State Veterans' Homes (SVH) Corrective Action Plan
Veterans Home of California-Barstow NH
March 29 – March 31, 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)
§51.43(d) Drugs and medicines for certain veterans. VA may furnish a drug or medicine under this section and under §17.96 of this chapter by having the drug or medicine delivered to the State home in which the veteran residents by mail or other means and packaged in a form that is mutually acceptable to the State home and to VA set forth in a written agreement. Rating: Not Met Scope and Severity – C Residents Affected - Many	No residents have been negatively impacted by the deficient practice. The facility has continued to provide pharmaceutical needs to all residents.	All residents have the potential to be affected by the deficient practice; however, no residents have had any interruptions in their medication regimens nor were negatively impacted by the deficient practice.	The VHC-Barstow Staff, with the assistance of CalVet Headquarters Staff, have been working to secure a Pharmacy Sharing Agreement between VHC-Barstow and the Loma Linda V.A., since March 2022. Our efforts to complete this task are recorded and can be accessed to confirm that we have been diligent in our efforts. Correspondence dated March 28, 2023 from the Loma Linda V.A. Staff advised VHC-Barstow that the package that had been sent to VISN 22 for completion of the Sharing	The VHC-Barstow will continue to call and e-mail the Loma Linda V.A. Staff for regular updates until the process has been completed. Also, the VHC-Barstow has no authority to put mandates on the Loma Linda V.A., to make this process a priority in their daily job duties, therefore, the most that VHC-Barstow can do is call and e-mail for updates as we have been doing since March, 2022.	Proposed Completion Date: June 30, 2023 An update received via e-mail on June 2, 2023, from Hung Le, PharmD, BCPS Associate Chief of Pharmacy Operations at the Loma Linda V.A., stating the Agreement has been sent for signatures, and before it can become official it has to be reviewed by the National personnel. On June 6, 2023, the Veterans Home of California-Barstow (VHC-Barstow)

			Agreement was rejected and Loma Linda V.A., was working on making the required corrections. On May 4, 2023, the Loma Linda V.A. Staff informed VHC-Barstow, that they were close to completing the Sharing Agreement but could not confirm a final date of full execution. The VHC-Barstow Staff will continue to get updates regularly until the process has been completed.		Administrative Staff advised Hung Le, that the VCH-Barstow 2023 USDVA Survey CAP cannot be certified without a copy of the fully executed Pharmacy Sharing Agreement, however, no response has been received as of June 7, 2023.

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§51.70(c)(5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows Rating – Not Met Scope and Severity – D Residents Affected – Few	No residents have been negatively impacted by the deficient practice. The Accounting Staff have been in serviced on the Conveyance of Funds on Resident's Death (All Homes) policy #3635v.3 protocol for conveying funds within the allotted timeframe. All Patient Fund Balances report will be monitored by Accounting and follow up with legal each month to make sure funds are conveyed within the expected timelines. On accounts that are over 90 days due to unclaimed funds will be documented.	All residents have the potential to be affected by the deficient practice; however, no residents have had any negative impacts on this deficient practice. Admissions will provide a monthly report to the Accounting Department each month with the names of all discharged and expired residents. A quarterly report will also be given to the QAPI Committee to address and respond.	Admissions will send accounting a monthly report on all discharged and expired residents. The accounting department will act accordingly to clear on funds that need conveying. A report will be sent to the Administrator each month and a quarterly report will be given to the QAPI Committee showing that all accounts have been closed within the 90 days.	Accounting and Finance Manager will monitor the monthly report to ensure the home is following the 90-day policy. Any variances will be reported by the Accounting and Finance Manager to quarterly QAPI committee for 2 quarters.	December 30, 2023

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§ 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. Based on observations, interviews, record review, and review of facility policy, the facility failed to prevent the development of multiple pressure sores (PS) for two (2) of two (2) residents reviewed for the development of PS,	Resident #1: a) Braden Scale dated 2/15/2023, reviewed to be accurate. Braden Scale re-assessed on 5/9/2023, score (17), and reviewed to be accurate to residents' current condition. The Licensed Nurse who completed the Braden Scale on 2/15/2023, will be re-educated on the procedure for completion of the Braden Scale (a tool used to assist staff in predicting pressure sore risk), with emphasis on the follow through of the care plan interventions for prevention (based on the score); b) Care Plan "Potential for Skin Integrity Impairment", dated 2/17/2023, reviewed to be accurate. Reviewed on 4/11/2023 and updated to residents' current condition. Pressure Sores to Right ankle and heel, resolved as of 4/2/2023. c) The Licensed Nurse(s) who failed to assess the wounds on a weekly basis from 2/18/2023 to 3/13/2023, will be re-educated to appropriate procedures for weekly assessment of Pressure Sore(s) per facility Policy and Procedure, "Wound Management and Skin Breakdown Prevention (#8183v2); d) Physician Order dated 2/19/2023 for "Heel protector on Right heel and float to keep off pressure to Right heel	All residents with Pressure Sores will have a review of the Braden Scale, the care plan, the Physician Orders for treatment, the weekly assessments reviewed for measurements, and Registered Dietician notes reviewed for interventions, to ensure the facility policy is followed. All resident without Pressure Sores will have a review of the Braden scale for accuracy, followed by care plan review to ensure the facility policy is followed for prevention of skin breakdown for those at risk (based on the score). No other residents were identified to be affected by the deficient practice.	All Licensed Nursing staff will be provided education by the Nurse Instructor on the Policy regarding "Wound Management and Skin Breakdown Prevention" (#8183v2), to ensure each resident receives treatment and care in accordance with professional standards of practice in wound management and prevention. Education will include emphasis on assessment, measurement, and documentation on any wound on admission, and weekly (if present). Education will also include emphasis on the Licensed Nurses' Notes Weekly Summary documentation (completed on each resident weekly, per protocol), which includes a skin assessment, and measurement of any Pressure Sore(s), if indicated by the resident's condition. All Licensed Nursing staff will be provided education by the Nurse Instructor on the procedure for completion of the Braden Scale (a tool used to assist staff in predicting	The SRN/designee will conduct a weekly audit of the resident(s) with Pressure Sore(s) by review of each Weekly Summary to review the skin condition documentation, to ensure measurements were taken and documented. This will be completed weekly x 4 weeks, then monthly x 3 months. The SRN/designee will conduct an audit of each new admission medical record to ensure the Braden Scale was completed, and based on the score, would have appropriate interventions in the care plan for prevention of pressure sores (if indicated). This will be completed monthly x3 months (on new admissions). A	Education Completed by June 30, 2023. QA Monitors: Pressure Sores: Weekly x4 weeks completed by June 19, 2023; Monthly x3 months completed by September 19, 2023. Braden Scale: Monthly x3 months (new admissions) completed by 7/31/2023; Monthly x6 months (Quarterly assessments) completed by 10/31/2023.

(Resident #1 and Resident #2).	at all times Q shift", reviewed to be appropriate; Physician Order updated to residents' current condition on 4/2/2023, "D/C wound treatment for Right heel and Right Anterior ankle blisters (healed)". e) On 3/30/2023 the Registered Dietician re-assessed the resident, completed a progress note in the medical record, and made recommendations to the Physician for supplements. The Physician Order was obtained on 3/31/2023 for protein and vitamin supplement. The Registered Dietician who documented a progress note on 3/13/2023, (onset of the Pressure Sore 2/18/2023), and failed to make recommendations for a supplement is no longer employed (for corrective education). Resident #2: a) Braden Scale dated 11/30/2022, reviewed to be accurate. Braden Scale re-assessed on 4/14/2023, score (17), and reviewed to be accurate to residents' current condition. The Licensed Nurse who completed Braden Scale on 11/30/2022, will be re-educated on the procedure for completion of the Braden Scale (a tool used to assist staff in predicting pressure sore risk), with emphasis on the follow through of the care plan interventions for prevention (based on the score); b) Care Plan "Potential for Skin Integrity Impairment", dated 1/23/2023, reviewed to be accurate. The Licensed Nurse who assessed the Pressure Sore on 1/21/2023, and		pressure sore risk), with emphasis on the follow through of the care plan interventions for prevention (based on the score). Education will also include emphasis on assessment protocols upon admission and quarterly on each resident. All Registered Dietician(s) will be provided education by the Nurse Instructor on the Policy regarding "Wound Management and Skin Breakdown Prevention", (#8183v2) with emphasis on the Dieticians responsibility in collaboration with the Interdisciplinary Team (IDT), the Dietician develops nutritional goals for the resident to meet nutritional needs for wound healing.	random sample of (8) resident quarterly Braden Scale assessments will be audited monthly x6 months. The SRN/designee will report findings to the DON. The DON will report findings to the Quality Assurance and Performance Improvement Committee. The Committee will evaluate the findings Quarterly to determine if continued monitoring is required.	

	updated the care plan on 1/23/2023 will be re-educated on the procedure for review and update of the care plan at the onset of the new interventions for treatment of the Pressure Sore. Care Plan Reviewed on 3/18/2023 and updated to residents' current condition. c) The Licensed Nurse who assessed the Pressure Sore on 2/2/2023, will be re-educated to correct the nurses' note documented erroneously as Left Heel (instead of Right). The Licensed Nurse(s) who failed to assess the wounds on a weekly basis from 2/24/2023 to 3/14/2023, will be re-educated to appropriate procedures for weekly assessment of Pressure Sore(s) per facility Policy and Procedure, "Wound Management and Skin Breakdown Prevention (#8183v2); d) Physician Orders for current treatment reviewed and updated 4/25/2023 to be accurate to residents' current condition; e) On 3/30/2023 the Registered Dietician re-assessed the resident, completed a progress note in the medical record, and made recommendations to the Physician for supplements. The Physician Order was obtained on 3/31/2023 for protein and vitamin supplement. On 4/1/2023 the Registered Dietician completed a Nutritional Assessment. The Registered Dietician(s) who failed to re-assess Nutritional Assessment at the onset of the Pressure Sore(s) will be re-educated				

	on the Policy regarding “Wound Management and Skin Breakdown Prevention” (#8183v2), with emphasis on the Dieticians responsibility in collaboration with the Interdisciplinary Team (IDT), the Dietician develops nutritional goals for the resident to meet nutritional needs for wound healing.				

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§51.120(g) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility management must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. Rating – Not Met Scope and Severity – D Residents Affected – Few	A memorandum was sent to all VHC-Barstow Residents on May 3, 2023, as a reminder that all of their Primary Care needs will be provided through the Home. VHC-Barstow Medical Team will refer Residents to specialists within the VA system and contracted physicians, such as cardiologists, dermatologists and others. In addition, VHC-Barstow has a MOU dated May 3, 2023, in place with the High Desert Psychological Services of Victorville, CA for all mental and psychosocial services . These services are already being utilized on a regular basis.	Resident #8 whom was interviewed and identified during this survey has already attended his first appointment which was held on April 13, 2023, and will attend each month until provider has discharged Resident #8 from their care. The Medical Team are currently working to schedule all other Residents that were identified as needing these services and they will continue each month until discharged by the Provider.	Monthly assessments and reviews of medical records will continue on an on-going basis by the Medical Team.	The Medical Team will continue to monitor its performance with the usage of the Casper Report and 802 Form which identifies all Residents needing mental and psychosocial services. The Medical Team will report their findings each quarter to the QAPI Committee for evaluation for 2 quarters.	December 30, 2023

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§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 mediation errors and adverse reactions are implemented. Rating – Not Met Scope and Severity – D Residents Affected – Few Based on observation, interview, and record review, the facility did not administer medications without error for one (1) of five (5) residents observed (Resident #15). Observation included 27 opportunities.	On 4/5/2023, LVN (A) was provided education by the Nurse Instructor on the importance of looking around the entire room for medications when/if pills were dropped by the resident. She was also educated to separate out the meds in two separate cups so the resident didn't have too many medications in each cup. No adverse outcome to resident #15 was noted to have occurred.	All residents who receive medications could have the potential to be affected by the deficient practice. On 3/29/23, the Nurse Instructor initiated Licensed Nursing staff re-education on appropriate medication pass procedures. No other residents were identified to be affected by the deficient practice.	All Licensed Nursing staff will be provided education by the Nurse Instructor on appropriate medication pass procedures. Education will include: review of Procedure, "Administering Medication" (#7501); review of Policy, "Administering Medications" (#6451v4); and will be observed performing medication pass by use of a skills competency checklist.	The SRN/designee will observe medication pass of (8) resident opportunities, monthly x 3 months, then quarterly x 2, to ensure that the appropriate medication pass procedure was followed. The SRN/designee will report findings to the DON. The DON will report findings to the Quality Assurance and Performance Improvement Committee. The Committee will evaluate the findings Quarterly to determine if continued monitoring is required.	Completed by June 30, 2023 QA Monitors: Monthly x3 months completed by 7/31/2023; Quarterly x2 months completed by 12/31/2023.

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§ 51.190 (a) Infection control program. 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. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. Based on observation, interview, record review, and review of facility policy, the facility failed to provide care using infection control techniques for two (2) residents during medication administration (Resident #14, Resident #15)	On 4/5/2023, LVN (A) was provided education by the Nurse Instructor on Infection Control procedures during medication pass, which includes the use of gloves when administering Ophthalmic (eye drop) Medication. The Infection Control RN checked the "Alert Charting" List (which includes residents with active infections) for observation of Resident #15. Resident #15 observed to be without signs/symptoms of infection, x3 days. On 3/29/23, LVN (B) was provided education by the Nurse Instructor on Infection Control procedures during medication pass, which includes to clean and disinfect the Glucometer (after every use), and the case (if/when taken into a resident room), or use of a barrier.	All residents who receive medications could have the potential to be affected by the deficient practice. On 3/29/23, the Nurse Instructor initiated Licensed Nursing staff re-education on appropriate Infection Control procedures during medication pass. Review of Physician Orders for residents with Ophthalmic (eye drop) medications, and Blood Sugar (Glucose Check) readings, to create tracking list(s) for use during medication pass skills competency. No other residents were identified to be affected by the deficient practice.	All licensed nursing staff will be provided education by the Nurse Instructor on Infection Control procedures during medication pass, which includes the use of gloves when administering Ophthalmic (eye drop) Medication, and Glucometer cleaning and/or use of a barrier. Education will include: review Policy "Infection Control and Standard Precautions" (#5394v1); Review of Policy "Cleaning and Disinfecting Resident Equipment" (#5447v2); and will be observed performing medication pass by use of a skills competency checklist for Ophthalmic (eye drops) and Glucometer check procedures. Each medication cart provided a service tray (barrier) for use if/when taking the Glucometer in the resident room.	SRN/Designee will observe medication pass of (8) resident opportunities, monthly x3 months, then quarterly x2, to ensure appropriate Infection Control procedures were followed during medication pass. The SRN will report findings to the DON. The DON will report findings to the Quality Assurance and Performance Improvement Committee. The Committee will evaluate the findings Quarterly to determine if continued monitoring is required.	Education Completed by June 30, 2023. QA Monitors: Monthly x3 months completed by 7/31/2023; Quarterly x2 months completed by 12/31/2023.

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§51.200(a) Life Safety from Fire (a)The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Rating – Not Met Scope and Severity – E Residents Affected – Some	1. Requested facility maintenance to repair door through Sprocket system. 2. Contacted Vortex Doors Services to have technicians come out to evaluate if doors need to be replaced or just part repaired, waiting on estimate. 3. In the process of getting a Fire Door Maintenance Contract to service all Fire Doors in VHC-B. Also, through budgeting process allocated funds to replace Fire Doors that are not in compliance.	Will have all Fire Doors in the facility inspected and repaired if needed in order to comply with state and federal regulations.	Once door is replaced or repaired monthly assessments of all smoke barrier doors and sprinklers to ensure smoke barriers are operational, and to perform preventative maintenance checks and services.	Security, Plant Operations and Health and Safety Departments will ensure all Fire Doors are compliant and annotated once complete. Will also monitor through QAPI committee quarterly to ensure doors are repaired and contract is maintained for 2 quarters.	December 30, 2023

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§51.210(h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and	The Residents identified to have been affected by this deficient act were only being seen at the Loma Linda V.A. on an emergent case to case basis for their mental and psychosocial needs. The Medical Team is now scheduling all Residents for their care with the High Desert Psychological Services in Victorville, CA, and they will continue to been seen until they have been discharged by the Provider.	All residents have the potential to be affected by the deficient practice; however, no residents have been negatively impacted by the deficient practice. The Residents that were identified during the survey are being assessed and evaluated by the Medical team. All Residents to been identified as an emergent case, has been scheduled and will be seen on a regularly basis.	The Medical Team will evaluate each Resident that is identified on the Casper Report and 802 Form that is provided through the MDS Staff. Once the Residents have been identified the Medical Team will see that the appropriate care is ordered for the Resident. The Administrative Staff will work with the Loma Linda V.A., to obtain a Psychiatry Sharing Agreement that will be utilized on an emergent basis when services with High Desert Psychological Services are not available.	All assessments will be reported to the QAPI Committee and evaluated for quality of care on a quarterly basis for 2 quarters.	December 30, 2023

(ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran. Rating – Not Met Scope and Severity – F Residents Affected – Many					

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