State Veterans' Homes (SVH) Corrective Action Plan
Delaware Valley Veterans' Home 12/17/2024 – 12/20/2024

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
§ 51.100 (i) (2) Environment. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	Shower chair was removed from the tub room on 12/19/24 to place it out of service. A new seat pad, mast-to-chair cover were ordered.	All residents living on the affected unit, C unit, were reviewed and determined to have potential to be affected.	Facility and Grounds Director or designee will conduct weekly audits of facility shower rooms for six (6) weeks to ensure all equipment is in orderly and comfortable condition. These audits will commence on 02/02/2025 and extend through 03/15/2025. Registered Nurse Instructor/designee will educate nursing staff on shower tub locations. Registered Nurse Instructor and Facility Grounds Director will educate their staff on identifying any equipment in need of repairs and the work order process for requesting maintenance action.	Facility Grounds Director will report the findings of the shower room audits to the Quality Assessment and Assurance (QAA) Committee and the QAA Committee will evaluate the need for additional audits/interventions based on a benchmark of 100%.	04/01/2025
§ 51.140 (h) Sanitary Conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local	The open bag of cornstarch and open bottle of parsley were removed on 12/17/24; the unopened garlic powder was dated on 12/17/24. The unopened and undated ketchup was dated with an expiration date on 12/18/2024 by the	All residents living in the facility were reviewed and determined to have potential to be affected.	The DVVH Food Storage Policy will be reviewed and revised, and all dietary staff will be educated on the revised DVVH Food Storage Policy with a special focus on storing dry food items in a sanitary manner to ensure all dry food items are dated before being	Dietary Director will report the findings of the storage of dry food audits to the Quality Assessment and Assurance (QAA) Committee. The QAA Committee will determine the need for additional audits/ interventions to ensure ongoing compliance	04/01/2025

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authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly.	Dietary staff.		placed on the shelf. Food Service Manager/designee will conduct weekly audits for six (6) weeks of the storage of dry food items to ensure dietary staff are storing dry foods in a sanitary manner by dating the dry food items before placing the item(s) on the shelf. This will commence on 02/09/2025 and extend through 03/22/2025.	based on a benchmark of 100%.	
§ 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 professional practice.	The Registered Nurse (RN) was immediately educated on Enhanced Barrier Precautions (EBP), hand hygiene, and the necessity of wearing proper personal protective equipment (PPE) to avoid splashes or sprays from body fluids through a review of the Tracheostomy Care policy and Resident Care Services: Infection Prevention procedures with the RN.	Facility reviewed all residents in the home to determine if any other potential residents could be affected and identified only one resident as receiving tracheostomy care.	Registered Nurse Supervisor (RNS)/designee will conduct a tracheostomy care audit once a week for six (6) weeks to ensure proper infection control techniques are followed during the performance of tracheostomy care. Audits will commence on 02/09/25 and extend through 03/22/25. To ensure infection control during tracheostomy care, all licensed nurses will be educated on the Bureau of Veterans Homes (BVH) Resident Care Services: Infection Prevention procedures with a focus on Infection Control Precautions and the DVVH Tracheostomy Care policy; with a special focus on hand hygiene, enhanced barrier precautions (EBP), and tracheostomy care.	The Clinical Service Manager/designee will report the findings of the tracheostomy care audits to the Quality Assessment and Assurance (QAA) Committee. The QAA Committee will determine the need for additional audits/ interventions to ensure ongoing compliance based on a benchmark 100%.	04/01/2025
§ 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	The facility will pursue an agreement with the Veterans Administration Medical Center (VAMC) who provides mental health, podiatry, and dental services to the thirty-three (33) residents to ensure coordination of services.	All residents living in the facility were reviewed and determined to have potential to be affected.	The Deputy Commandant/designee will review with the VAMC regularly whether a Mental health, podiatry, and dental Sharing Agreement has been obtained or to receive an update on the status of the agreement. All residents' physician's orders will be reviewed by the Quality Assurance Risk	The findings of the physician order audits will be reviewed at the Quality Assessment and Assurance (QAA) Committee. The QAA Committee will determine the need for additional audits/interventions to ensure ongoing compliance based on a benchmark of 100%.	08/01/2025

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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 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.			Management Coordinator (QARMC)/designee x1 to ensure the facility is providing the required services or has obtained the required services from an outside source. This will commence on 02/14/2025 and will be completed by 03/27/2025.		
§ 51.210 (p) (1) Quality Assessment and Assurance. (1) Facility management must maintain a quality assessment and assurance committee consisting of— (i) The director of nursing services; (ii) A primary physician	The Quality Assurance Risk Management Coordinator (QARMC) will be educated to ensure a primary physician designated by the facility is present at the quarterly Quality Assessment and Assurance (QAA) Committee meetings. The Medical Director/primary physician has been	All residents living in the facility were reviewed and determined to have potential to be affected.	The Deputy Commandant/designee will conduct quarterly audits to ensure a primary physician designated by the facility is present at the quarterly Quality Assessment and Assurance (QAA) Committee Meetings. Audit will commence on 01/31/2025. The Bureau of Veterans Homes (BVH)	The Deputy Commandant/designee will report the findings of the quarterly Quality Assessment and Assurance (QAA) Committee Meeting attendance audit to the QAA Committee and evaluate the need to continue at that time. Based on a benchmark of 100%.	04/01/2025

designated by the facility; and (iii) At least 3 other members of the facility's staff.	reminded of the next quarterly QAA Committee meeting requirement for attendance.		Quality Assessment and Assurance Procedure will be reviewed and revised, and the Quality Assessment and Assurance (QAA) Committee will be educated on the procedure with a special focus on required committee members.		

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