State Veterans' Homes (SVH) Corrective Action Plan
Georgia War Veterans Home July 24-27, 2024

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)
§51.190 (b) Preventing spread of infection 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. 2. The facility management must prohibit employees with communicable disease or infected skin lesions from engaging in aby contact with residents or their environment that would transmit the disease. 3. The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by	Resident #6 was monitored x 72 hours for signs and symptoms of infection.	All current residents receiving foley catheters are at risk to be affected by this deficient practice and were monitored x 72 hours for signs and symptoms of infection.	The Director of Nursing /designee started immediately educating Certified Nursing Assistants on the procedure for foley catheter care, starting 7/25/2024. Director of Nursing/designee will have Certified Nursing Assistants checked off on skills checklist form, starting 9/3/2024.	An audit tool was created to ensure that foley catheter care is being completed per policy. Audits of foley catheter care will be completed daily by one week, via unit manager/designee, starting 9/9/2024 (then); Audits of foley catheter care will be completed three times per week, via unit manager/designee, (then); Audits of foley catheter care will be completed two times per week, via unit manager/designee, (then); Audits of foley catheter care will be completed one time per week, via unit manager/designee, (then) Audits of foley catheter care will be completed monthly, via unit manager/designee, for two months or until substantial compliance is achieved.	11/30/2024

accepting professional practice.				Results from audits will be brought to QAPI x 3 months or until substantial compliance is achieved. Substantial compliance will be identified as > 90%. The Executive Director and Director of Nursing will ensure that the Plan of Correction is compliant. The QAPI nurse will keep records of compliance to review in QAPI	
§51.200 (a) Life Safety from fire. Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	All residents who reside in the Wheeler Building are at risk of this deficient practice.	All residents who reside in the Wheeler Building are at risk of this deficient practice. No negative outcomes identified.	The Maintenance Director will educate the maintenance team on the smoke barrier penetration/Life Safety Codes regarding penetration in smoke barriers completed 8/28/24. Maintenance Director immediately corrected the identified penetration in the smoke barrier completed 7/25/2024.	An audit tool was created to ensure that smoke barriers penetrations are maintained according to current Life Safety Codes. Audits of smoke barrier penetrations will be completed weekly by four weeks, via Maintenance Director/designee starting 9/5/2024. (then); Audits of smoke barrier penetrations will be completed monthly, via Maintenance Director/designee, for two months or until substantial compliance is achieved. Results from audits will be brought to QAPI x 3 months or until substantial compliance is achieved. Substantial compliance will be identified as >90%. The Executive Director and Director of Nursing will ensure that the Plan of Correction is compliant. The QAPI nurse will keep records of compliance to review in QAPI	11/30/2024

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