State Veterans' Homes (SVH) Corrective Action Plan
Thomson Hood Veterans Center - 11/19/2024 – 11/22/2024

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
§ 51.110 (e)(3) Comprehensive Care Plans. The services provided or arranged by the facility must- (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care	Resident #8's fluid restriction was dis-continued on 11-26-24 after the provider reviewed the restriction and resident's wishes to consume more fluids.	All residents in the facility that have fluid restrictions were assessed by the Registered Dietitian (RD) and their providers on 11-26-24. Two residents #8 and another resident had their restrictions discontinued by their providers.	All licensed staff were educated by the staff development nurse, 11-25-24, on fluid restrictions: notifying dietary of the new order, the registered dietitian of how to divide the fluids for dietary and nursing to write the order in the physician order book to be checked on the 24-hour chart checks if the order is verbal or by phone.	Audits of residents receiving fluid restrictions were started by R.D. on 11/27/2024 and will continue weekly for four weeks then monthly for two months to ensure compliance with this process. The audit results will be taken to the QAPI committee after two months for further instruction on whether to discontinue or continue audits. The goal for compliance is 100% of residents receiving fluids within their recommended fluid restriction.	3-15-25
§ 51.120 (e) (1) – (2) Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that- (1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (2) A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	The nursing staff who provided the incontinence care for resident #6 were immediately re-educated by the neighborhood unit manager, the day the incident occurred, with return demonstration on incontinence care.	All incontinent residents in the facility have the potential to be affected by the deficient process. Therefore, skills check offs for incontinence care, male or female, are being done with all staff by the neighborhood managers, Register Nurses (RNs), and Staff Development nurse starting 11-26-24.	Incontinent care audits, both skills check offs and direct observation, are being done by the neighborhood managers, staff development nurse, infection preventionist and the Director of Nursing (DON) starting 11-26-24. Education was presented to the nursing staff by the DON on 11/25/24 concerning incontinence care of male and female residents.	Skills check offs on incontinence care and weekly incontinence audits will be done by the nursing staff for 2 months beginning 11-26-24. The audit results will be taken to the QAPI committee for further instruction in March 2025 meeting. The goal for compliance is 100% of incontinence care will be delivered to male and female residents correctly per protocol.	3-15-25

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§ 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 to prevent accidents.	Resident #8 had Dycem (nonskid mat) replaced on wheelchair cushion, top and bottom on 11-21-24 by the neighborhood manager. This was done after the surveyor mentioned to the neighborhood manager that there was no Dycem on the top of the chair.	The neighborhood managers audited all residents on 11-26-24 who had Dycem ordered by their provider to ensure the Dycem was present.	The facility has a Falls Coach through the VA Medical Center CONCERT series. This coach is working with the nursing staff on HUDDLES, presenting pertinent information to prevent falls and understanding the root causes of falls. The nursing managers are assessing all residents with orders for Dycem in their chair, top and bottom of the cushion, to ensure the Dycem is needed to prevent falls. This audit was initiated 11-26-24 and is weekly for two months. A task was added to Point Click Care for Dycem to be checked each shift by nursing assistants and on daily rounding by the neighborhood managers.	The nursing staff and staff development nurse will audit resident wheelchairs, recliners, and any other device that has an order for Dycem above and under the cushion to ensure the Dycem is placed correctly. These audits will be done weekly for two months starting 11-26-24. The audits will then be taken to the QAPI meeting to receive further input on whether to continue the audits. The goal for compliance is 100% accuracy.	3-15-25
§ 51.120 (n) Medication Errors The facility management must ensure that- (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented.	Licensed Practical Nurse (LPN) G was immediately educated on the checking for proper placement of PEG tubes by the Unit Manager on 11-25-24 before administering medications. There was a return demonstration from the nurse. The Medication and Controlled Substance Pass and Documentation Policy (NSA 7135), section on Administering medication via Enteral tube was updated by the DON on 11-25-24.	All licensed nurses were re-educated by the staff development nurse, DON and unit managers on 11-25-24 on checking placement of the PEG tube before administering medications.	Nurses completed competencies on how to properly check PEG tube placement before administering medications or feedings. This competency was completed by the Staff Development nurse, the DON and the unit managers on 1-13-25. Employees on leave during this time must do the competency before returning to work.	A quality assurance audit will be done weekly for four weeks, beginning 1-13-25, to monitor nurses checking appropriate placement of the PEG tube before administering anything by the tube. This will be done until all nursing staff have been audited. Newly hired licensed staff will be checked off on PEG tubes during orientation. The audit results will be taken to the QAPI meeting 3/25 for further input on whether to continue the audits. The goal will be for 100% accuracy.	3-15-25
	LPN E was immediately educated by the Nursing Director, 11/20/24, on the administration of eye drops and holding the inner canthus after the administration of the eye drops.	All licensed nurses and Kentucky Medication Aides were re-educated by the staff development nurse, DON and unit managers on 11-26-24 and 11-27-24 on how to properly administer eye drops and hold the inner canthus after the administration.	Effective 11-26-24 and 11-27-24 all residents with orders for eye drops have their eye drop instructions on the Medication Administration Record. Nurses completed competencies on how to properly administer eye drops. This competency was completed by the Staff Development nurse, the DON and the unit managers on 1-13-25. Effective 1-2-25, all new licensed nurses and Kentucky Medication Aides will be given this competency exam in orientation prior to working with the residents. Employees on leave during this time must do the competency before returning to work.	Quality assurance audits will be done weekly for four weeks to monitor nurses administering eye drops beginning 1-13-25. Audits will be done until all staff have been audited. Results will be taken to the QA meeting 3/25 for further instruction or to discontinue the audits. The goal will be for 100% accuracy.	3-15-25

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.	LPN D was immediately re-educated on administering Flonase nasal spray and how to instruct resident #23 on how to occlude the opposite nares and how many sprays to administer. This re-education was done by the DON on 11/20/24. LPN D was educated on reading and double checking the order on 11-25-24 by the DON to give the ordered dosage.	All licensed nurses and Kentucky Medication Aides were educated on properly administering nose spray, specifically Flonase, by the Staff Development nurse, DON and unit managers. Also, education was done 11-25-24 by the DON on reading and double checking the physician orders to ensure the correct dosage was given as ordered.	All new licensed staff and Kentucky Medication Aides will be tested for competency of administering nose spray by the staff development nurse in new employee orientation. All licensed staff and Kentucky Medication Aides were assessed for competency of administering nasal spray by the DON, Staff Development Nurse and Unit managers on 1-13-25. Employees on leave during this time must do the competency before returning to work. Effective 11-26-24 and 11-27-24 all residents with orders for nose spray have their spray instructions on the Medication Administration Record. Employees were also educated on reading and double-checking physician orders during this education on 11-25-24 to ensure correct dosage of medication ordered was given.	QA audits of administering nasal spray will be done weekly until all nurses and Kentucky Medication Aides have been observed. These audits will begin on 1-13-25. After these audits, the data will be taken to the QAPI meeting 3/25 to determine if the audits should continue or be discontinued. The goal is 100% accuracy. Audits of comparing the physician orders with the administration of medication will begin on 1-13-25 and continue for six weeks to ensure the ordered medication dosage is given correctly. These audits will be taken to the March QA meeting for further instruction. The goal is 100% accuracy.	3-15-25
§ 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	Nursing assistants L and M were immediately re-educated on enhanced barrier precautions by the DON and unit manager on 11/20/24.	All nursing staff were re-educated by the Staff development nurse, DON, unit managers and Infection Preventionist 11-20-24 on enhanced barrier precautions. Other staff that were re-educated on enhanced barrier precautions were the housekeeping staff, Sunshine Aides and Interactive Guides.	Effective 1-2-25, all new nursing staff will be tested on enhanced barrier precautions by the staff development nurse in new employee orientation prior to the completion of the orientation. All current staff will have received individualized training on enhanced barrier precautions by 1-13-25.	QA audits of using the correct PPE for residents with enhanced barrier precautions will be done weekly for four weeks beginning 1/9/25. These audits will be done by the Staff Development nurse, Infection Preventionist, Unit managers and DON. After all staff are assessed, the data will be taken to the QA meeting to determine the need for further audits or to discontinue the audits. Compliance goal is 100% accuracy.	3-15-25

accepted professional practice.					

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