State Veterans' Homes (SVH) Corrective Action Plan

Alaska Veterans and Pioneers Home (AVPH), May 21 -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)
§ 51.80 (b) (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.	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 standardized for all residents leaving the home for anything expected to be an overnight stay off the premises. This procedure was created during a period of no more than 3 days in October 2024.	All transfers were tracked during the monthly QA meeting by the Nurse Manager and/or Medical Records department. Staff were trained on recognizing events in which a Bed-Hold Notice was applicable for 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. This process began on July 1st, 2024 and completes on October 31st, 2024. Procedures and the inclusion of notices and monitoring were included have been included in QA meetings and will continue to be included until 100% compliance is reached and completion will be 01/06/2025.	1/6/2025
§ 51.110 (a) Admission orders. (a) Admission orders. At the time each	Resident #6's medical record was immediately reviewed and updated to include a proper hospice order by clinical staff. Comprehensive dietary assessments for Residents #7 and #9 were conducted, and their	A nursing home audit of care plans and medical records was conducted to identify any missing admission orders, with a particular focus on hospice and dietary orders. These audits occurred in October 2024 and	A comprehensive admission checklist was developed by medical records or the clinical team and include all required orders, including hospice and dietary needs, for any resident admitted. A double-check system was implemented	Quarterly audits of new admissions and continuing care plans ensured compliance with admission order requirements. Admission order compliance was a standing agenda item in monthly QA meetings and conducted	1/6/2025

resident is admitted, the facility management must have physician orders for the resident's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.	diet orders were implemented based on individual needs.	were conducted over a period of no more than 5 days. MDS assessments were reviewed to ensure alignment with current orders and care plans. These were conducted by medical records or the clinical team.	where a second staff member verified the completeness of admission orders. These follow-up checks occurred during quarterly reviews.	by the AVPH leadership team. If deficiencies were discovered, they were corrected within 24 hours of discovery. These audits began in October 2024 under the clinical staff. Review to continue until 90% compliance is reached.	
§ 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	Immediate comprehensive reviews of Care Plans for Residents #6, #7, and #8 were conducted by clinical team. Care Plans were updated to include individualized, specific information, addressing all identified issues, including CPAP use, medication management, and fall prevention.	MDS assessments were reviewed and compared with current Care Plans to identify discrepancies. These reviews began in October 2024 and were conducted over a period of 3 days. Medication administration records were examined to ensure all prescribed medications were addressed in Care Plans. These were conducted by the clinical team.	Clear guidelines were established for addressing specific care needs (e.g., CPAP use, medication management) in Care Plan by the clinical team. Regular care conferences involved residents and families to gather feedback and ensure Care Plans were current and effective, and were reviewed at least quarterly.	Quarterly reviews of Care Plan policies and procedures were conducted to ensure they remained effective. Care Plan compliance was a standing agenda item in QA meetings, with regular evaluations to ensure ongoing improvement, and was conducted by the AVPH leadership team. Creation of guidelines has occurred as of October 2024. These care plan reviews, along with their continual evaluation will be a regular component of QA reviews and will continue to be included until 100% compliance is reached and	1/6/2025

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 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.				completion will be 01/06/2025.	
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be—	Resident #2's Care Plan was updated to address smoking behaviors and safety concerns. A comprehensive risk assessment for Resident #2 regarding smoking while using oxygen was conducted, followed by the development and	A facility-wide audit identified all residents who smoked or had a history of substance use by clinical and/or social work teams. This audit occurred in October 2024 and took no more than three days. Care Plans for these residents were reviewed to	A system to flag and regularly review Care Plans for residents with smoking or substance use history was implemented by clinical and/or social work teams. Immediate Care Plan updates were required following incidents or changes in resident condition. IDT meetings and QA	Monthly reviews of incident reports were conducted to ensure proper follow-up and Care Plan updates. Smoking safety and Care Plan compliance were standing agenda items in QA meetings and were conducted by the AVPH leadership team.	1/6/2025

(i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	implementation of a smoking safety plan created by clinical and/or social work teams.	ensure smoking and substance use concerns were addressed.	meetings dictated precautions on violations for residents on a case-by-case basis. AVPH leadership and clinical teams decided procedures that were tailored to each resident and their appropriate circumstances.	Audit complete as of October 2024. Ongoing reviews, audits, and further follow ups continue as directed in QA meetings. Audits began in early October 2024 and finished in three days on October 9th, 2024 with 90% compliance.	
§ 51.120 (i) Accidents. The facility management must ensure that—	Resident #2's Care Plan will be updated to address smoking behaviors and safety concerns. A comprehensive risk assessment regarding smoking while using oxygen will be conducted, followed by the development and	A facility-wide audit will identify all residents who smoke or have a history of substance use by clinical and/or social work teams. This audit will occur in October 2024 and will take no more than three days. Care Plans for these residents will be	A system to flag and regularly review Care Plans for residents with smoking or substance use history will be implemented by clinical and/or social work teams. These review Immediate Care Plan updates will be required following incidents or changes in resident condition.	Monthly reviews of incident reports will be conducted to ensure proper follow-up and Care Plan updates. Smoking safety and Care Plan compliance will be standing agenda items in QA meetings and conducted by the AVPH leadership team.	1/6/2025

(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.	implementation of a smoking safety plan by clinical and/or social work teams.	reviewed to ensure smoking and substance use concerns are addressed	IDT meetings and QA meetings will dictate precautions on violations for residents on a case-by-case basis. AVPH leadership and clinical teams to decide procedures that are tailored to resident and their appropriate circumstances.	This review has yet to be included in QA meetings but will occur before the end of October 2024. Reviews will continue to be included in QA meetings until 100% compliance is reached and completion will be 01/06/2025.	
§ 51.140 Dietary services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	Portion sizes for all meals will be immediately reviewed and adjusted to ensure compliance with specified amounts by dietary staff. Food Service Worker D and all kitchen staff will receive additional training on proper portion control techniques.	A facility-wide audit of portion sizes over a one-week period will be conducted by clinical staff and/or dietary staff. This will occur in November 2024. All residents' dietary orders will be reviewed to ensure they align with the portions being served, and residents and family members will be interviewed about meal satisfaction.	The "Portion Control" policy will be updated to include specific guidelines for measuring and serving each menu item. A daily pre-service check of portion sizes will be implemented, supervised by the Hospitality Manager or designee.	Daily spot checks of portion sizes during meal preparation and service will be conducted by the clinical leadership team. Weekly audits of portion sizes for randomly selected meals will be performed, with findings discussed in monthly dietary department meetings or in IDT meetings that involve staff, residents, and the AVPH leadership team. Reviews to begin in November 2024. Reviews will continue until a compliance of 90% is achieved.	1/6/2025
§ 51.140 (d) Food. Each resident receives and the facility provides— (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper	Immediately review and adjust meal preparation for all 13 affected residents to ensure compliance with their prescribed diets. This is to be done by the dietary team. Conduct individual assessments of each affected resident's nutritional needs and dietary restrictions. Update kitchen staff on each resident's specific dietary requirements. Implement a system to double-check meals against dietary orders before serving. Provide additional training to kitchen staff on preparing mechanically altered and therapeutic diets	Conduct a facility-wide audit of all residents' dietary orders and compare them to meals being served by clinical staff and/or dietary staff. This audit will be conducted in late October 2024 and will be conducted over a time period of five days. Review all residents' medical records to ensure accurate and up-to-date dietary prescriptions. Interview residents and family members about meal satisfaction and adherence to dietary needs. Observe meal preparation and service for all units in the facility.	Update the "Alaska Pioneer Homes Special Diet Guide" to include more specific instructions for meal preparation. Develop a standardized process for communicating dietary changes between medical staff and kitchen staff, preferably at admissions and at level of care change. Dietary changes are to be reviewed as needed at IDT meeting and QA meetings by clinical staff and/or dietary staff.	Conduct daily audits of meal trays to ensure compliance with dietary orders as directed by the clinical leadership team. Conduct quarterly reviews of the dietary policies and procedures to ensure they remain current and effective and these may also be done through the IDT meetings that involve staff, residents, and AVPH leadership. Reviews to begin in late October 2024 and will continue to be audited and reviewed until compliance of 90% is achieved.	1/6/2025

temperature; (3) Food prepared in a form designed to meet individual needs; and (4) Substitutes offered of similar nutritive value to residents.					
§ 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 refrigerator on the Nursing Home Unit will be immediately cleaned and repaired or replaced by dietary or maintenance staff. All food and beverage items will be properly labeled and dated, and any potentially unsafe items will be discarded by dietary staff.	A facility-wide audit of all refrigerators and freezers used for food storage will be conducted. This audit will occur during the last two weeks of October 2024 over a period of two days. Food labeling and storage practices will be reviewed in all units by dietary staff, maintenance staff, and/or leadership staff.	A standardized food labeling system will be developed, along with a protocol for proper utensil storage and handling by clinical staff and/or dietary staff. Regular communication between dietary and maintenance staff will be established to promptly address equipment issues.	Regular, no less than once a month, audits of refrigerator cleanliness and food storage practices will be conducted. Weekly observations of meal service will ensure proper sanitation, with findings discussed in monthly staff meetings by clinical, culinary, and/or AVPH leadership. Audits and reviews will begin in late October 2024 by clinical staff and/or dietary staff. Reviews and compliance measures will be conducted weekly until 100% compliance is reached.	1/6/2025
§ 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.	All sprinkler heads in the facility will be immediately inspected, particularly those near the dishwasher and other high-humidity areas by maintenance staff. The three corroded sprinkler heads near the dishwasher will be replaced, and the kitchen area will be thoroughly cleaned to remove potential sources of corrosion.	A facility-wide inspection of all sprinkler heads will be conducted to identify any other signs of corrosion or damage by maintenance staff. High-humidity areas will be assessed for potential risks to the sprinkler system.	A comprehensive sprinkler system maintenance program will be developed in accordance with NFPA 25 standards. A regular inspection schedule will be created, with increased frequency in high-risk areas. Inspections and any corrective action to be conducted by maintenance staff and leadership staff.	Regular audits, at least quarterly, of sprinkler system inspection and maintenance records will be conducted by maintenance staff. These audits began in June 2024. Quarterly visual inspections of all sprinkler heads will be performed by qualified personnel, with findings reviewed by maintenance and/or AVPH leadership. These were completed in June 2024 by maintenance staff once compliance reached 100%.	1/6/2025

§ 51.200 (b) Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	Conductance testing on the maintenance-free generator battery will be scheduled and completed immediately by maintenance staff. Annual fuel quality testing of the emergency generator fuel will be arranged, and an emergency power system testing protocol will be implemented in compliance with NFPA 101 requirements.	A review of all emergency power system components and testing records will be conducted to identify any other potential deficiencies by maintenance staff. The impact of these deficiencies on residents and staff will be assessed, and the facility's emergency preparedness plan will be evaluated. These measures will be conducted by the maintenance staff.	A comprehensive maintenance and testing schedule for the emergency power system will be developed to comply with NFPA 101 standards. Training for maintenance staff on proper testing and maintenance procedures will be provided, and all activities will be documented by maintenance staff.	Conduct regular audits of emergency power system testing and maintenance records, no less than quarterly. Implement quarterly reviews of the emergency power system maintenance schedule. Include emergency power system compliance as a standing agenda item in QA meetings and conducted by the maintenance team. Develop a performance improvement project focused on emergency power system maintenance and testing. Create a dashboard to track compliance with NFPA 101 standards for emergency power systems. Establish a system for ongoing staff education and competency checks related to emergency power system maintenance. Conduct annual third-party inspections of the entire emergency power system to ensure compliance with NFPA standards. Implement a feedback loop where inspection and testing results are shared with staff to promote continuous improvement and accountability. These were completed in June 2024 by maintenance staff.	1/6/2025
§ 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	Review the current mental health services being provided to Residents #2 and #3 to ensure they meet professional standards by the administrative team. Document the timeliness and quality of mental health services currently being provided.	Conduct a facility-wide audit to identify all residents receiving any services from outside providers. This should include services rendered under VISN 20 sharing agreements to ensure comprehensive coverage for all outside services being provided. This audit is to occur during November 2024 over a 5 day period of time. Administration team will be responsible for these reviews, agreements, and management. Administrative team has reached out to VA and began the process of executing a sharing agreement.	Develop a protocol for establishing and maintaining written agreements with all outside service providers, including a specific sharing agreement for mental health services as done by the administrative team. This protocol must include periodic reviews of the expiry and validity of current sharing agreements, with a focus on agreements established under VISN 20. Create a checklist of required elements for all sharing agreements, such as service specifications, timeliness requirements, and service delivery standards.	The administrative team will conduct regular audits, no less than quarterly, of outside service provision to ensure compliance with written agreements. Implement monthly status updates to track progress and identify potential areas for improvement. Include outside service compliance as a standing agenda item in Quality Assurance meetings. Ensure any readjustment of services occurs at the point when a review indicates that existing services no longer meet clinical or professional standards. This must be without becoming a mechanism to pay for services that would otherwise fall outside the scope of	1/6/2025

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 (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				the agreement. Transition planning must be incorporated for residents requiring changes in outside services. Develop a transition protocol that ensures continuity of care when residents transfer between providers, with input from all involved parties and oversight from VISN 20. These reviews and outline actions will begin in November 2024 by the administrative team. QA meetings will be reviewing whether or not a sharing agreement is valid and necessary on a monthly basis with 100% compliance being the goal. These reviews will not continue past 01/06/2024.	

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.					
§ 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 weather, and missing residents.	Update the Hazard Vulnerability Analysis (HVA) to include elopement and missing residents as potential facility-based hazards. Develop detailed written plans and procedures for handling elopement and missing resident situations. These will be developed between the clinical team and maintenance team.	Review all residents' risk assessments for elopement potential to be completed by the clinical team and maintenance team. This review will take place during late October 2024 and will be no more than 5 days of review. Assess the facility's current procedures for resident monitoring and security.	Implement a regular review process for the Hazard Vulnerability Analysis. Develop a checklist of required elements for the Emergency Preparedness Plan. These plans are to be reviewed during QA meeting and done by maintenance or by leadership.	Conduct quarterly reviews of the Emergency Preparedness Plan by either the clinical team, with partnership by the maintenance team. Implement bi-annual testing of emergency procedures, including elopement response. Include emergency preparedness as a standing agenda item in QA meetings and conducted by maintenance and/or AVPH leadership. Continuous, quarterly reviews will be conducted. Reviews will commence in late October 2024 and discontinue once 90% compliance is reached.	1/6/2025
§ 51.210 (s) Compliance with Federal, State, and local laws and professional standards. The facility management must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and	Conduct a comprehensive safety assessment for Resident #2. Develop and implement a personalized smoking cessation plan for Resident #2. Provide education to Resident #2 on the dangers of smoking while using oxygen. Implement a supervised smoking schedule for Resident #2 in a designated safe area outside the facility. Remove all smoking materials from Resident #2's room. Increase monitoring of Resident #2, especially during high-risk times for smoking. Create a formal agreement with Resident #2 regarding smoking policies and consequences. All assessments and procedures to be created and monitored by the clinical and/or social work staff.	Conduct a facility-wide audit to identify all residents who smoke or have a history of substance use by the clinical and/or social work staff. This audit will occur during November 2024 and will take no more than 3 days. Review all residents using oxygen for potential smoking risks. Interview staff to identify any unreported instances of residents smoking in their rooms. Assess all residents for cognitive impairment that may impact their ability to follow safety protocols	Revise and strengthen the facility's smoking policy to include clear consequences for violations. Implement a system to regularly assess and document residents' smoking habits and risks. Develop a formal process for documenting and addressing policy violations.	Conduct regular room checks, no less than monthly, for evidence of smoking or smoking materials for applicable residents. Housekeeping, clinical staff, and/or leadership will conduct and participate in room checks. Implement regular audits of high-risk residents' rooms and belongings. Conduct monthly reviews of incident reports related to smoking violations. These reviews and assessments will commence in November 2024. Room checks will begin November 4th, 2024 and will be conducted daily until November 8th. 90% compliance will be achieved no later than 01/06/2024.	1/6/2025

principles that apply to professionals providing services in such a facility. This includes the Single Audit Act of 1984 (Title 31, Section 7501 et seq.) and the Cash Management Improvement Acts of 1990 and 1992 (Public Laws 101-453 and 102-589, see 31 USC 3335, 3718, 3720A, 6501, 6503).					
§ 51.210 (t) Relationship to other Federal regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other Federal laws and regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, national origin, handicap, or age (38 CFR part 18); protection of human subjects of research (45 CFR part 46), section	Conduct a comprehensive safety assessment for Resident #2. Develop and implement a personalized smoking cessation plan for Resident #2. Provide education to Resident #2 on federal laws prohibiting marijuana use in federally funded facilities. Implement a strict monitoring protocol for Resident #2 to prevent further marijuana smoking incidents. Remove all marijuana smoking materials and marijuana items from Resident #2's room. Create a formal agreement with Resident #2 regarding smoking policies and consequences that have to do with marijuana use. All reviews and procedures are to be completed by the clinical and/or social work staff.	Conduct a facility-wide audit to identify all residents who use marijuana in any form or have a history of substance use, including marijuana, whether smoked, ingested, vaporized, or used in any other form, or any other illicit drugs, prescription drug misuse, or alcohol abuse. Thes reviews will be conducted by the clinical and/or social work staff. Review all residents' records for any documented incidents marijuana or substance use. This review is to occur during no later than November 2024 over a period of three days.	Revise and strengthen the facility's smoking policy to include clear consequences for violations, especially regarding marijuana use. Implement a system to regularly assess and document residents' smoking habits and risks. Develop a formal process for documenting and addressing policy violations.	At least monthly room checks (more frequently, if needed) will occur. These checks will be looking for evidence of marijuana or evidence of substance abuse for applicable residents. Monthly audits of high-risk residents' rooms and belongings. Conduct monthly reviews of incident reports related to smoking violations in QA meetings as conducted by AVPH leadership. These reviews and assessments will commence in November 2024. Room checks will begin November 4th, 2024 and will be conducted daily until November 8th. 90% compliance will be achieved no later than 01/06/2024.	1/6/2025

504 of the Rehabilitation Act of 1993, Public Law 93-112; Drug-Free Workplace Act of 1988, 38 CFR part 48; section 319 of Public Law 101-121; Title VI of the Civil Rights Act of 1964, 38 CFR 18.1-18.3. Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.					

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