## State Veterans' Homes (SVH) Corrective Action Plan North Dakota Veterans Home July 9-11, 2024

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 (b) Drugs and medicines for certain veterans.  VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by *17.96 of this chapter, subject to the limitation in *41.41(c)(2).  The facility was unable to demonstrate that medications are only furnished subject to the limitations in *51.41(c)(2).  Based on interviews and		10-0460 (Request for Prescription Drugs from an Eligible Veteran in a State Veterans Home) for all qualifying new admits.	changes are being sent to the pharmacy at the Fargo VAMC. This will allow the Fargo VAMC to also assist with tracking new residents, discharged residents, and residents that transfer from basic care/domiciliary to skilled nursing or	CFO will report verification results to the SVH Administrator with a compliance goal of 100%	verifications of resident status changes,

ļ
i
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
ļ
025 (or
er once
ng
ement is
leted)
,
ļ
n

agreement	work to get it entered into the	options. Mental health care		
	contracting system. Once assigned	options outside of the VA provide		
	a Contracting Office Representative			
		depending on the residents'		
		expressed needs, wants, or goals.		
	further action was needed from the			
	SVH at the time of the August 27th,			
	2024 communication.	resident so that they understand		
by outside		the availability, location, and		
resources must		payment requirement of the		
specify in writing		mental health care service		
that the facility		provider. As of September 18 <sup>th</sup> ,		
		2024, the SVH had 10 residents		
management				
assume		actively utilizing mental health care services through the VA and zero		
responsibility for—				
		residents utilizing mental health		
(i) Obtaining a series		care services elsewhere (Lisbon,		
(i) Obtaining services		ND has no in-person options for		
that meet		mental health care services).		
professional				
standards and				
principles that				
apply to				
professionals				
providing services				
in such a facility;				
and				
(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 Home				

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.			
Based on interview and			
record review, the			
facility's management			
failed to obtain a sharing			
agreement that			
governed mental health			
services provided by the			
Veterans Administration			
Medical Center (VAMC)			
for 12 residents. This			
failure had the potential			
to affect all residents in			
the facility who would			
need mental health			
services.			
L			
The findings include:			
Review of the facility's			
professional services			
contracts that pertained			
to outside service			
providers revealed the			
facility did not have a			
sharing agreement for			
residents who received			
mental health services			
at VAMC.			
On 7/9/24, at 2:46p.m.,			
the Administrator			
juio Aurillinolialui			

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