State Veterans' Homes (SVH) Corrective Action Plan
Alaska Veterans and Pioneers Home (AVPH), May 24, 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(e) Drugs and medicines for certain veterans. As a condition for receiving drugs or medicine under this section or under §17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 with the corresponding prescription(s) for each eligible veteran.	VA Form 10-0460 was completed and submitted immediately for the identified eligible Veteran by administrative team. A comprehensive review of the Veteran's medication records was conducted to ensure all prescribed medications were properly documented.	A facility-wide audit identified all Veterans eligible for VA-provided medications. Admission records were reviewed to ensure all Veterans' eligibility statuses were correctly documented. This audit commenced in October 2024 over a period of several days, but no more than five, and was conducted by clinical, medical records, or social work team members.	A standardized process for completing and submitting VA Form 10-0460 for all eligible Veterans was developed and used by admissions staff. Each form was submitted and checked with a checklist added to the admission procedures.	Quarterly audits of VA Form 10-0460 submissions for all eligible Veterans were conducted. Quarterly reviews of medication records were performed to ensure compliance, with findings discussed in quality assurance meetings. These reviews and audits were done by the medical records staff, clinical staff, and/or admission staff. Reviews began in October 2024. Reviews continued until 90% compliance was reached.	1/6/2025
§ 51.140 (e) Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician.	Diet orders from the primary care physician were obtained immediately for Residents #3 and #5. Their electronic health records were updated with the appropriate diet orders, and a nutritional assessment was conducted to ensure their dietary needs were met by dietary and/or clinical. Meal plans were adjusted accordingly.	A facility-wide audit of meal portion sizes over a one-week period was conducted by IDT attendees, which included dietary staff, clinical staff, and leadership staff. This audit was conducted in October 2024 and took place over five days. All residents' dietary orders were reviewed to ensure they aligned with the portions being served. If not aligned, care plans and dietary orders were adjusted to reflect	Verifying diet orders during admission was implemented, along with a standardized process for obtaining and documenting diet orders from primary care physicians. These double-checks were done quarterly and during the quarterly care plan reviews by members of either the clinical or administrative teams.	A review of dietary orders was done at admissions to ensure diet orders were properly obtained and documented. Quarterly reviews of a sample of resident records verified the presence of current diet orders, with compliance discussed in quality assurance meetings. These reviews were done quarterly along with the care plans by clinical or administrative staff.	1/6/2025

		proper diet orders.		Reviews began in July 2024 and will continued until 90% compliance was reached.	
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly.	The damaged gasket on the commercial-grade roll-through refrigerator was replaced immediately. An internal thermometer was installed for accurate temperature monitoring, and a thorough cleaning and sanitization of the refrigerator was conducted by dietary and/or maintenance staff.	A facility-wide audit of all refrigeration units used for food storage was conducted. This audit was completed in October 2024 and took no longer than two days. All refrigerator gaskets and thermometers were inspected, and temperature logs were reviewed by either maintenance or dietary staff.	A regular maintenance schedule for all refrigeration units, including gasket inspections, was established and done at least monthly by maintenance staff. Daily temperature checks were implemented. Dietary staff received training on proper food storage and equipment maintenance procedures at least annually.	Regular audits of refrigerator temperatures and condition were conducted by maintenance staff. Weekly inspections of all refrigeration unit gaskets and thermometers were performed, with findings discussed in dietary department meetings. Quarterly reviews of food storage policies ensured they remained effective. These reviews and audits began in July 2024. Reviews to be continued until 90% compliance was reached.	1/6/2025
§ 51.200 (c) (2) Space and equipment. (2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	Conductance testing on the maintenance-free generator battery was scheduled and completed immediately. Annual fuel quality testing of the emergency generator fuel was arranged, and an emergency power system testing protocol was implemented in compliance with NFPA 101 requirements. These are conducted by maintenance staff.	A review of all emergency power system components and testing records was conducted to identify any other potential deficiencies. This review was conducted over October and November 2024 by maintenance staff, and it took place over five days. The impact of these deficiencies on residents and staff was assessed, and the facility's emergency preparedness plan was evaluated.	A comprehensive maintenance and testing schedule for the emergency power system was developed to comply with NFPA 101 standards. Training for maintenance staff on proper testing and maintenance procedures was provided, and all activities were documented. These methods, procedures, and testing protocols are to be performed by maintenance staff.	Regular audits of emergency power system testing and maintenance records were conducted, no less than quarterly. Quarterly reviews of the emergency power system maintenance schedule were implemented and to be conducted by maintenance staff members. Emergency power system compliance was included as a standing agenda item in QA meetings and conducted by the maintenance team. A performance improvement project focused on emergency power system maintenance and testing was developed. A dashboard to track compliance with NFPA 101 standards for emergency power systems was created. A system for ongoing staff education and competency checks related to emergency power system maintenance was established. Annual third-party inspections of the entire emergency power system were conducted to ensure compliance with	1/6/2025

				NFPA standards. A feedback loop where inspection and testing results were shared with staff was implemented to promote continuous improvement and accountability. Regular audits, reviews, and inspections began in July 2024 and will continue until 90% compliance is achieved.	
§ 51.200 (h) (1) Other environmental conditions. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must— (1) Establish procedures to ensure that water is available to essential areas when there	Immediate repairs were made to the identified damaged areas, including the wooden roof beams and drywall ceiling. Affected residents were temporarily relocated, if necessary, until repairs were completed. Staff were trained to identify and report any potential safety hazards related to the environment. These are conducted by maintenance staff.	A facility-wide inspection was conducted to assess all smoke compartments for signs of water damage. These inspections took place in October 2024 over a two-week period by maintenance team members. This included reviewing past maintenance reports and conducting interviews with staff about any observed issues. All residents were informed about the inspections, and additional assessments were made for those in close proximity to the affected areas.	A comprehensive maintenance schedule that included regular inspections of roofing and structural components was implemented. These schedules are performed and set by maintenance staff. A standardized procedure for immediate reporting and addressing environmental safety concerns, including water damage, was established. A training program for maintenance staff to ensure timely reporting and resolution of issues was developed.	Quarterly follow-up inspections were conducted to ensure the effectiveness of repairs and ongoing safety in the environment. A feedback mechanism for staff and residents to report environmental safety issues was implemented. Compliance was discussed in quality assurance meetings, and results were documented. Maintenance staff monitors inspections, effectiveness, and safety as outlined in this section.	1/6/2025
§ 51.210 (q) (1) Disaster and emergency preparedness. (1) The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe	The Hazard Vulnerability Analysis (HVA) was updated to include elopement and missing residents as potential facility-based hazards. Detailed written plans and procedures for handling elopement and missing resident situations were developed. These are conducted by clinical staff.	All residents' risk assessments for elopement potential were reviewed. This review took place during October 2024 and took no more than five days. Reviews were conducted by clinical, social work, or general leadership team members. The facility's current procedures for resident monitoring and security were assessed.	A regular review process for the Hazard Vulnerability Analysis was implemented. A checklist of required elements for the Emergency Preparedness Plan was developed. These plans were reviewed during QA meetings and conducted by maintenance or by leadership.	Quarterly reviews of the Emergency Preparedness Plan were conducted. Bi-annual testing of emergency procedures, including elopement response, was implemented. Emergency preparedness was included as a standing agenda item in QA meetings and conducted by maintenance and/or AVPH leadership. Continuous, quarterly reviews were conducted. Reviews began in October 2024 and were led by maintenance and	1/6/2025

weather, and missing residents.				leadership. Reviews discontinued once 90% compliance was reached.	
§ 51.300 (d) (5) Timing of the notice. (i) The notice of transfer or discharge required by paragraph (d)(4) of this section must be made by the facility at least 30 calendar days before the resident is transferred or discharged, except when specified in paragraph (d)(5)(ii) of this section, (ii) Notice may be made as soon as practicable before transfer or discharge when (A) The safety of individuals in the facility would be endangered; (B) The health of individuals in the facility would be otherwise endangered; (C) The resident's health improves sufficiently so the resident no longer needs the services provided by the domiciliary; or (D) The resident's needs cannot be met in the	A written transfer notice was added to Resident #2's electronic health record for the 10/12/23 hospital transfer. A review of Resident #2's record was conducted to ensure all other transfers were properly documented by social work team and/or clinical team. Education was provided to Resident #2 and their family about the transfer notice process.	A facility-wide audit was performed on all resident transfers within the last six months to identify any instances of missing or improperly documented transfer notices. This audit occurred in October 2024 over a period of several days, but no more than five, and was conducted by clinical, medical records, or social work team members.	A standardized process for documenting transfer notices was developed and implemented by the administration and clinical teams. This included a checklist for staff to follow during resident transfers to ensure all notices were properly completed and filed. When these transfer, bed hold, and other applicable notices were used became part of staff training so all staff presented these notices to residents.	Regular audits of all resident transfers were conducted to ensure compliance. These audits occurred quarterly and were done by the Social Worker, Clinical Staff, or AVPH Leadership. Transfer notice compliance was reviewed in monthly reviews and quarterly evaluations during QA meetings and within care plans. Reviews began in October 2024 and are to be done by clinical, medical records, or social work team members. Reviews to continue monthly as a standing review at QA meetings until 90% compliance is achieved.	1/6/2025

domiciliary.					
§ 51.300 (e) Notice of bed-hold policy and readmission – notice before transfer. The State home must have a written bed-hold policy, including criteria for return to the facility. The facility management must provide written information to the resident about the State home bed-hold policy upon enrollment, annually thereafter, and before a State home transfers a resident to a hospital. A Resident has the right to decide whether to have the State home notify his or her legal representative or interested family member of transfers.	A Facility Transfer Form/Bed Hold Agreement was developed, and all nursing and medical records staff were trained on the required procedures. A monthly summary of transfers was sent by the Nurse Manager or the Medical Records department.	This procedure was standard for all residents leaving the home for anything expected to be an overnight stay off the premises. This procedure was created in October 2024. It was developed over three days and conducted by medical records, social work, or clinical team members.	All transfers were tracked during the monthly QA meeting and conducted by staff from either clinical, social work, or medical records. Staff were trained on recognizing events in which a Bed-Hold Notice was applicable with a resident.	Transfer notices were monitored as part of monthly QA meetings, focusing on the number of transfers and the issuance of transfer notices within residents. This process was integrated into the ongoing AVPH quality assurance efforts by the AVPH leadership team. These reviews began in October 2024. Reviews discontinued once 90% compliance was reached.	1/6/2025

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