ensure that proper technique was utilized during pressure sore treatment for one	Resident #8 and resident #4 were monitored x 72 hours for signs and symptoms of infection.	All current residents receiving care are at risk to be affected by this deficient practice and were monitored x72 hours for signs and symptoms of infection.	The Infection Preventionist will educate Nurses on the steps for decontaminating surface areas before use. An audit tool was created to ensure	Audits of decontamination of surfaces will be completed daily by one week, via the Infection Preventionist. (Then) Audits of decontamination of surfaces will be completed three times a week, by one week via the	9/30/23

(1) resident (Resident #8) and for one (1) resident (Resident #4) during incontinent care of 29 sampled residents.			decontamination of surface when utilizing over bed table for treatments.	Infection Preventionist. (Then) Audits of decontamination of surfaces will be completed two times a week, by one week via the Infection Preventionist. (Then) Audits of decontamination of surfaces will be completed once a week, by one week via the Infection Preventionist. (Then) Audits of decontamination of surfaces will be completed monthly, via the Infection Preventionist for three months or until substantial compliance is achieved.	
51.200 (a) Life Safety from fire Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patientcare Related Electrical Equipment (PCREE). The deficient practice affected one (1) of four (4) smoke compartments in the Wheeler Building and four (4) of eight (8)	All residents who reside in the facility are at risk of this deficient practice.	All residents who reside in the facility are at risk of this deficient practice. There were no negative outcomes identified.	Executive Director will educate all maintenance staff on the process for checking the date on the sprinkler heads. The Maintenance Director will educate maintenance partners on the process of checking the date on sprinkler heads in all walk-in freezers and that all vitals monitoring machines must be electrically tested sticker annually.	Audits of the electrical testing stickers will be completed on all vital sign machines and provided to the QAPI. A contract will be established with Welch-Allen to have all vital sign machines functionally inspected.	9/30/2023

smoke compartments in the Wood Building, staff, and all residents. Based on observation and interview, the facility failed to properly maintain the sprinkler system. The deficient practice affected one (1) of 23 smoke compartments, staff, and four (4) residents.			Ordered replacement sprinkler head. Completed 9/1/2023. Audits of the vitals monitoring machines electrically testing will be completed and will be forwarded to the QAPI.		
51.200 (b) Emergency power. Based on records review and interview, the facility failed to properly inspect and test all components of the facility's emergency generators. The deficient practice affected 23 of 23 smoke compartments, staff, and all residents.	All residents who reside in the facility are at risk of this deficient practice	All residents who reside in the facility are at risk of this deficient practice	The Executive Director will educate maintenance staff on checking battery monthly. An advanced battery conductance meter was ordered on July 12, 2023. (2 ordered) and two more ordered in August. Audits of the generator battery check form will be completed once the meter arrives. Audits of the generator	Audits of the generator battery check form will be completed. Starting August 2023. Audits of the generator battery check form will be completed monthly, via the maintenance partners.	9/30/23

			battery check form will be completed monthly, via the maintenance partners.		
51.210 Administration Based on observation, interview, record review, and review of facility policy it was determined the facility was not administered in a manner to use its resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Quality deficiencies were identified that demonstrate the operation and management of the facility was not being administered effectively.	All residents who reside in the facility are at risk of this deficient practice	All residents who reside in the facility are at risk of this deficient practice	The Executive Director/designee will educate all partners on the identified deficiencies and the corrective action plans. Audit tools will be provided to QAPI nurse weekly during the Performance Improvement meetings held weekly.	All corrective action plans will be reviewed monthly during scheduled QAPI meetings. **If deficient practices or procedures are noted during routine audits, then corrective action will be implemented to address the specific identified issues.** **The policy and procedure meeting will be held each Tuesday morning to review current policies until all policies have been reviewed.**	9/30/23
51.100 (g) Patient Activities Based on interview, record review, and review of facility policy, it was determined the facility failed for three (3) of four (4) Units to provide an on-going activities program to meet the interests and	Residents #22, #24, #25, #26. #27. #28 and #29. #6, #8 and #10 participated in a small group to better understand the grievances.	All residents who reside in the facility are at risk of this deficient practice. The Recreation Hall and Library were immediately opened.	Activity Director educated staff on the times the library and recreation hall are open. A new activity schedule was created by the Activities Director to include activities daily after 5 o'clock and on the weekends.	The Activity Director will provide a calendar of activities for each month to the Executive Director and QAPI nurse monthly. All activity calendars will be posted for the residents to see what activities are up coming.	9/30/2023

needs of the residents. Individual and group interviews with residents revealed the residents complained there were no activities provided in the evenings and on weekends. A review of the activity calendar for June and July 2023 revealed a lack of consistently planned activities in the evenings and on weekends. The resident census was 142 and 125 residents resided on the three (3) Units affected by the deficient practice.				The Activity Director has assigned one partner to work twice weekly to provide after-hours activities and one partner to work 1pm-5pm on weekends to provide activities. The Activity Director will provide a calendar of activities for each month to the Executive Director and QAPI nurse monthly. Will be taken to QAPI x 3 months or until substantial compliance is achieved.	
51.100 (d) Participation in resident and family groups Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure that residents had the right to attend scheduled Resident Council meetings without staff present. Additionally, concerns presented by residents to facility management regarding issues affecting resident care and life in the facility were not acted upon.	Resident #5, #22, #24, #25, #26, #27, #28 and #29 participated in a small group to better understand the grievances.	All residents who reside in the facility are at risk of this deficient practice.	The Administrator will educate Activity Partners about the Patient/Resident Council Policy and the Forms included in this process and how they will be provided to the Grievance designee to complete the process. They were also educated on the need to start meetings with the identification of all partners present so that residents can ask partners to leave. Partners are to inform the resident at the start of a meeting that they	The Clinical Competency Coordinator/designee will educate all partners on the process for attending a Resident Council Meeting. At the beginning of each meeting all partners will state their name and title to Council and the Council will decide whom they wish to stay with during the meeting and this will be documented in minutes. At the beginning of each meeting the Council will be informed they have the right to meet without partners present, this will be documented in minutes.	9/30/2023

			have the right to meet without partners present, this is to be documented in minutes. Completed 8/21/2023. **The first meeting since education of staff was scheduled for September 19, 2023, but the meeting had to be rescheduled to due to a localized outbreak of nausea and vomiting on one of the units. This meeting will be rescheduled as soon as possible.** Activity Assistant will be completing the Patient/Resident Council/Family Council Department Response Form as directed. The SSD will monitor compliance via the submission of the Patient/Resident Council/Family Council Department Response Form by Activity Assistant. The Executive Director and QAPI nurse will monitor the QAPI process.	An audit tool (Patient/Resident Council/Family Council Department Response Form and the Grievance Log) will be completed and submitted to the QAPI nurse monthly by three months or until substantial compliance is achieved. **The goal is that all grievance logs will demonstrate a 95% or higher resolution and follow up rate.**	

51.70 (f) (1) – (2) Grievances. Based on interview, record review, and review of facility policy, it was determined for two (2) of 29 residents (Resident #10 and Resident #23) that the facility failed to make prompt efforts to resolve grievances when residents and/or a responsible party (RP) voiced concerns with treatment not received.	Resident #23- CNAs were provided immediate education proper oral hygiene. Resident #10- Temperatures taken prior to each meal service	All current residents had an oral hygiene observation completed, except for residents who were in the hospital or refused.	The Social Service Director was named Administrator as designee for Grievance Program. Completed 8/16/2023. The Administrator will educate Social Service partners on the steps for filing and completing the grievance process. Completed 8/16/2023. The Clinical Competency Coordinator will educate all partners on the process for filing a grievance.	An audit tool (Grievance/Compliant Log Form) will be completed and submitted to the QAPI nurse monthly by three months or until substantial compliance is achieved. **The grievance log was revised to indicate a follow up column.** **The goal is that all grievance logs will demonstrate a 95% or higher resolution and follow up rate.**	9/30/2023
§ 51.70 (a) (1) – (5) Exercise of rights. Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from physical restraint by failing to disengage his/her wheelchair brakes upon the resident's request. This deficient practice affected one (1) resident from a total of 29 residents sampled.	Resident #15's Broda chair was unlocked	100% audit of all residents in Broda chairs were assessed for restraints	**The Director of Health Services will educate nurses on the restraint policy and what could be considered a restraint.** **An audit tool was created to ensure that all residents are restraint free.** **All residents/responsible party will be given a copy of the Resident Rights.**	Audits of the restraint form will be completed daily by one week, via the unit manager. (Then) Audits of the restraint form will be completed three times a week, by one week via the unit manager. (Then) Audits of the restraint form will be completed two times a week, by one week via the unit manager. (Then) Audits of the restraint form will be completed once a	9/30/23

			Resident rights will be posted in common areas for residents to review. **During the Veterans Council meeting that was scheduled for September 19, 2023, (to be rescheduled asap) residents will be notified of their rights and how to exercise them.** **Staff will be provided education on Resident Rights immediately. This will be re-emphasized during Resident Right's month which is in October with additional staff education.**	week, by one week via the unit manager. (Then) Audits of the restraint form will be completed monthly, via the unit manager for three months or until substantial compliance is achieved.	