State Veterans' Homes (SVH) Corrective Action Plan
(MVH – Saint Louis 9/19-9/22/2023)

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)
51.90 (c) (3) Staff Treatment of Residents	Allegation regarding resident #16 was completed and unsubstantiated on 9/28/23	Nursing Management to review all incident reports for July – August by December 15th.	All-Staff will be educated and competency will be provided to follow the facility policy regarding allegations of abuse/neglect by December 8th. Nurse Management will complete five random staff interviews regarding abuse/neglect reporting weekly x 60 days from 11/6-12/31/23 to ensure competency of training. 95% compliance after 30 days.	DNS/ADNS to review abuse/neglect incident reports x 60 days to ensure completion from 11/6-12/31/23. Review of findings from weekly interviews and incident reporting will be discussed in monthly QA for November and December.	12/31/23
51.90 (c) (4) Staff Treatment of Residents	Allegation regarding resident #16 was completed and unsubstantiated on 9/28/23	Administration to review all abuse allegations reported from January 2023-September 2023 to ensure reporting and investigations were completed, within 5 business days, as required by MVC Policy K-6 by January 15th.	All-Staff will be educated and competency will be provided to follow the facility policy regarding allegations of abuse/neglect by December 8th. Administration to audit all abuse allegations are investigated per MVC Policy and meet reporting and investigation timeline requirements from November 1-December 31st, compliance goal of 100%.	Review of findings from Administration audits of abuse allegations will be discussed in monthly QA for November and December.	12/31/23

§ 51.100 (f) Accommodation of needs.	Resident # 6 was evaluated by therapy and received adaptive equipment on 9/21/23. Resident #6 care plan was updated with his dining status and new adaptive equipment on 9/21/23. Resident #20 and #21 where brought meals at 12:50 and 12:51. Meal service times shall be observed and posted as follows: Breakfast: 6:30 – 8:30 Lunch – 11:30 – 1:30 Dinner – 4:30 – 6: 30.	All staff education will be provided on adaptive equipment, to include the appropriate reporting of Veterans having difficulty eating and serving meals timely upon Veterans arrival to the dining room by no later than December 8th. Meal tickets shall be presented with each meal/plate served. If there are meal tickets left over at end of meal service, nursing and dietary services are to assess whether those residents still need a meal.	Dining Services/ Food service Manager will manage inventory of adaptive equipment required for all residents and communicate with therapy when new items are needed. Adaptive equipment shall be noted on the resident's meal card. Dietary aides and nursing staff shall ensure resident receives appropriate adaptive equipment at meal times	Unit Manager or designee will audit that adaptive equipment is given to Veteran as stated on their meal card weekly M-F for 30 days, then 3 times weekly for 30 days from 11/6-12/31/23. 95% compliance within 30 days. FSM and or/ Food Supervisor shall audit for late meals daily by monitoring number of meal tickets left over after any meal starting 12/11/23-12/31/23. Then follow-up with Residents with meal tickets not used. Audit findings/compliance to be reviewed in monthly QA meeting for November and December, with a goal of 95% of meals being served timely.	12/31/23
Comprehensive Care Plans 51.110 (e) (2)	Resident # 2's care plan was updated to include a focus area and interventions for inappropriate sexual behaviors on 9/21/23. Resident #6's care plan was updated to include a skin tear injury on 9/21/23.	Nursing management will conduct a House wide audit of all Veterans on psychotropic medications or hormone replacement therapy to ensure appropriate diagnosis and care plans with interventions by December 8th. Licensed Nurse Education and competency will be provided on incident reporting by December 8th. SDC will educate staff related to facility skin tear policy P-4 by December 8th. Nurses will complete weekly skin assessments on all Veterans per MVC policy.	All new admissions Care Plans will be reviewed by the Interdisciplinary team within 48 hours per MVC policy P-1. ADNS/Designee will review all weekly skin assessments and skin reporting documents for validation or training compliance for x60 days from 11/6-12/31/23. 95 % compliance within 30 days.	All new admissions with psychotropic or hormonal medications or any history of behavior will be discussed in behavior meetings weekly for 90 days from 11/6/23-1/31/24. All audit findings will be reviewed in monthly QA meeting for the next 2 months for November and December.	01/31/2024
Quality of Care 51.120	Resident # 6's care plan was updated to include skin tear injury and interventions on 9/21/23. Staff educated on appropriate dementia approach related to resident #8 by	Staff Development Coordinator will educate staff assigned to the dementia care unit regarding appropriate response to dementia related behaviors by November 30th.	Nurse Management/IDT will ensure Veterans care plans are updated with appropriate skin or dementia related interventions upon admissions, quarterly or as needed upon condition change.	ADNS/Designee will review all skin reporting documents for validation or training compliance for x60 days from 11/6-12/31/23. ADNS/Designee will observe staff approach to	12/31/2023

	November 30th.	SDC will educate staff related to facility skin tear policy P-4 by November 30th.		dementia Veterans Monday – Friday daily x30 and then 3x weekly for the next 30 days from 11/6-12/31/23. Results of observations and training competency audits will be reviewed in monthly QA for November and December.	
Accidents 51.120 (i)	Resident # 9 use of urinal was removed from Care Plan during survey. On 8/17/23 resident was transferred to our Memory Care Unit. Care Plan was reviewed to ensure all proper interventions. • Signs removed from Veterans room when he was transferred • Resident encouraged to stay in social area, however if he declines to do so he is escorted back to his room by staff after meals as Veteran has right to choices • Perimeter mattress determined not to be appropriate • Rounds typically occur every two hours. Increased rounding would be more than every two hours. We do not have a specific timeframe.	MDS Coordinator/Unit Manager or Designee will ensure a safety huddle will be called for each fall event. All Care plans will be reviewed for compliance of active fall interventions by 12/15.	Staff education will be provided on fall management program, to include placement of effective interventions post fall by no later than December 8th An Incident and Accident report will be filled out on each fall event and will include a fall intervention.	Unit Manager/DNS/ADNS or Designee will ensure Daily IDT Meeting to review Incident and Accident reports, check interventions and review care plan for 60 days from 11/6-12/31/23 to ensure training competency. Designated staff to complete Intervention rounds to ensure that fall interventions are in place for those designed as high fall risk daily x30 then 3x weekly for the next 30 days from 11/6-12/31/23. Our goal is to have 85% compliance for the first 30 days of auditing and 95% after 30 days. Results of audit findings will be reviewed in monthly QA for November and December.	12/31/23
Unnecessary Drugs 51.120 (m)(1)	Resident # 2 Care Plan was updated on 9/21/23 to reflect behavior and as well as non-pharmacological interventions.	Nursing management will conduct a House wide audit of all Veterans on psychotropic medications or hormone replacement therapy to ensure appropriate diagnosis and care plans with interventions by December 8th. Pharmacy will complete monthly medication regimen reviews and	All new admissions Care Plans will be reviewed by the Interdisciplinary team within 48 hours per MVC policy P-1.	All new admissions with psychotropic or hormonal medications or any history of behavior will be discussed in behavior meetings weekly for 90 days from 11/6/23-1/31/24. All audit findings will be reviewed in monthly QA meeting for the next 2 months for November and December.	01/31/2024

		submit any recommendations to the Medical Director for their decision.			
Medication Errors 51.120 (n)	Educate Licensed staff and CMT's on MVC Policy P-3 Medication Management and Administration by December 8th.	Nurse Management to review resident medication lists and results of med pass audit to determine if medication administration times should be adjusted to promote an even distribution for timely administration by December 8th.	Educate Licensed staff and CMT's and competency will be provided on MVC Policy P-3 Medication Management and Administration by December 8th.	Nurse Management will implement a daily med pass audit Monday – Friday x30days, then 3x weekly for the next 30 days from 11/6-12/31/23. Results of audit findings will be reviewed in monthly QA for November and December, with a goal of 90% compliance.	12/31/2023
Nursing Services 51.130 (e)	Review of MVC staffing case mix methodology to ensure adequately capturing care hours completed November 17th. Review completed with the Medical Director of Veterans receiving medications outside of designated time frames to ensure no adverse reactions were noted due to administration. No adverse reactions were noted.	Nursing Management will review Residents medication lists to determine if medications administration times need to be adjusted to provide staff adequate time to ensure medications are given within therapeutic time frames as designated by the physician by November 30th. Educate on MVC Policy P-3 Medications & Administration to all licensed nursed and certified medication technicians by November 30th. MVC will review the need to possibly allocate more CMT positions within its homes structure	Daily review of medication administration reports for timely administration. Late medications will be reviewed and trended by Nurse/CMT for performance issues and appropriate notification to the physician. From December 12-January 15th. Weekly staffing meetings held to review appropriate case mix of Residents and staff coverage of CMT's/Medication Nurses for the next 60 days from 11/6-12/31/23.	Results of weekly staffing meetings, daily Per Patient Day hours and daily medication administration review will be reviewed in monthly QA meeting for November-January.	01/15/2024
§ 51.140 (h) Sanitary conditions.	Bottle of sanitizer, hand soap, and dented cans were removed immediately upon survey observation rounds. Fish was removed and disposed of prior to service on 10/3/23. Ice machine was cleaned and sanitized on 10/3/23.	All Veterans have the potential to be affected by dietary sanitary conditions.	Dietary Staff education by no later than 12/8/23: • chemical storage • Refrigerator/Freezer temperature logging MVC policy L-4 • disposal of dented cans • MVC policy L-2 Food Production, Storage and Dating • Ice Machine cleaning & sanitation per MVC policy L-4. • No longer serving fresh fish	Supervisor and/or Food Service Manager shall perform daily kitchen inspections Monday - Friday of main kitchen and kitchenettes for proper chemical storage & refrigerator/Freezer temperature logging for 30 days from 12/6/23 – 1/6/24. Weekly audit by FSM or assigned staff member of dry storage area to check for dented cans from 12/6-1/6/24. Goal of 95%. Food Service Manager will monitor ice machine cleaning monthly for 3 months from November-February. 100 % compliance	2/28/24

				All audit findings will be reported in monthly QA meeting for November-February.	
§ 51.170 (a)-(c) Dental services	MVH – STL established a dental contract with an outside resource as of 10/15/23	All residents are under this contract.	HQ procurement team will audit all contracts annually during Mock Survey to ensure written agreements are current for professional services that the facility utilizes that are provided by outside resources utilizing the Procurement Mock Survey	Quarterly Credentialing meetings will be held to review outside resource agreements. Results of the quarterly meetings will be shared at the QA meeting for monitoring for the next 2 quarters. 10/1/23 – 3/31/24	3/31/24
Preventing the Spread of Infection 51.190 (b)	Pest Control Company contacted to begin routine visits.	Staff Development Coordinator will educate all-staff on infection prevention in relation to dining practices by November 30th.	Pest Control company will be on-site weekly to address any concerns from 9/19/23-12/31/23.	Nurse Management/ and or other trained designee will observe special care unit dining room for infections and pest control practices daily Monday – Friday x 30 days and then 3x weekly for the next 30 days from 11/6-12/31/23 to ensure training competency. 85% compliance for the first 30 days and 95% after 30 days. Results of dining observations & Pest control company findings will be reviewed in monthly QA meeting for November and December	12/31/2023
Life Safety for fire 51.200(A) **1. Smoke Barrier:**	Preventative Maintenance Order (PMO) created for Weekly Audits beginning 11/6/23 – 12/31/23. Penetration were corrected immediately during survey.	All smoke barriers were checked during survey, identified penetrations were corrected immediately.	All smoke barrier walls will be checked weekly and repaired as needed. During Weekly Preventive Maintenance Check/inspect smoke barrier walls for penetration.	Check complete in the Preventive Maintenance system software	12/31/2023
Life Safety for fire 51.200(A) **2. Kitchen equipment placement**	Tracks installed for kitchen equipment to be placed back in position under the hood system on 9/26/23	All Veterans have the potential to be affected.	Checking position of kitchen and restraints are in place for kitchen equipment added to daily rounds from 11/6/23 – 12/31/23. This will be included in a permanent monthly PM.	Review of daily/weekly rounds findings in Safety Meeting minutes for November & December	12/31/23
Life Safety for fire 51.200(A) **3. Self-closing devices**	Installed self-closing door hardware to double doors in dry food pantry and purchasing office/stock room on 9/26/23	All Veterans have the potential to be affected.	Maintenance will conduct daily rounds auditing for self-closing door compliance. 100% compliance	Review of daily rounds findings in Safety Meeting minutes for November & December	09/26/2023

Life Safety for fire 51.200(A) **4. Kitchen equipment restraint system**	Installed a tethered restraint system to all kitchen equipment located under the kitchen the kitchen hood 9/26/23	All Veterans have the potential to be affected.	Maintenance will conduct daily rounds auditing for compliance. 100% compliance	Review of daily rounds findings in Safety Meeting minutes for November & December	09/26/2023
Life Safety for fire 51.200(A) **5. Monthly Fire Drills**	Educate Maintenance team on how to properly document fire drill information to be completed no later than 9/30/23.	All Veterans have the potential to be affected.	Maintenance Supervisor will audit monthly fire drill documentation and initial/date them upon approval to ensure completion for the next 90 days from 11/1/23-1/31/24	Maintenance Supervisor will report audit findings for drills within the monthly Safety Meeting for the next 90 days from 11/1/23-1/31/24.	1/31/24
Emergency power 51.200 (B)	Preventative Maintenance Order (PMO) created on 10/20/23 to scheduled monthly testing and documentation for testing Generator Batteries to include: A) Specific Gravity Conductance	All Veterans have the potential to be affected.	Maintenance Supervisor will audit monthly testing and documentation to ensure compliance for the next 90 days. 11/1/23 – 1/31/24.	Maintenance Supervisor will report audit findings in monthly Safety Meeting to monitor findings for the next 90 days 11/1/23 – 1/31/23	1/31/24
§ 51.210 Administration.	Education to the Administrator and Assistant Administrator on MVC policy K-5 Quality Assurance and Performance Improvement (QAPI) Process by November 30, 2023.	MVC policy and procedure will be reviewed routinely to ensure they remain effective and in line with industry standard. Any new changes to policy/procedure will receive education at the home level in relation to the change and the new standard of practice.	Department managers will report findings of their audits monthly within QAPI meeting from November 2023-February 2024. Where the Administrator will review	HQ Homes team will review MVH-St. Louis Key Factor/QA documentation monthly for compliance and trend analysis of quality indicators for October-December 2023.	02/28/2024

§ 51.210 (h) Use of outside resources	The facility will meet with all Veterans utilizing VA psych services and discussed move to internal provider with MVC by November 30th. Cancellation notices from the VA were requested for confirmation.	An audit will be completed by the home to identify all Veterans that received mental health services through the VA by no later than October 15, 2023.	Upon admission of new Veterans requiring outpatient psychiatric services, the facility will gain consent to utilize the facilities contracted services	Director of Social Services will completed a monthly audit of all Veterans requiring outpatient psych services and ensure they are being seen by the contracted provider as needed for their treatment plan for December and January. Results of these audits will be discussed in monthly QA for December-January. With a goal of 100% compliance.	01/31/24
Laboratory Services 51.210 (m) (1)	Licensed staff to be educated on specimen collection and documentation of refusals or delay in collection by December 8th.	DNS to review lab pick up days to evaluate the need for additional days added to schedule for more timely specimen retrieval by December 8th.	Licensed staff to be educated on specimen collection and documentation of refusals or delay in collection by December 8th. Competency review will be a weekly review of all lab orders and timely specimen collection and appropriate documentation x 60 days from 11/6-12/31/23 85% compliance after the first 30 days and 95% compliance after 30 days.	Results of audit findings will be reviewed in monthly QA for November and December.	12/31/2023

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