State Veterans' Homes (SVH) Corrective Action Plan
Veterans Home of California – Yountville 09/30/24-10/3/24

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 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
§ 51.120 (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	On 10/1/24, Resident #10 received complete pericare and wound care following proper infection control practices. On 10/1/24, the Veterans Home California Yountville (VHCY) Registered Nurse (RN) monitored and assessed the resident for any potential signs and symptoms of infection. The VHCY RN confirmed no adverse event due to these findings. On 10/1/24, the VHCY Nursing educator in-serviced the VHCY Wound Care Nurse (WCN) and VHCY – RN. The Wound Care Nurse was immediately re-	All residents receiving wound care have the potential to be affected. On 10/2/24, the VHCY DON, with the WCN, audited all current residents receiving wound care to assess proper cleaning and technique during would care. A review of wound care practices was completed for all nurses providing wound care. The VHCY DON and VHCY Supervising Nurse (SN) II confirmed that no other residents were affected by this finding.	On 10/3/24, the VHCY DON provided in-service education to all licensed nurses, including registry nurses, on proper wound care techniques, including: • Proper hand hygiene and glove use • Clean to dirty technique • Single-use, single-stroke cleaning method • Proper peri care before wound care • Complete removal of stool/incontinence The facility's wound care policy was	From October 2, 2024, through June 30, 2025, the VHCY DON or designee conducted direct observation audits of wound care procedures on five residents, or 10% of residents receiving wound care (whichever is greater) weekly for 4 weeks, then monthly thereafter. Audits will focus on proper cleaning techniques, infection control practices, and complete pericare. The DON or designee will report monitoring results to the Quality Assurance Performance Improvement (QAPI) Committee Quarterly. The QAPI Committee will analyze data for patterns/trends and the need for	June 30, 2025

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services to promote healing, prevent infection and prevent new sores from developing.	educated on proper wound care techniques, including cleaning from clean to dirty, using single strokes, and proper pericare procedures. The Director of Nursing (DON) completed a skin assessment on Resident #10 to ensure no complications from improper wound care techniques.		reviewed to ensure it included specific step-by-step instructions for proper cleaning techniques. All new licensed nursing staff will review this policy as part of their training during orientation.	additional corrective actions. Monitoring will continue until 100% compliance is achieved for two consecutive quarters.	
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	On 10/1/24, Resident #10 received immediate proper pericare following infection control guidelines. The Certified Nursing Assistant and Wound Care Nurse were immediately re-educated on proper pericare techniques, including wiping front to back and using clean areas of wipes for each stroke. The resident was assessed by the charge nurse for any skin integrity issues related to improper cleaning technique, with no adverse effects noted.	All residents requiring assistance with pericare have the potential to be affected. On 10/2/24, the Director of Nursing (DON) initiated a facility-wide audit of all residents requiring assistance with pericare to ensure proper technique was being utilized and confirmed that no other residents were affected by this finding.	On 10/3/24, the DON and Infection Preventionist reeducated the staff on pericare protocol emphasizing proper cleaning technique. The DON and the Nurse Educator will in-service all licensed nurses and certified nursing assistants on: • Proper pericare technique, including front-to-back wiping • Using clean areas of wipes for each stroke • Proper hand hygiene before and after resident care • Proper glove use and changing The in-service was completed by 10/10/24. Any staff member not present for the in-service will be required to complete it before their next scheduled shift. New hire orientation will include this pericare	From October 2, 2024 through June 30, 2025, the VHCY Supervising Registered Nurses will conduct direct observation audits of the pericare technique on all shifts weekly for 4 weeks then monthly thereafter. The DON will review audit results. Any identified deficiencies will result in immediate re-education and additional monitoring. The Director of Nursing or Designee will report audit findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI Committee will analyze data for patterns/trends and recommend ongoing monitoring or process changes until 90% compliance is achieved and maintained for two consecutive quarters.	June 30, 2025

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professional practice**.**			protocol.		
§ 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.	On 10/1/24, the unapproved space heaters were identified in Exam Room 1A01 and Exam Room 1A12. The space heaters found were not plugged, and no residents were in the exam room at the time of the finding. On 10/1/24, the VHCY Supervising Registered Nurse (SRN) removed the unapproved space heaters from the affected areas.	On 10/1/24, the VHCY DON confirmed that the finding potentially affects all residents residing in the building. On 10/1/24, the VHCY SRNs checked all rooms and confirmed that there were no other space heaters in the building.	On 10/1/24, the VHCY SRNs in-service staff were told not to bring space heaters to the facility. On 10/1/24, the VHCY DON informed staff to create a work order if their area was cold. On 10/22/24, the VHCY Direct Construction Supervisor (DCS) I purchased approved UL space heaters. The heaters will have a sticker indicating that they were inspected. Plant operations will monitor the heaters' disbursement and maintenance. On 11/4/2024, the VHCY DCS I developed the heater protocol to ensure compliance.	From October 2, 2024, through June 30, 2025, the VHCY Service Chiefs will conduct monthly environmental rounds to ensure staff do not use unapproved space heaters and report compliance to the Fire Life Safety Quality Assurance and Performance Improvement (QAPI) committee until the target goal of 100% compliance rate for two consecutive quarters.	June 30, 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,	On October 4, 2024, the VHCY Direct Construction Supervisor I (DCSI) was made aware of the deficiency of not having Remote Manual Stop Stations for Emergency Generators. The violations were for the following buildings: Annex I- R Roosevelt, Annex 2- Eisenhower, and	No other areas on campus were affected. The three buildings in the violation are the only buildings on emergency power.	1. Once installed, the facility's Monthly Generator Log Sheets will be updated with the locations of Remote Manual Stop stations. 2. On October 18, 2024, the VHCY DCSI conducted in-service training for all maintenance staff who work	The VHCY DCSI will provide a monthly timeline regarding the installation's progress. Once the work is completed, the VHCY DCSI will use the new Monthly Generator Log to conduct monthly inspections of all emergency generator systems, including remote manual stop stations. To ensure ongoing compliance, the VHCY DCSI will perform quarterly audits of these inspections and report	June 30, 2025

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and generator task illumination. (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. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	Holderman. The Emergency Generator Maintenance and Repairs contract was executed on October 15, 2024. Additionally, the VHCY DCSI contacted North American Power and Control Inc. (NAPC) [vendor] and discussed installing the Remote Manual Stop station, and the walkthrough was scheduled for October 30, 2024. On October 30, 2024, the NAPC was scheduled to look at the location of the Remote Manual Stop station installations. Materials to complete the installation and testing of Remote Manual Stop stations were discussed by the vendor, and the VHCY DCSI will expedite installation. Work will be completed to NFPA 110 Standard for Emergency and Standby Power Systems (2010), Section 5.6.5.6 and 5.6.5.6.1. The Remote Manual Stop stations will be installed outside the generator room and properly labeled per code requirements. Currently, the quote is still pending.		with Emergency Generators. The training included NFPA 110 requirements.	compliance to the Fire Life Safety Quality Assurance and Performance Improvement (QAPI) committee until the target goal of a 100% compliance rate for two consecutive quarters.	

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	On or before 06/30/25, the installation of the Remote Manual Stop station will be completed. No resident was identified as affected by this finding.				

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