State Veterans' Homes (SVH) Corrective Action Plan:

Missouri Veterans Home-Warrensburg 8/1-8/4/2023

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)**
Regulation: **§ 51.110 (e) (2) Comprehensive care plans.** A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Findings:** Based on observation, interview, record review, and facility	Resident #5's care plan was updated on August 1st 2023 to reflect the current wound prevention interventions in place. MVH Director of Nursing or Designee shall conduct a mandatory veteran specific care plan education in-service with nursing staff caring for Resident #5 to ensure staff are aware of veteran's current pressure ulcer prevention measures. **This education started on August 7th 2023.**	MVH Director of Nursing Service/designee shall conduct nursing in-service for members of Nurse reviewing facility policy, R-5 RAI/MDS and Care plan policy. The facility will validate education via post education demonstration of how to access, initiate or update skin or wound care plans. This is expected to be completed no later than October 31st, 202. MVH MDS Care Pan Coordinator will audit 100% of care plans for veterans that have known open wounds by October 1st 2023 to ensure appropriate care plans are in place for all veterans with skin concerns.	MVH House Supervisors will initiate a care plan for veterans with reported skin concerns within 24 hrs of the noted concern. Starting no later than October 31st 2023.	MVH MDS Care Plan coordinator will audit all new skin and wound care plans **starting no later than October 1st** weekly for eight (8) weeks to ensure 100% compliance. This should be completed no later than December 31st 2023 This shall be documented on an Audit tool and reported to the IDT monthly in QAPI. Any noncompliance that is found during these audits will result in immediate intervention, staff education and corrective action as needed.	December 31st 2023.

policy review, the facility failed to review and revise the Care Plan for one (1) of 17 sampled residents (Resident #5).					
Regulation: **§ 51.120 (d) Pressure sores.** Based on the comprehensive assessment of a resident, the facility management must ensure that—(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **Findings:** Based on observation, interview, record review, and facility policy review, the facility did not ensure that a resident who entered the facility without pressure sores did not develop pressure sores for one (1) of 17 sampled residents (Resident #5).	Resident #5's care plan was updated on August 1st 2023 to reflect the current wound prevention interventions in place. Skilled therapy services assessed resident #5 for appropriate pressure relieving devices and wheel chair positioning August 1st 2023 Veteran continues skilled therapies three times a week. MVH Director of Nursing or Designee shall conduct a mandatory veteran specific care plan education in-service with nursing staff caring for Resident #5 to ensure staff are aware of veteran's current pressure ulcer prevention measures starting. **This education started on August 7th 2023.** Charge nurses will ensure the placement of pressure relieving devises for veteran resident #5 three times daily until the area of concern is resolved. This will be documented in the veterans EMR under the treatment record starting no later than September 15th 2023. Resident #5 will continue to be assessed by the wound care provider weekly for wound monitoring. A special care plan meeting was completed on September 1st 2023 with Resident #5's DPOA to educate regarding DPOA's refusa of diabetic management related to wound healing. DPOA agreed to treatment, and veteran was started on an anti-diabetic medication on September 9th 2023.	MVH Director of Nursing Service/designee shall conduct an all nursing staff in-service reviewing facility policy, W-2 Wound-Skin Care Assessment Treatment policy, the care and prevention of pressure ulcers, and the appropriate uses of pressure reliving devices. The facility will validate education via post education quiz and staff demonstration of appropriate use of pressure reliving devices. Along with proper documentation on "Bath and Shower Flow Sheets" This is expected to be completed no later than October 31st, 2023 MVH Unit Managers will review and audit 100% of completed "Daily Bath and Shower Flow Sheets" weekly for eight (8) weeks using the skin and wound audit sheet. **Audits will continue monthly thereafter until 100% compliance is reached**. These audits will start no later than 10/1/2023. Then unit mangers will continue this audit on 25% of monthly documentation thereafter for two (2) months or until 100% compliance is obtained. This should be completed no later than December 31st 2023.	Support care assistants will document veterans skin condition and any areas of concern on the daily "Bath and Shower Flow Sheet" for charge nurse review, assessment, and follow up starting no later than October 1st 2023. Daily bath and shower flow sheets will be turned in to the Unit manager for auditing. Charge nurses will complete a head-to-toe skin assessment on each scheduled veteran weekly, upon admission or re- admission/return from a hospitalization and document in the veterans EMR per facility policy. All new open areas will be reported to the House supervisor. Starting no later than 10/1/2023.	Members of Nurse Management shall conduct audits using the wound prevention audit form daily for four (4) weeks **starting no later than October 1st 2023**, then weekly for four (4) weeks to ensure **100%** compliance. Audits will ensure veterans have the required pressure relieving devices in place and are being turned/positioned per Veteran's plan of care and staff understanding of prevention measures and that staff are completing weekly skin assessments per policy. Audits will be completed by December 31st, 2023. This shall be documented on an Audit tool which shall be submitted to the Director of Nursing Services for oversight and to maintain the documentation. Any noncompliance that is found during these audits will result in immediate intervention, staff education and corrective action as needed. Audit findings from the Skin and Wound Auditing sheets and House Supervisor wound prevention audits will be turned into the DNS for review. Audit findings will be reported monthly during the facilities QAPI meeting.	December 31st 2023

Regulation: **§ 51.180 (e) (1) Storage of drugs and biologicals.** (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. **Findings:** Based on observation, interview, record review and facility policy review, the facility failed to store all drugs and biologicals in locked compartments for two (2) of six (6) medication carts.	MVH licensed staff that were found to have violated the facilities medication safety policy were educated immediately on August 2nd 2023.	MVH Director of Nursing Service/designee shall conduct an all nursing staff in-service reviewing facility policy, Medication Administration and medication safety policy. This is expected to be completed no later than October 31st, 2023. Licensed Nursing staff and CMT's will participate in Omnicare's Medication webinar presentation. Presentation includes: Medication storage guidance; Preparation for medication pass; Resident rights; Administration of oral, ophthalmic, OTC and nasal medications; Additional routes of medication administration; & Preventing medication errors. This should be completed no later than October 1st 2023.	Members of Nurse Management shall conduct audits of all medication carts in use daily **starting no later than October 1st 2023** for four (4) weeks to ensure carts are locked with proper medication storage. These audits will continue weekly for four (4) weeks to ensure continued compliance **at 100%. These audits should be completed by November 30th 2023.**	Members of Nurse Management shall conduct audits of one medication administration weekly on their assigned unit using the CMS Medication Administration Auditing tool. Staff should be educated immediately upon any discovery of error. Starting no later than October 31st 2023. The results of these audits will be will be reviewed with the IDT in QAPI.	DEC 31 2023
§ 51.200 (b) Life safety from fire. ***Smoke Barriers and Sprinklers*** *Based on observations and interview, the facility failed to properly install portable fire extinguishers*. The deficient practice affected one (1) of 14 smoke compartments, staff, and no residents. The facility had a capacity for 200 beds with a Census of 91 on the first day of the survey. The findings include: Observation during the building inspection tour, on 8/2/23, at 12:11 p.m., revealed the K type extinguisher in the kitchen was installed above eye level, and the facility staff measured the top of the K extinguisher to be at 5' (feet) 3" (inches) from the floor, as prohibited by section 6.1.3.8.2 of NFPA 10, Standard	Fire extinguisher cited for being out of compliance was removed and remounted at a height that measured within compliance according to NFPA 10 6.1.3.8.1 (extinguisher in question is not more than 40 lb. with new installed height at 46" from top to the ground and 26" from bottom to ground)	Corrected deficiency will be reported and reviewed during monthly internal Quality Assurance (QAPI) meetings.	A procedure to inspect for correct installation height is now included in monthly fire extinguisher preventative maintenance inspection. Results will be reviewed by Physical Plant Supervisor for 90 days (3 QAPI cycles).	A procedure to inspect for correct installation height is now included in monthly fire extinguisher preventative maintenance inspection. Results will be reviewed by Physical Plant Supervisor for 90 days (3 QAPI cycles).	**08/03/2023 Complete**

for Portable Fire Extinguishers. An interview with the Maintenance Supervisor, on 8/2/23, at 12:11 p.m., revealed the facility was not aware of installation height requirements for portable fire extinguishers. The census of 91 was verified by the Administrator on 8/1/23, at 9:00 a.m. The findings were acknowledged by the Administrator and Director of Nursing Services (DNS), and verified by the Maintenance Supervisor during the exit interview on 8/4/23, at 12:00 p.m. Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.3.5.12 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. Actual NFPA Standard: NFPA 10, Standard for Portable Fire Extinguishers (2010) 6.1.3.8 Installation Height. 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. 6.1.3.8.2 Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be installed					

so that the top of the fire extinguisher is not more than 3 1⁄2 ft (1.07 m) above the floor. 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm).					
§ 51.200 (b) Emergency power. ***Electrical Systems*** *Based on observation and interview, the facility failed to maintain the remote annunciator for the emergency generator in location readily observed by operating personnel.* The deficient practice affected 14 of 14 smoke compartments, staff, and all residents. The facility had the capacity for 200 beds with a census of 91 on the first day of survey. The findings include: Observation during the building inspection tour , on 8/2/23, at 11:45 a.m., revealed the remote annunciator for the emergency generator was installed at the nurses' station in Wing #A of the facility, which was a regular duty station but currently vacant/unoccupied, as prohibited by section, 6.4.1.1.17 of NFPA 99. Health Care Facilities Code. An interview with the Maintenance Supervisor , on 8/2/23, at 11:45 a.m., revealed the nurses' station at Wing #A, where the generator annunciator was installed, was currently not occupied, but was last year until recently when the position became vacant. Additional interview revealed the facility	Electrical contractor requested for site visit to review NFPA and how it pertains to the generator remote annunciator panel. Contractor provided quote dated 08/29/2023 to remove remote annunciator panel from its current location and install on the closest occupied Nurses Station (B Unit). Proposed date for work completion provided materials are available within time frame is 10/29/2023. Until this work is completed the facility will maintain the remote annunciator by completing rounds every 2 hour 24/7 by the Shift Supervisor. Environmental services completes approximately 1 hour daily cleaning of this area and all staff have been educated on what to do if remote annunciator panel is alarming.	Deficiency and status updates will be reported and reviewed during monthly internal Quality Assurance (QAPI) meetings.	A procedure to check that remote annunciator panel is located at a regular duty station is now included in weekly generator preventative maintenance inspection. Results will be reviewed by Physical Plant Supervisor for 90 days (3 QAPI cycles).	A procedure to check that remote annunciator panel is located at a regular duty station is now included in weekly generator preventative maintenance inspection. Results will be reviewed by Physical Plant Supervisor for 90 days (3 QAPI cycles).	10/29/2023

had not filled the vacant position that occupied the nurses' station in Wing #A. The census of 91 was verified by the Superintendent 8/1/23, at 9:00 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 8/4/23, at 12:00 p.m. Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012) 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular workstation (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine–generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains					

less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed 6.4.1.1.17.1* A remote, common audible alarm shall be provided as specified in 6.4.1.1.17.4 that is powered by the storage battery and located outside of the EPS service room at a work site observable by personnel. [110:5.6.6] 6.4.1.1.17.2 An alarm-silencing means shall be provided, and the panel shall include repetitive alarm circuitry so that, after the audible alarm has been silenced, it reactivates after the fault condition has been cleared and has to be restored to its normal position to be silenced again. [110:5.6.6.1] 6.4.1.1.17.3 In lieu of the requirement of 5.6.6.1 of NFPA110, a manual alarm-silencing means shall be permitted that silences the audible alarm after the occurrence of the alarm condition, provided such means do not inhibit any subsequent alarms from sounding the audible alarm again without further manual action. 6.4.1.1.17.4 Individual alarm indication to annunciate any of the conditions listed in Table 6.4.1.1.16.2 shall have the following characteristics: (1) It shall be battery powered. (2) It shall be visually indicated. (3) It shall have additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. (4) It shall have a lamp test					

switch(es) to test the operation of all alarm lamps.					
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. Based on observations and interviews, the facility failed to adhere to professional standards for food service safety as indicated by unlabeled and/or undated, opened packages of food, staff personal food items stored with resident food, and food items not used or disposed of by the use by or expiration date. *The findings include: During the initial kitchen tour, on 8/1/23, that started at 1:45 p.m., accompanied by Interim Dietary Manager (IDM) K, observations revealed three (3) dented #10 cans of fruit cocktail on the "for-use" storage rack and an opened, undated/unlabeled bag of dry pasta in the dry storage; an employee lunch in a plastic bag on the shelf of the walk-in cooler; opened and unlabeled breadsticks; and a container of strawberry sauce in the walk-in freezer. Additionally observed were an opened, plastic jug of corn syrup, with dating that could not be determined, but the jug had dust on it that indicated it had not recently been opened;*	All identified areas were corrected on 8/31/23. Dietary Manager will schedule a department meeting to educate staff on proper storage of food and dating and labeling food by no later than September 30th. DNS or SDC will schedule a nursing department meeting to educate nursing staff on dating and labeling food and drinks after opening them as well as not storing personal food with Veteran's food items by no later than September 30th.	Dietary Manager or designee will audit dry food storage daily M-F to ensure food is stored, dated and labeled properly. They will inspect all cans to ensure they are not damaged and will dispose of any dented cans immediately. They will use the dry food storage auditing tool and turn it in to the Assistant Administrator weekly for 4 weeks. Audits will occur starting 9/1/23 and will end 9/30/23. Dietary Manager or designee will audit walk-in refrigerator, walk- in freezer and all unit nutrition room refrigerators daily M-F for food not dated or labeled. They will ensure that no personal food items are stored with Veteran's food. They will use the refrigerator/freezer/nutrition refrigerator auditing tool and turn it in to the Assistant Administrator weekly for 4 weeks. Audits will occur starting 9/1/23 and will end 9/30/23.	The infection control committee will perform monthly rounds in the dietary department and report the findings to the Dietary Manager and in the infection control committee meeting.	Audit findings and in-service education updates will be reported and reviewed during monthly internal Quality Assurance (QAPI) meetings until 4 weeks of audits are completed. The Home will have compliance goal of 90% or higher.	SEPT 30, 2023

and two (2) 56-ounce cans, one (1) opened and one (1) unopened, of sesame oil, with received dates of December, 2019 in the food preparation area.					

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