State Veterans' Homes (SVH) Corrective Action Plan
Minnesota Veterans Home - Minneapolis – Skilled (SVH), 10/21/24-10/24/24

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. Please reference VA GEC's CAP Standard Operating Procedure for detailed guidance on completing this CAP template.

State the Issue Identify the Regulation Number and language only	Address how corrective action will be accomplished for those residents found to be affected by the deficient practice	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 & what benchmarks will be used to determine sustainment	Proposed Completion Date
§ 51.100 (b) Self-determination and participation. (b) Self-determination and participation. The resident has the right to— (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident.	The facility has a current Resident COVID Illness Standard of Work (SOW) that states residents residing on a floor that currently has COVID positive residents are encouraged to stay on the floor; if they choose to leave the floor, they are encouraged to wear surgical masks, perform hand hygiene, and social distance as able. Off-unit activities will not be removed from activity calendars on floors that have COVID positive residents. The above practice guidelines will be utilized for future COVID positive floors, including 22-5 where residents #44 and #45 reside.	All residents residing on a floor that has a COVID positive resident have the potential to be affected. For future instances of floors with COVID positive residents, the Resident COVID Illness SOW, including practices for when residents want to leave the floor, will be reviewed with staff, including nurses, human service technicians (HSTs), and recreation.	Nurses, HSTs, Recreation, Social Workers, and Leadership will be re-educated on the Resident COVID Illness SOW. 90% of the above department employees will be re-educated by 1/10/25 with remaining staff education provided upon their return to work. Following of the above SOW protocols will be observed through an interviewing/auditing process.	Registered Nurse Managers (RNMs) or designees will each audit/interview 2 different staff members on the COVID outbreak protocol, specifically seeing how they would respond to a resident wanting to attend an off-unit activity for 3 months. Audits will be completed weekly x 4 and then monthly x 2. Audits will begin 1/13/25 and end 4/5/25. with a compliance goal of 95% by the end of auditing. Audit results will be reported to QAPI monthly; if audits are not meeting the compliance goal, audits will continue and will be monitored at QAPI monthly. The DON is responsible.	April 8, 2025

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§ 51.110 (e) (1) Comprehensive care plans. (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— (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 (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.	Current COVID positive residents as of 10/23/24 had their care plans updated to include a care plan item addressing COVID illness.	Any resident with a future COVID illness has the potential to be affected. For future residents testing positive for COVID, the resident's comprehensive care plan will be updated, as appropriate, to include a care plan item addressing COVID.	Registered Nurse Managers (RNMs), Floor Registered Nurse Seniors (RNSs), and Assistant Directors of Nursing (ADONs) will be educated on care planning requirements for COVID positive residents. 90% of the above employees will be re-educated by 1/10/25 with remaining staff education provided upon their return to work. Following of the above care planning requirements will be observed through an auditing process.	Quality Director or designee will audit future COVID positive residents' care plans for addition of a care plan item addressing COVID for 12 weeks. Audits will be completed weekly for new COVID positive residents. Audits will begin 1/13/25 and end 4/5/25 with a compliance goal of 95% by the end of auditing. Audit results will be reported to QAPI monthly; if audits are not meeting the compliance goal, audits will continue and will be monitored at QAPI monthly. The DON is responsible.	April 8, 2025

§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	Resident #19's fall care plan was updated to reflect current interventions and ensure interventions were in place by 11/26/24.	All residents in the facility have the potential to be affected. All resident fall care plans will be reviewed for proper, up-to-date interventions with current interventions checked to be in place by 1/10/25.	Registered Nurse Managers (RNMs), Floor Registered Nurse Seniors (RNSs), Minimum Data Set (MDS) Nurses, and Assistant Directors of Nursing (ADONs) will be educated on care planning requirements following new falls. 90% of the above department employees will be re-educated by 1/10/25 with remaining staff education provided upon their return to work. Following each RNMs post-fall review, RNMs will review and update the resident's fall care plan as appropriate and ensure interventions from the care plan are in place/use and still appropriate. Following of the above care planning requirements will be observed through an auditing process.	ADONs or designee will each audit 5 post-fall documentation and care plan updates per building for 3 months. Audits will be completed monthly. Audits will begin 1/13/25 and end 3/31/25 with a compliance goal of 95% by the end of auditing. Audit results will be reported to QAPI monthly; if audits are not meeting the compliance goal, audits will continue and will be monitored at QAPI monthly. The DON is responsible.	April 8, 2025
§ 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 a communicable disease or infected skin lesions from engaging in any 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 accepted professional practice.	Staff throughout the facility, including staff on 19-4, 21-3, and 22-5, were re-educated on proper personal protective equipment (PPE) usage and additional, clarifying signs for which PPE was required on each floor were posted throughout various entry points to the floors on 10/22/24.	All residents residing on a floor or building that has a COVID positive resident have the potential to be affected.	The Resident COVID Illness Standard of Work (SOW), including practices for which PPE needs to be worn on each floor in a building with a COVID positive resident, will be reviewed with all departments' staff. Re-education will also be provided on referencing the Units on Isolation list as well as watching for signage on the floors indicating which PPE is required. 90% of the above department employees will be re-educated by 1/10/25 with remaining staff education provided upon their return to work. Following of the above SOW protocols related to PPE usage will be observed when buildings have a COVID positive resident through a monitoring/auditing process.	When a new resident floor has a COVID positive resident, the Infection Preventionist (IP) or designee will audit each floor in the building for proper signage posted on the floors. Registered Nurse Managers (RNMs) or designees will each audit 5 different staff members during upcoming building's COVID outbreaks for proper on-the-floor PPE usage for 12 weeks. Audits will be completed each week for 2 weeks during each building's COVID outbreak. Audits will begin 1/13/25 and end 4/5/25 with a compliance goal of 95% by the end of auditing. Audit results will be reported to QAPI monthly; if audits are not meeting the compliance goal, audits will continue and will be monitored at QAPI monthly. The DON is responsible.	April 8, 2025

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§ 51.200 (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.	Testing of illuminated exit signs including battery backup will begin by December 31,2024. The illuminated exit sings with battery backup will be visually inspected, and functionally tested for no less than thirty seconds at least monthly. The illuminated exit signs will be tested on battery annually for at least ninety minutes.	Residents who may need to evacuate the aera may be affected by illuminated exit signs.	A preventive maintenance schedule will be created to ensure that the illuminated exit signs are tested per regulation. The electronic work order system will be updated to include the preventive maintenance schedule. Physical plant staff will be educated on the fire alarm system requirements by the Plant Operations Director or designee.	Monthly audits of the testing of the illuminated exit signs will be completed for three months starting January 1, 2025, with results reported to the Quality Assurance and Performance Improvement Committee, (QAPI) for further review. Regulatory standards will continue to be followed thereafter.	March 31, 2025
.§ 51.200 (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.	The fire alarm system semi-annual testing to include the alarm system battery charge, back up battery, and discharge testing will be completed by low voltage contractors (vendor) by March 31, 2025. (semi-annual testing is due In March).	Residents who may need to evacuate due to smoke in a compartment may be affected by this practice.	A preventive maintenance schedule will be created to ensure that the semi-annual fire alarm testing is tested per regulation. The electronic work order system will be updated to include the preventive maintenance schedule. Powerhouse staff will be educated on the fire alarm system requirements by the Plant Operations Director or designee.	The semi-annual fire alarm testing to include the alarm system battery charger, back up battery, and discharge testing has been scheduled for March 19,2025 at 09:00am with low voltage contractors. Regulatory standards will continue to be followed thereafter.	March 31, 2025
§ 51.200 (b) Emergency Power. (1) An emergency electrical power system must be provided to supply power adequate for 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.	A remote manual stop device will be installed outside of the entrance to the generator in Building 20 by approved vendor, Cummins.	Residents who may require back up power by the generator may be affected by this practice.	The remote manual stop device will be installed, and plant operations support staff educated on regulatory requirements by the Plant Operations Director or designee.	The Remote manual stop installation has been scheduled with our vendor, Cummins. This work will be completed the first week of January 2025.Upon completion the remote manual stop will be tested monthly with the generators monthly load testing for three months, starting on 1/13/2025 and ending on 3/31/2025.With results reported to the Quality Assurance and Performance Improvement Committee, (QAPI) for further review. Regulatory standards will continue to be followed thereafter.	March 31, 2025

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