State Veterans' Homes (SVH) Corrective Action Plan
Michigan Veteran Homes at Grand Rapids 12/9/25-12/12/25

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, title 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.	Corrective action was implemented through resident-specific intervention and staff-focused remediation for the individual directly affected by the deficient medication-administration practice. For Resident #6, nursing leadership completed on 2/6/26 a targeted review of medication orders, administration parameters, and the Medication Administration Record (MAR) to verify accuracy and appropriateness. The resident's medication schedule was clarified with assigned nursing staff to ensure medications are administered only when the resident is present, ready, and under nurse supervision, in accordance with provider orders and facility policy. Nursing staff were instructed that medications for this resident are not to be left unattended and must be administered by a licensed nurse unless formal self-administration authorization is assessed and documented. No adverse outcomes were identified, and the resident continues to receive medications as ordered with appropriate supervision. For the involved licensed practical nurse	To identify other residents who may have the potential to be affected by the same deficient medication-administration practice, the State Veterans Home (SVH) conducted on 2/6/26 a targeted review of medication administration records (MARs) and medication-pass practices limited to residents receiving nurse-administered oral medications with scheduled administration times, hold parameters, or assessment requirements. Nursing leadership will review recent MAR documentation and conduct focused medication-pass observations to confirm nurse presence during administration, adherence to ordered timing, and accurate documentation after administration. This review will be limited in scope to identifying any similar practice deviations related to unattended medications or pre-documentation. Any resident identified through this process will receive immediate review and corrective action as appropriate, and findings will be incorporated into the ongoing monitoring plan to ensure resident safety and sustained compliance.	To prevent recurrence of the deficient medication-administration practice, the State Veterans Home (SVH) will reinforce existing medication-administration safeguards using a high-reliability, human-factors approach. Licensed nursing staff were reminded at the nursing meeting held on 2/11/26 and 2/12/26, that medications are to be administered only when the resident is present, ready, and supervised, and that prepared medications may not be left unattended. When a resident is not immediately available, nurses are expected to retain medications in the medication cart and administer them when the resident is ready or notify the provider if ordered timing parameters cannot be met. Focused education was provided to all licensed nursing staff to reinforce these expectations, reduce reliance on informal workarounds, and strengthen reliability at the point of care. Nursing leadership will continue targeted medication-pass observations and MAR reviews to verify adherence to administration timing, supervision, and documentation standards. In addition, leadership reviewed human-factor conditions that may contribute to perceived pressure during medication passes, including medication volume, timing, workflow	To ensure corrective actions are sustained, the State Veterans Home (SVH) will conduct targeted monitoring of medication-administration practices for Resident #6, the involved licensed nurse, and other residents with the potential to be affected by the same process. Starting the week of March 2, 2026, nursing leadership will perform 7 weekly medication-pass observations and MAR audits to verify nurse presence during administration, adherence to ordered timing and parameters, and completion of MAR documentation after administration. Sustainment will be measured by achieving 100% compliance with supervised administration, accurate timing, required assessment documentation, and MAR integrity for a 4-week period, with no recurrence of unattended medications or documentation discrepancies. Successful sustainment will be demonstrated by consistent compliance throughout the monitoring period without the need for additional corrective counseling or identification of repeat findings. The results of the audits will be submitted to the Quality Assurance Performance Improvement	April 20, 2026.

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	(LPN E), corrective action consisted of one-on-one coaching and education by the Assistant Director of Nursing on January 7, 2026. Consistent with VA patient safety and high-reliability principles, the root cause was identified as behavioral drift during a routine, high-frequency task, rather than a failure of policy or systems. Education focused on re-establishing critical safety controls, including nurse presence through ingestion, adherence to ordered administration times, accurate MAR documentation after administration, and appropriate actions when a resident is not immediately available. These actions reinforce human-factors awareness, interrupt reliance on informal workarounds, and support sustained safe practice. LPN E acknowledged the deviation, demonstrated understanding of expectations, and resumed medication administration in compliance with policy.		sequencing, and competing clinical demands, to ensure existing processes support safe practice. These measures reinforce adherence to current policy and professional standards and are intended to sustain safe medication-administration practices without introducing unnecessary system-wide changes.	(QAPI) committee for further analysis and recommendations and will be discontinued once substantial compliance is achieved.	
§ 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 #18 expired on 12/4/25; therefore, corrective action specific to the resident could not be implemented. However, immediately upon identification of the incident, the State Veterans Home (SVH) initiated a comprehensive internal investigation, notified appropriate authorities, reviewed all clinical, operational, and policy-related factors contributing to the event, and conducted an interdisciplinary review of the resident's care, supervision, and monitoring practices. The facility ensured notification of the resident's legal guardian, engaged leadership oversight, and initiated facility-wide corrective actions to address the identified system failures to prevent recurrence for other residents with similar risk profiles. The root cause of the incident was the facility's failure to consistently identify, reassess, and respond to the resident's ongoing risk for elopement despite a	The State Veterans Home (SVH) will identify other residents with the potential to be affected by the deficient practice through a structured, interdisciplinary review process. The Director of Nursing (DON), Social Services, and the Interdisciplinary Team (IDT) will conduct a census-wide review by 2/20/2026 of all residents who ambulate independently or semi-independently and who have one or more risk factors, including but not limited to: a history of elopement or attempted elopement; diagnoses of dementia, depression, PTSD (Post Traumatic Stress Disorder), or other psychiatric or neurocognitive disorders; fluctuating cognition; expressed desire to leave the facility or return home; unsupervised off-unit or outdoor privileges; or a pattern of signing in and out of the facility. The review will include examination of elopement risk assessments for accuracy and scoring consistency, evaluation of	The State Veterans Home (SVH) will implement comprehensive system-level changes to ensure consistent identification, monitoring, and timely response to residents at risk for elopement, or unsafe wandering. First, the home will complete revised elopement risk assessments with accurate scoring that incorporates prior elopement events, fluctuating cognition, and psychosocial risk factors by 2/27/26. Elopement risk assessments will be completed on admission, quarterly, with any significant change in condition, and following any behavioral or psychosocial concern, with supervisory review to validate scoring accuracy. Second, the SVH will require that any resident with a history of elopement or unsupervised off-unit privileges have a clearly defined, person-centered care plan that specifies approved locations, expected duration of absence, frequency of location checks, supervision	The State Veterans Home (SVH) will monitor its performance to ensure corrective actions are sustained through an ongoing, structured Quality Assurance and Performance Improvement (QAPI) process. The MDS (Minimum Data Set) Nurse/Designee will conduct weekly audits starting March 2, 2026, for 7 weeks, to verify compliance with elopement risk assessment, care planning, monitoring, and response protocols. Audits will include review of elopement risk assessments for accuracy and timeliness, verification that residents identified as at risk have individualized care plans addressing supervision, approved locations, monitoring frequency, and escalation procedures, and confirmation that sign-in/sign-out logs are completed with expected return times documented. The SVH will strengthen oversight and accountability by implementing routine audits	April 20, 2026.

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	documented history of elopement, fluctuating cognition, and psychosocial distress. Specifically, the facility did not ensure accurate elopement risk scoring and did not establish clear expectations for monitoring duration, location checks, or timely escalation when the resident failed to return as expected. The staff did not recognize missed scheduled medications, prolonged absence, and deviation from the resident's usual routines as indicators requiring immediate intervention, resulting in a delayed initiation of the missing resident protocol and law enforcement notification. These system-level breakdowns in assessment, communication, monitoring, and policy implementation collectively contributed to the adverse outcome.	comprehensive care plans to ensure elopement risk and monitoring expectations are clearly addressed, and validation that interventions align with each resident's current cognitive, behavioral, and psychosocial status. Medication Administration Records, sign-in/sign-out logs, progress notes, and recent behavioral or mood changes will be reviewed to identify missed medications, prolonged absences, or deviations from established routines that may indicate increased risk. Residents identified through this process as having potential risk will receive an immediate IDT reassessment, including nursing, social services, and mental health input, with updates to elopement risk scoring, supervision levels, monitoring expectations, and person-centered interventions as indicated. Findings and care plan changes will be communicated to all relevant staff to ensure consistent implementation and timely response to risk indicators.	expectations, weather-related restrictions, and escalation thresholds when the resident does not return as expected. Care plans will explicitly define staff responsibilities for monitoring and documentation, including required actions for missed medications, missed meals, or deviation from routine. The member care plans will be reviewed by the Interdisciplinary Team (IDT) and revised as needed by March 20, 2026. Third, the SVH will standardize and reinforce its sign-in/sign-out and location monitoring processes by 2/12/2026. Sign-out logs will require documentation of destination, expected return time, and staff verification. Failure to return within the established timeframe will trigger immediate location checks and prompt initiation of the missing resident/elopement protocol without delay. Missed scheduled medications or treatments due to resident unexpected absence will require real-time location verification and supervisory notification. Finally, the SVH will enhance interdisciplinary communication and staff education. Nursing, social services, and activities staff will receive re-education by 2/12/2026, on elopement risk factors, policy requirements, and early warning signs requiring escalation. Staff will be trained to recognize that historical risk factors remain relevant even when a resident's cognition appears improved and that deviations from established routines warrant immediate follow-up.	starting the week of 3/9/26 of elopement risk assessments, care plans, sign-in/sign-out logs, and response times to missing resident indicators. Audit results will be reviewed by the Administrator/Designee who will track and trend these key performance indicators and any identified variances will be reviewed by nursing leadership with immediate corrective action and staff re-education as necessary. Sustainment will be measured by maintaining 100% compliance with elopement risk assessments and care plan requirements, 100% initiation of location checks and escalation protocols when residents fail to return within the defined timeframe, and zero repeat incidents related to delayed identification or response to missing residents. Audit results and trends will be reviewed monthly by the QAPI committee and reported to facility leadership, with corrective actions implemented promptly to ensure continued adherence and resident safety.	

§ 51.120 (m) (1) Unnecessary drugs (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or	Corrective action was implemented through resident-specific intervention and staff-focused remediation for the individual directly affected by the deficient medication-administration practice. For Resident #6, nursing leadership completed on 2/6/26 a targeted review of medication orders, administration parameters, and the Medication Administration Record (MAR) to verify accuracy and appropriateness. No adverse outcomes were identified, and	To identify other residents who may have the potential to be affected by the same deficient medication-administration practice, the State Veterans Home (SVH) will conduct a targeted review on 2/6/26 of medication administration records (MARs) and medication-pass practices limited to residents who receive blood pressure medications. Nursing leadership will review recent MAR documentation and conduct focused medication-pass observations to confirm that licensed nursing staff are recording vital signs	To prevent recurrence of the deficient medication-administration practice, the State Veterans Home (SVH) will reinforce existing medication-administration safeguards using a high-reliability, human-factors approach. Licensed nursing staff were reminded on 2/11/26- 2/12/26 that prior to administering a medication with set parameters for administration, that the licensed nurse, or nurse aide, must obtain immediately prior and record necessary vitals in the medical record, ensuring that the medication is necessary for administration. Focused education was provided	To ensure corrective actions are sustained, the State Veterans Home (SVH) will conduct targeted monitoring of medication-administration practices for all identified residents who receive blood pressure medications, with the potential to be affected by the same process. Beginning week 2/15/26, nursing leadership will perform a 10% audit of weekly medication-pass observations and MAR audits to verify adherence to ordered timing and parameters, and completion of MAR documentation after administration.	April 20, 2026.

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(iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or Any combinations of the reasons above.	the resident continues to receive medications as ordered with appropriate supervision. Consistent with VA patient safety and high-reliability principles, the root cause was identified as behavioral drift during a routine, high-frequency task, rather than a failure of policy or systems. Education focused on re-establishing critical safety controls, including adherence to ordered administration parameters, accurate MAR documentation of vital signs before administration, and appropriate actions when a resident's vital signs are outside of acceptable parameters. These actions reinforce human-factors awareness, interrupt reliance on informal workarounds, and support sustained safe practice.	and following the established parameters set within the order. Any resident identified through this process will receive immediate review and corrective action as appropriate, and findings will be incorporated into the ongoing monitoring plan to ensure resident safety and sustained compliance.	to all licensed nursing staff to reinforce these expectations, reduce reliance on informal workarounds, and strengthen reliability at the point of care. Nursing leadership will continue targeted medication-pass observations and MAR reviews to verify adherence to administration timing, supervision, and documentation standards. In addition, leadership reviewed human-factor conditions that may contribute to perceived pressure during medication passes, including medication volume, timing, workflow sequencing, and competing clinical demands, to ensure existing processes support safe practice. These measures reinforce adherence to current policy and professional standards and are intended to sustain safe medication-administration practices without introducing unnecessary system-wide changes.	Sustainment will be measured by achieving 100% compliance with required medication administration and assessment documentation, and MAR integrity for a 4-week period, with no recurrence of medication administration outside of established parameters or missed documentation of necessary vital signs. Successful sustainment will be demonstrated by consistent compliance throughout the monitoring period without the need for additional corrective counseling or identification of repeat findings. The results of the audits will be submitted to the QAPI committee for further analysis and recommendations and will be discontinued once substantial compliance is achieved.	
§ 51.190 Infection control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.	No residents were identified to be affected by the deficient practice. The Holland Lighthouse and Grand River household medication storage rooms, medication and treatment carts were cleaned out and all expired items discarded upon discovery on 12/9/25. The root cause was determined to be that the nurses were combining supplies from multiple boxes with different expiration dates which allowed older supplies to expire after they were moved into an unexpired box.	Current residents have the potential to be affected by this practice. A one-time audit was completed on 12/9/25 by the DON/Designee of all medication storage rooms, medication and treatment carts to ensure medical and/or treatment supplies were discarded if the sterility of their packaging was compromised or they were past the manufacturer's expiration date.	Current licensed nurses were educated on 2/11/26- 2/12/26 about ensuring medical and/or treatment supplies are discarded if the sterility of their packaging was compromised or they are past the manufacturer's expiration date and to ensure they check expiration dates prior to use of any item on a member.	The Nurse Managers/Designee will be responsible for completing a weekly audit for 4 weeks starting the week of March 9, 20206, of the medication storage rooms, medication and treatment carts on each neighborhood to ensure compliance with medical and/or treatment supplies being discarded if the sterility of their packaging is compromised or past the manufacturer's expiration date. The results of the audits will be submitted to the QAPI committee for further analysis and recommendations and will be discontinued once substantial compliance is achieved. The benchmark will be to receive 95% or above on audits. For any items found for the remaining 5% the nurse's will be the double check and discard prior to use on a member according to their training.	April 20, 2026.

§ 51.200 (a) Life safety from fire. (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 sprinkler head in the walk-in cooler and the walk-in freezer were cleaned from any foreign material at the time of discovery. The root cause was determined to be that the sprinkler heads in the walk-in cooler/freezer build up dust/other foreign materiel due to the cardboard being used and the high circulation in those enclosed areas.	A one-time audit of all sprinkler heads was completed by the Physical Plant Director/Designee on 1/22/26 to ensure the sprinkler system is maintained and sprinkler heads are free from foreign material. There was no other sprinkler head identified with having dust/other foreign material.	The maintenance department staff was educated by 1/20/2026 on section 5.2.1 of the NFPA (National Fire Protection Association) 25 standard to ensure they are checking for dust/other foreign material on sprinkler heads, placing a work order, and cleaning material from the sprinkler head upon discovery. The dietary staff will have a sprinkler head check assigned to their daily duties and will be educated	The Physical Plant Manager/designee will complete a weekly audit x 4 starting the week of 3/2/2026, of all sprinkler heads to ensure they are free from dust/other foreign material. The preventative maintenance program will have an annual sprinkler head check assigned as required by 5.2.1 of the NFPA 25 standard. The results of the audits will be submitted to the	The date of compliance will be April 20, 2026.

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			by 3/16/2026, on ensuring a TELS work order is submitted if dust/other foreign material is found on any sprinkler head in their area.	QAPI committee for further analysis and recommendations and will be discontinued once substantial compliance is achieved. The benchmark will be to receive 100% on these audits.	

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