State Veterans' Homes (SVH) Corrective Action Plan
Arizona State Veteran Home – Yuma, 4/23/24-4/25/24

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)
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Rating** – Not Met **Scope and Severity** – D **Residents Affected** – Few	The facility issued a check for the remaining trust balance to the family of resident #12 on 6/5/2024.	The Business Office Manager (BOM) and Administrator have been educated on this regulation. The Billing Specialist position is currently posted and the new hire will also be educated on this regulation. The BOM reviewed the trust accounts for all deceased residents to verify that their accounts had been closed appropriately and identified that another account took 45 days to close on 4/18/2024.	The facility created a tracking spreadsheet "Conveyance of Funds Upon Death" to ensure compliance with this regulation. Upon the death of a resident, the BOM or designee will use the tool to monitor and track the status of the trust account to ensure that it is closed within 30 days.	A monthly summary of the conveyance of funds tracking tool will be reported on at the facility's monthly Quality Assurance and Process Improvement (QAPI) meeting which is held on the 3rd Wednesday of every month. The BOM or designee will report at the facility's QAPI meeting for the next 3 months (June, July, and August 2024) to ensure compliance with a goal of 100%. Monitoring and audits started on May 5th, 2024 and will progress through August 9th, 2024.	August 21st, 2024
§ 51.120 (a) (4) Reporting of Sentinel Events The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to	The facility acknowledges that it did not meet the requirement but established a plan to remain compliance moving forward.	The Administrator has been educated on this regulation will submit the sentinel event report with all required elements to it's assigned VA region (South Arizona Health Care) within 10 working days.	The facility created a tracking spreadsheet "Reportable and Sentinel Event Tracking" to ensure compliance with this regulation. Upon identification of a reportable event, the Administrator will utilize the	A monthly summary of the "Reportable and Sentinel Event tracking" tool will be reported on at the facility's monthly Quality Assurance and Process Improvement (QAPI) meeting which is held on the 3rd	August 21st , 2024

residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility. **Rating** – Not Met **Scope and Severity – D** **Residents Affected** – Few		The Director of Nursing will be the backup in the event that the Administrator is unavailable.	tool to track the dates and submission to the appropriate entities if the incident meets state reporting and/or sentinel event criteria.	Wednesday of every month. The Administrator or designee will report at the facility's QAPI meeting for the next 3 months (June, July, and August 2024) to ensure compliance with a goal of 100%. Monitoring and audits started on May 5th, 2024 and will progress through August 9th, 2024.	
§ 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. **Rating** – Not Met **Scope and Severity** – F **Residents Affected** – Many	On 4/23/24, the Food Service Manager (FSM) and dietary staff completed a full review of inventory on all fridges and freezers to ensure that all inventory was appropriately labeled or disposed of.	The FSM and all dietary staff were educated on this regulation and the facility policy and procedure "Receiving" to ensure compliance with labeling and dating of food inventory.	The facility created the "Food labeling and audit tracker" to ensure compliance with this regulation. The Food Service Manager or designee will audit the kitchen fridges and freezers to ensure that inventory is labeled and dated. The audits will be conducted weekly for 4 weeks and then bi-monthly for 4 cycles.	A monthly summary of the "Food labeling and audit" tool will be reported on at the facility's monthly Quality Assurance and Process Improvement (QAPI) meeting which is held on the 3rd Wednesday of every month. The FSM or designee will report at the facility's QAPI meeting for the next 3 months (June, July, and August 2024) to ensure compliance with a goal of 100%. Monitoring and audits will start on the week of June 10th, 2024 and will progress through August 16th, 2024.	August 21st , 2024
§ 51.210 (c) (7) Required Information. Annual State Fire Marshall's report; **Rating** – Not Met **Scope and Severity – F** **Veterans Affected** – Many	The facility acknowledges that it did not meet the requirement but established a plan to remain in compliance moving forward.	The Maintenance Director and Administrator were educated on this regulation.	The Maintenance Director, and Administrator created a monthly calendar reminder for the 3 months prior to the 12-month requirement for the State Fire	For the months of January 2025 through April 2025, the Maintenance Director or designee will report at the facility's Quality Assurance and	6/7/2024

	The State Fire Marshall conducted the yearly inspection which yielded no findings on 4/23/2024.		Marshall inspection. The facility will scheduled with Yuma Fire Department 2 months advance and check-in 1 month before the due date to ensure the inspection is completed.	Process Improvement meeting on the status of the upcoming State Fire Marshall inspection to ensure that it is being tracked and scheduled by April 23rd, 2025.	

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