State Veterans' Homes (SVH) Corrective Action Plan
Oklahoma Veterans Center-Claremore, July 23-26, 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)
51.41 (c) Payments under State home care agreements. (2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a State home care agreement. Also, as a condition of receiving payments under paragraph (c), the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment	Oklahoma Veterans Center-Claremore (Facility) does not currently have a completed sharing agreement with the VA of jurisdiction for dental and mental health services. Facility does have current, completed, written agreements for both dental and mental health services with community providers.	All prevailing rate residents, this Facility receives payment for care by the Department of Veterans Affairs (VA), were reviewed 7/26/24 concerning dental and mental health services, with a lookback period of one month. Seven residents were identified as accessing dental services thru the VAMC; twelve residents were identified as accessing mental health services thru the VAMC; no veterans or their insurance were identified as requiring reimbursement per VA regulations, 51.41(c)(2).	Beginning 9/16/24, Facility's Veteran Appointments department will audit all prevailing rate residents receiving mental health and/or dental services for the following to ensure that: - prior to scheduling an appointment, responsibility for payment has been reviewed with the provider clarifying Facility is to be invoiced for services this facility is responsible for providing, correcting any instances of noncompliance per VA regs. 51.41(c)(2), and where appropriate reimbursing expense to the veteran or their insurance. - following an appointment, Veteran Appointments department will follow-up with provider, and the resident, reconfirming resident nor their insurance was charged for services this Facility is responsible for. Business Office will review and validate all resulting invoices for same.	Audits will continue until a compliance rate of 100% is achieved for three consecutive months. Results will be reported quarterly at Quality Assurance Performance Improvement (QAPI) meetings. Upon completion of monthly audits, Facility will continue monitoring its performance to help ensure residents, and their insurance, are not charged for services this Facility is responsible for.	4/30/25

under this paragraph (c) includes payment for drugs and medicines). Rating: Not Met Scope and Severity - C Residents Affected – Many The facility was unable to demonstrate that no individual, insurer, or entity was charged for the nursing home care paid for by VA under a VA provider agreement for dental and mental health services rendered by VA.			Facility is currently transitioning from VAMC dental health providers to community dental health providers. For residents with currently scheduled dental appointments at the VAMC, per VAMC letter received 9/10/24, those appointments will be honored thru 12/30/24. Facility is currently working towards a written sharing agreement with VAMC for mental health services and anticipate this to be completed by 4/30/25. Current community agreements for dental health services already include language that specifies facility is responsible for payment per 51.41C) VA regulations. Sixteen community dental providers were notified 9/10/24 with request for written agreements for dental services, and included language specifying Facility is responsible for payment per 51.41(c) VA regulations. Appointments staff will continue to send an *Acknowledgement of Financial Responsibility* letter with each veteran at the time of their appointment helping to ensure the veteran and their insurance will not be charged for services this Facility is responsible for and to bill this facility directly. All agreements and contracts will be reviewed annually at the start of the Fiscal Year to determine if renewal is required.		

			ODVA admission application and Standard Operating Procedures will be reviewed at next Administrator meeting (October/November, 2024), revising to help Facility meet compliance with VA 51.41(c) regulations. Beginning 8/6/24, Administrator or designee will contact VAMC liaison monthly to monitor progress until a written sharing agreement for mental health services is completed, documenting contact efforts.		

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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	Facility contacted hospice agency and community pharmacies 8/26/24 and 8/30/24, requesting a claim reversal for hospice drugs and medicines provided, and to bill this Facility directly, for the sixteen prevailing rate residents, plus an additional two, this Facility is required, per VA regs. 51.43(b), to cover in	All prevailing rate residents' records were reviewed 8/26/24. Two additional veterans were identified as receiving hospice medications this Facility is responsible for covering in full. Facility contacted pharmacies 8/26/24 and 8/30/24, requesting reversal of claims for 18 identified	Pharmacists and Administration will be re-educated on VA regs. 51.43(b), to ensure drugs and medicines are covered in full by the facility for those residents the Facility receives the prevailing rate VA Per Diem for. Pharmacy Manager or designee, will complete 5 audits weekly, of prevailing rate veterans, beginning 8/26/24, to ensure this Facility	Weekly audits will continue until a compliance rate of 100% is achieved for a minimum of three consecutive months. Pharmacy Manager or designee will report weekly audit results during quarterly QAPI meetings.	11/30/24

of this chapter, subject to the limitation in §51.41(c)(2). Rating: Not Met Scope and Severity - C Residents Affected – Many The facility was unable to demonstrate they provided drugs and medicines for sixteen Residents for whom the facility receives the prevailing rate of VA Per Diem (Prevailing Rate Veterans) pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter subject to the limitations in § 51.41(c)(2).	full.	residents, with subsequent billing to be sent directly to Facility.	covers in full, those drugs/medicines facility is responsible for, including hospice drugs and medicines, correcting any instances of noncompliance per VA regs. 51.43, and reimbursing expense to the veteran or their insurance. Anticipated end date of audits, 11/30/24. A written agreement for pharmacy services with community pharmacist, specifying this Facility was responsible for payment of all drugs and medicines, including those for prevailing rate residents, was submitted to (Oklahoma Department of Veterans Affairs) ODVA Finance department for signature 8/29/24.		

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51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. Rating – Not Met Scope and Severity – F Residents Affected – Many Based on interview and record review, the facility failed to provide evidence that a surety bond, or other satisfactory assurance, for the security of all personal funds of residents who had deposited personal funds with the facility. This failure affected all	Facility's copy of the State's Liability Crime Insurance policy, that covers the Facility for acts of crime up to $1,000,000 lapsed 7/1/24. Facility has received copy of updated policy, good thru 7/1/25. Facility has submitted a packet to the VA Under Secretary for Health of all necessary documents to demonstrate the alternative meets satisfactory compliance requesting review of the alternative to surety bond.	This has the potential to affect all residents. Facility conducted a review of all current residents' trust funds 8/6/24 to ensure the total balance of all accounts does not exceed $1,000,000. The total balance was not in excess.	Beginning August, 2024, the Business Office will run monthly a Trust Fund Balance report that includes the sum of all residents' accounts. The Administrator or designee will audit the balance total monthly to ensure it is under $1,000,000 correcting any instances of noncompliance per VA regs. 51.70(c)(6). If the total of all account balances exceeds $1,000,000 the Facility will increase the crime policy total. Beginning 8/2/24, Administrator or designee will document monthly requests for progress updates.	Audit results of Trust Fund balance totals will be reported quarterly to the QAPI committee by the Administrator or designee. Audits will end once a surety bond is obtained, or approval of an alternative to a surety bond is received, from the Under Secretary for Health. Audit results of monthly progress updates will be reported quarterly to QAPI committee by the Administrator or designee.	4/30/25

residents whose funds were managed by the facility.					

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51.100 (h) (1) Social Services (1) The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident;	Resident #16 discharged from the Facility 7/31/24. A letter clarifying the role and responsibilities of Social Services (SS) staff, including advocacy for the resident, and who Social Workers are employed by, was presented to all	Beginning 8/25/24, Social Services Supervisor or designee, will complete weekly, 5 random chart audits, reviewing SS notes to ensure SS staff are providing medically related social services, including advocacy for, to help the resident attain or maintain	Social Services Supervisor re-educated Resident #16's Social Services Specialist III, on their job description, and job responsibilities, including advocacy for the resident, 8/28/24. All SS staff were re-educated 8/26/24, with Eastern Oklahoma Veteran Affairs Health Care	Weekly audits will continue until a minimum compliance rate of 90% is achieved for three consecutive months. SS Supervisor or designee will report audit results during quarterly QAPI meetings. The CVC AM Meeting form was revised 8/30/24 to include a notes section on provision of medically related SS.	11/30/24

Rating – Not Met Scope and Severity – D Residents Affected – Few Based on interview and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable mental and psychosocial wellbeing for one (1) of (1) one sampled resident (Resident #16).	residents, and sent to all resident contacts 8/27/24. Same letter was inserted into resident daily newspaper (Daily Chronical) 8/29/24. Social Services Supervisor clarified the role and responsibilities of Social Services (SS) staff, including advocacy for the resident, and who Social Workers are employed by, during Resident Council meeting 8/28/24.	their highest practicable mental and psychosocial wellbeing.	System's (EOVAHCS), State Veteran Home Liaison in attendance, concerning the role and responsibilities of the Social Worker, including advocacy for the resident. All SS staff were re-educated on Social Services Standard Operating Procedures (SOP), including job role, job responsibilities and advocacy for the resident, 7/30/24, 8/22/24, and 8/27/24-8/28/24. Competency was assessed during 8/27/24-8/28/24 re-educations. SS job description and responsibilities (Performance Review) were updated in Workday (HR/Timekeeping platform) as of 7/29/24.	Beginning 9/2/24, all residents on the 24-hour Report will be reviewed during daily AM meeting, utilizing the revised CVC AM Meeting form, to ensure all medically related social services are received appropriate to the resident. SS job description and responsibilities will be reviewed mid-year and annually, via Workday, with all SS staff.	

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51.120 (i) Accidents The facility management must ensure that – (1) The resident environment remains as free of accident hazards as is possible, and (2) Each resident receives adequate supervision and assistance devise to prevent accidents. Rating – Not Met Scope and Severity – D Residents Affected – Few Based on interviews, record review, and facility policy review, the facility failed to ensure residents received adequate supervision to prevent accidents for two (2) of 10 residents who were reviewed for falls (Resident #12 and #18).	Resident #12 - 3/9/24 fall was further investigated in accordance with Facility policy "Assessing Falls and their Causes" 8/29/24, to determine why resident fell, and has been included in the resident's chart. Resident #18 discharged from the Facility 4/15/24.	Beginning 8/30/24, the Director of Nursing (DON) or designee will complete a minimum of 5 weekly, random, chart audits for falls, verifying residents received adequate supervision to prevent accidents, and in alliance with facility policy "Assessing Falls and Their Causes".	All nursing staff will be educated by 9/15/24, on Nursing SOP "Assessing Falls and Their Causes", with written competency, and on supplemental documentation and Root Cause Analysis (RCA). Education will include live presentation. Same education will be added to Nursing orientation, and annual Skills Fair. Beginning 8/30/24, a Supplemental Note will be completed by nursing staff for all falls incidents, that documents fall items not currently included in PointClickCare (PCC) fall Incident Reports. The change will align current falls incident reporting documentation with Facility's Nursing SOP, "Assessing Falls and Their Causes". The Supplemental Note documents the following: - Time of last meal - What the resident was doing - Was resident among other persons or alone. - Was resident trying to get to the toilet. - Last time resident was observed/toileted.	Weekly audits will continue until a minimum compliance rate of 90% is achieved for three consecutive months. DON or designee will report weekly audit results during quarterly QAPI meetings.	11/30/24

			- Plan of Care Fall Safety measures reviewed with resident this shift. - Root Cause Analysis to determine the cause of fall. Beginning 9/15/24, the Root Cause Analysis (RCA) will include statements from potential witnesses and be included in PCC Risk incident reports. Beginning by 9/15/24, in PCC/POC Tasks, the following will be added concerning documentation of supervision: 1. Plan of Care/Safety measures related to falls are in place and reviewed with resident. 2. For high fall risk residents, two-hour checks, to anticipate needs, will be documented. High fall risk residents are defined as those needing assistance with ambulation.		

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51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory	All residents have the potential to be affected by the deficient practices. On 7/25/24, all departments using the dumpster were educated on proper usage	Dietician was consulted, provided feedback, and helped develop audits, to ensure process improvements. Beginning 9/1/24, Dietary Manager or Designee will	Dietary staff will be re-educated on hand washing, proper food storage, assuring food is consumed by safe dates, cleaning the fryers, maintaining a clean area around the dumpster, demonstrating competency by 9/15/24. Content of education and competencies	Audits to continue until a minimum of 90% compliance is achieved for three consecutive months, with results presented by Dietary Manager or designee, at quarterly QAPI meetings.	11/30/24

by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. Rating-Not Met Scope and Severity – E Residents Affected – Some Based on observations, interviews, and facility policy review, the facility failed to ensure effective and proper sanitary precautions were taken in the kitchen, main dining room, and food service areas, and the facility failed to ensure proper trash disposal. These failures had the potential to affect all residents who reside at the facility.	and maintain a pest/insect free environment. On 9/6/24 all dietary staff were-re-educated on hand washing, proper food storage, assuring food is consumed by safe dates, and cleaning of the fryers. On 07/31/24 the grease trap container was replaced by the company for one that was clean and in good repair. On 7/26/24 the facility deep cleaned the area around the dumpster. .	complete weekly, a minimum of five direct observation audits to ensure the following: - staff are washing hands when appropriate - food items are stored at least 6” off the ground - leftover food is stored in covered containers with clear labels and dates - food is consumed by their safe dates - fryers are properly cleaned and maintained - dumpster area is clean and free of pests/insects. A Root Cause Analysis was completed 9/11/24 The deficient practice of ensuring food was distributed and served under sanitary conditions occurred due to staff error and lack of consistent cleaning assignment. Deficiencies are currently being addressed via a new Dietary Kitchen Rounds Log, staff educations and competencies, annual educations, ongoing audits, direct observations by Assistant Administrator, and consultations and observations from the Dietician. The Dietician will review audit results to gain and implement feedback/guidance accordingly in her reports.	will be reviewed by Administration, Dietary Manager, and Dietician, and revised dependent upon results of Dietary Kitchen Rounds audits, to ensure effectiveness of education. Revised Dietary Kitchen Rounds (direct observation audits for demonstration of proper hand washing, proper food storage, food is consumed by safe dates, fryers are clean, and a clean area around the dumpster is maintained, with staff educated accordingly) will continue with no end date.		

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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. Rating-Not Met Scope and Severity – E Residents Affected – Some **Smoke Barriers and Sprinklers** 1. Based on observation and interview, the facility failed to properly maintain the smoke barriers. The deficient practice affected three (3) of 18 smoke compartments, staff, and 44 residents. The facility had the capacity for 302 beds with a census of 215 on the day of survey. **Electrical Systems**	1. The unsealed penetration located on unit #2B, by resident room #216, was immediately sealed after building tour. The unsealed penetrations located on unit #2B, by resident room #224, were immediately sealed after building tour. 2. The improperly stored and marked oxygen cylinders were marked and separated 8/15/24.	All residents had the potential to be affected. All smoke barriers throughout the Facility were inspected 8/29/24-9/4/24; 25 penetrations were identified and immediately sealed. Results documented on Smoke Barrier and Oxygen Log. All residents had the potential to be affected. All oxygen cylinders were inspected 8/26/24 and none were identified as noncompliant per NFPA 99 standards. Results documented on Smoke Barrier and Oxygen Log.	Maintenance staff were re-educated on the National Fire Protection Association (NFPA) 101 requirements for smoke barrier penetrations 8/29/24. Maintenance Supervisor has created a smoke barrier inspection tracking system reminder to inspect smoke barriers monthly. Maintenance staff were re-educated on the NFPA requirements for cylinder segregation and marking empty/full cylinder 8/29/24. Beginning the week of 8/26/24, Maintenance Supervisor or designee will complete a minimum of 5, random, direct observation audits weekly, verifying smoke barriers are properly maintained; and oxygen cylinders are marked and stored properly.	Audits will continue until a minimum of 90% compliance is achieved for three consecutive months. Audit results will be presented at quarterly QAPI meetings.	11/30/24

2. Based on observation and interview, the facility failed to properly store oxygen cylinders. The deficient practice affected two (2) of 18 smoke compartments, staff, and 167 residents. The facility had a capacity for 302 beds with a census of 215 on the day of the survey.					

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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 (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not	1. Facility does not currently have completed sharing agreements with the VA of jurisdiction for mental health or dental services. 2. Facility does have current, written agreements with community mental health and dental providers.	All resident records were reviewed for the period 1/1/24-8/28/24, and 33 residents were identified as accessing Mental Health services through the VA Medical Center (VAMC); 74 were identified as accessing in-person Dental services through the VAMC. The Appointments Department keeps record of all residents accessing mental health services and dental services through the VAMC. All resident records were reviewed for the period 1/1/24-8/28/24 and zero residents were identified as accessing mental health services thru a community provider without a written agreement, and sixteen residents were identified as accessing dental services thru a community provider, without a written agreement. All sixteen dental providers were notified with request for written agreements for dental services 9/10/24.	Facility is currently transitioning from VAMC dental health providers to community dental health providers. For residents with currently scheduled dental appointments at the VAMC, per VAMC letter received 9/10/24, those appointments will be honored thru 12/30/24. As of 9/9/24, Facility is currently working on establishing written agreements for dental services with the 16 community providers it does not have agreements with, for the 74 residents identified. Facility continues to offer mental health and dental services through contracted community providers to all residents. The Facility will not disrupt current mental health services for those residents who choose not to transfer their care. The Facility will continue to work with the VAMC to complete a sharing agreement for those residents receiving mental health services. Facility admission's packet currently includes a list of community providers this Facility has a written agreement with for both mental health and dental services. Beginning 8/6/24, Administrator or	Audits will continue until a 100% compliance is met for three consecutive months with results reported at quarterly QAPI meetings. All agreements and contracts will be reviewed annually at the start of the Fiscal Year to determine if renewal is required.	4/30/25

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 Based on interview and review of facility documentation, it was determined the facility failed to ensure mental health services and dental services, provided outside of the facility, were provided under a written agreement.			designee will contact VAMC liaison monthly to monitor progress until a written sharing agreement for mental health services is completed, documenting contact efforts. Beginning 9/16/24, Facility's Veteran Appointments department will audit all prevailing rate residents verifying that prior to receiving mental health and/or dental services from a community provider, a written agreement is in effect and in alignment with VA regs. 51.210(h) correcting any instances of noncompliance.		

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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 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). Rating – Not Met Scope and Severity – D	All residents have the potential to be affected by deficient practice. Resident on Unit 2B was re-educated on health risks of smoking, ODVA policy and Federal and State laws concerning the prohibition of electronic cigarettes and vaping devices inside the facility and was offered smoking/vaping cessation resources 7/24/24 and 8/29/24, with Care Plan updated accordingly. An Interdisciplinary Care Plan–Admin (IDCP-Admin) meeting was held with 2B resident 7/25/24 due to resident's non-compliance with ODVA smoking policy that included corrective actions.	Healthcare records, including Care Plans, of all residents who smoke, use e-cigarettes or vaping products were reviewed 8/20/24, to identify any who have smoked/vaped inside the Facility and to verify the following: - preventive measures are in place – resident was educated on risks and safety concerns of smoking	DON or Designee will complete 5 random direct observation audits weekly, beginning 9/3/24, to ensure those residents who smoke or using vaping products do so in accordance with ODVA policy and Federal/State and local laws. Anticipated end date of audits, 11/30/24. DON educated all nursing staff during Staff Meetings, 9/4/24 and 9/5/24, reviewing 51.210 VA regulations, OK Statutes, and Facility policy, with live presentation and discussion, utilizing Staff Meeting PowerPoint presentation. Recreation Manager or designee to review Facility policy, and State/Federal regulations concerning smoking/vaping inside the facility to be reviewed at October, 2024 Resident Council meeting.	Audits will continue until a 100% compliance is met for three consecutive months with results reported at quarterly QAPI meetings.	11/30/24

Residents Affected – Few The facility was unable to demonstrate that operations and services are provided in compliance with all applicable Federal, State, and local laws, regulations, codes, and with accepted professional standards related to one (1) resident using an e-cigarette in the facility.					

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