State Veterans' Homes (SVH) Corrective Action Plan
(Watkins-Logan TSVH and 6/6/23 – 6/9/23)

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)
§ 51.120 (a) (3) Reporting of Sentinel Events The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification. **Rating** – Not Met	No residents were affected by this alleged deficit practice.	Residents with an incident resulting in inability to return to prior function may possibly be affected by this alleged deficit.	DON, Administrator and Director of Rehab (DOR) were educated regarding timeliness of reporting a sentinel event by Regional Clinical Consultant on June 9, 2023. DON educated Nurse Managers to report any significant change in resident condition to DON on 6/15/2023. Director of nursing will maintain a log of significant resident injuries.	DON will present information regarding Sentinel Events at facility QAPI meeting to ensure continued compliance. All progress will be monitored and discussed during the monthly QAPI.	Date of completion 10/23/2023

Scope and Severity – D **Residents Affected** – Few			During weekly clinical at-risk meeting DOR will review progress/ lack of progress for residents on their case load to determine if they are a possible Sentinel Event. DOR will also notify DON on resident's last therapy day. DON will then review to determine if this constitutes a Sentinel Event and will report to OSR that day and VA within 24 hours. DON will provide residents at risk of becoming a sentinel event to Administrator weekly x 6 weeks then monthly x 2 months.		
§ 51.190 (a) Infection control The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and	Residents #5, #7, #9, #10, #19, #20, #21, #22, # 23, # 24, #25, #26, #27, #28, #29, #30, #31, #32, #33, and #34 have received two step TB skin tests. These were completed on July 28, 2023, by charge nurses and audited by RN Supervisors. No resident was identified as having	This alleged deficient practice has the possibility to affect resident, staff and visitors who could unknowingly be exposed to TB.	DON and Infection Preventionist were educated by Regional Clinical Consultant on 6/9/2023 regarding resident TB Tests. An audit was	DON will present results of audits regarding TB tests at facility QAPI meeting to ensure continued compliance. All progress will be monitored and discussed during the monthly QAPI.	Date of completion 10/23/2023

comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. **Rating** – Not Met **Scope and Severity – F** **Residents Affected** – Many	TB.		completed by nurse managers on July 8, 2023, to determine any additional residents requiring TB tests. Any resident without a TB test were tested by July 28, 2023, by charge nurses. An order for two step TB test has been added to admission orders for all new admissions. Step one to be administered by charge nurse on day one of admission. Clinical team will audit new admission charts during the first two weeks of admission to assure TB testing is complete weekly x 12 weeks and added to the immunization tab for each resident. Results of these audits will be provided to DON for review.		

§ 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 required to provide under this part, the	No residents were affected by not having a current laboratory contract. All labs were completed as ordered. An updated signed laboratory contract was provided to surveyors on 6/9/2023.	Residents who receive services from contracted vendors had the potential to be affected by this alleged deficit practice.	Contracts were reviewed by administrative assistant on 7/1/2023 to ensure that all contracts were current. A spreadsheet will be used to track SVH contracts. This spread sheet will include start and end dates of contract. Contract book will be audited for current dates monthly x 3 months by administrative assistant. Any contracts expiring in next 60 days will be processed for renewal.	Results of these audits will to be provided to administrator to reviewed during facility QAPI meetings. All progress will be monitored and discussed during the monthly QAPI.	Completion date 10/13/2023

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					

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