State Veterans' Homes (SVH) Corrective Action Plan DJ Jacobetti Home for Veterans 4/17/2023-4/19/2023

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 effected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assurance/Performance Improvement activities (QAPI).

State the Issue **Identify the Standard and Findings**	**Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with QAPI 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 QAPI)	**Proposed Completio n Date**	**Status**	**Evidence to be provided**
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	Resident #4 continue to reside in the home without plans or attempts for self-harm. The member was assessed by his attending physician and found to be without suicide ideation at this time. Resident #4's care plan was reviewed and updated to include a problem, goal and intervention were added to address potential suicidal ideation.	All members who answered "yes" to Question #9 on the MDS Section D "PHQ9" at least once in last 12 months were reviewed by the home's social workers had their care plans reviewed and updated as appropriate.	The facility's policies on Care Planning and Member Assessment were reviewed and determined to be appropriate. Social Workers who are responsible for completing Section D of the MDS were re-educated to the Care Plan policies and competency validated through written testing.	The Director of Nursing, or Designee, will conduct a quality review of member care plans to assure MDS Section D "PHQ9" is addressed with appropriate problem, goal and interventions weekly X6. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. The Director of Nursing is responsible for sustained compliance.	6/29/2023	Member assessments completed. Education complete. Policy reviewed. Audits for weeks 1 and 2	Weekly audits until 6/29/2023

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. Based on interview, record review, and facility policy review, the facility failed to develop a Care Plan for one (1) of 21 residents reviewed for Quality of Care. Resident #4 was assessed as having suicidal ideation. The resident did not have a Care Plan addressing this concern.							
§ 51.120 (h) Enteral Feedings. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and (2) A resident who is fed by enteral feedings receives the appropriate treatment	Resident #8 was evaluated by a provider and had experienced no negative outcome related to the deficient practice. The resident no longer resides at the facility.	All residents residing in the facility with an enteral feeding tube and have the potential to be affected by the deficient practice. All residents with an enteral feeding tube were evaluated by a provider and experienced no negative outcome related to the deficient practice.	Manufacturer's instructions for the MIC-KEY gastrostomy tube were reviewed and determined to be appropriate. The facility's procedure on the Care, Treatment and Use of Feeding Tubes was reviewed determined to be appropriate. LPN A was interviewed, removed from medication administration duties, re-educated, and provided remediation training and competency testing on	The Director of Nursing, or Designee, will conduct a quality review of appropriate treatment and services to residents fed by enteral nutrition weekly X6. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. The Director of Nursing is responsible for sustained compliance.	6/29/2023	Member assessments completed. Education complete. Policy reviewed. Audits for weeks 1 and 2	Weekly audits until 6/29/2023

and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills. Based on observations, interviews, and record review, the facility failed to provide appropriate treatment and services to residents fed by enteral nutrition (tube feeding) by failing to 1) Verify the placement of a gastrostomy (feeding) tube prior to initiating the feeding and, 2) Maintain the head of the bed at 30 degrees or higher for at least 30 minutes after feeding administration. This deficient practice affected one (1) of one (1) resident reviewed from a total of 28 residents sampled (Resident #8).			caring for feeding tubes with emphasis on verifying placement and maintaining head of bed at 30 degrees. LPN A will not return to medication administration duties until validated as competent on this skill. Licensed nurses were educated and validated as competent on the caring for feeding tubes with emphasis on verifying placement and maintaining head of bed at 30 degrees.				
§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy	Resident #7 was assessed by a registered nurse related to his incentive spirometer and had experienced no negative outcome from the deficient practice. The provider was notified. Resident #8 was evaluated by a provider and had experienced no negative outcome related to the deficient practice. The resident no longer resides at the facility.	There are no other residents currently at the facility that use an incentive spirometer or have a tracheostomy.	The facility's procedures from the Lippincott manual for incentive spirometer and tracheostomy care were reviewed and deemed appropriate. LPN A was removed from medication administration duties, re-educated, and	The Director of Nursing, or Designee, will conduct a quality review of any future resident with tracheostomy or using an incentive spirometry weekly x6. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee	6/29/2023	Member assessments completed. Education complete. Policy reviewed. Audits for weeks 1 and 2	Weekly audits until 6/29/2023

care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. Based on observations, interviews, and record review, the facility failed to provide proper respiratory care by failing to 1) Appropriately monitor residents with orders for incentive spirometry, and 2) Administer humidification when needed for residents with tracheostomies. These deficient practices affected one (1) of one (1) resident with orders for incentive spirometry (Resident #7) and one (1) of one (1) resident with a tracheostomy (Resident #8) from a total of 28 residents sampled.			provided remediation training and competency testing on incentive spirometer use and monitoring, and tracheostomy care with an emphasis on when to provide humidification. LPN A will not return to medication administration duties until validated as competent on this skill. Licensed nurses were educated and validated as competent on the monitoring residents with an incentive spirometer and tracheostomy care with an emphasis on when to provide humidification.	monthly until committee determines substantial compliance has been met. The Director of Nursing is responsible for sustained compliance.			
§ 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. Based on observations, interviews, and record	Residents #26, #6, and #28 were assessed by a Registered Nurse and have experienced no negative outcome related to the deficient practice. Any concerns identified were brought to the attention of their medical provider.	All residents have the potential to be affected by this deficient practice. Specifically, all residents residing on the 2North nursing unit have the potential to be affected by the deficient practice. All residents residing on the 2North nursing unit were assessed by a Registered Nurse. Any concerns identified were brought to the attention of their medical	The facility's policy on Medication Administration was reviewed and determined to be appropriate. LPN A was removed from medication administration duties, re-educated, and provided remediation training and competency testing on medication	The Director of Nursing, or Designee, will conduct a quality review of medication administration on each unit weekly X6. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. The Director of Nursing is responsible for sustained	6/29/2023	Member assessments completed. Education complete. Policy reviewed. Audits for weeks 1 and 2	Weekly audits until 6/29/2023

review, the facility failed to prevent medication errors by failing to 1) Administer appropriate dosages of stool softener as ordered by the provider, and 2) Administer insulin timely after meals, and 3) Obtain blood glucose results for residents with insulin orders that included parameters to hold the medication. There were three (3) medication errors observed from a total of 27 opportunities for error.		provider.	administration. LPN A will not return to medication administration duties until validated as competent by a Registered Nurse. Licensed nurses were educated and validated as competent on medication administration.	compliance.			
§ 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. Based on observations,	Residents #25, #26, #6, #28 and #8 were assessed by a Registered Nurse and have experienced no negative outcome related to the deficient practice. Any concerns identified were brought to the attention of their medical provider.	All residents have the potential to be affected by this deficient practice. Specifically, all residents residing on the 2North nursing unit have the potential to be affected by the deficient practice. All residents residing on the 2North nursing unit were assessed by a Registered Nurse. Any concerns identified were brought to the attention of their medical provider.	The facility's policies on Infection Control including policies on Medication Administration and Injections Administration were reviewed and determined to be appropriate. LPN A was removed from medication administration duties, re-educated, and provided remediation training and competency testing on infection control with an emphasis on Hand Hygiene and appropriate glove use. LPN A will not return to medication administration duties until validated as	The Director of Nursing, or Designee, will conduct a quality review of Infection Control practices including hand hygiene and glove use on each unit weekly X6. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. The Director of Nursing is responsible for sustained compliance.	6/29/2023	Member assessments completed. Education complete. Policy reviewed. Audits for weeks 1 and 2	Weekly audits until 6/29/2023

interviews, and record review, the facility failed to ensure 1) Staff were performing adequate hand hygiene before and after care, and 2) Staff were preparing and administering medications in accordance with the facility's own infection prevention policies.			competent and compliant with infection control practices including hand hygiene and appropriate glove use. Licensed nurses were educated and validated as competent and compliant with infection control including hand hygiene and appropriate glove use.				

- This Corrective Action Plan is to be sent to the Medical Center Director of jurisdiction and VACO Pod Manager