Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Patient Abuse and Inadequate Community Nursing Home Program Oversight
Oklahoma City VA Medical Center
Oklahoma City, Oklahoma

Report No. 11-01829-209

June 28, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections evaluated the validity of allegations that a patient was abused at a community nursing home and inadequate community nursing home oversight was provided by the Oklahoma City VA Medical Center, Oklahoma City, OK.

We did not substantiate the allegation of patient abuse. The patient was diagnosed with multiple myeloma and was admitted with bruising and pressure ulcers. The patient had symptoms of depression, poor appetite, recent weight loss, and decreased mobility. We found that the patient received appropriate treatments including skin care, antidepressants, health shakes, and appetite stimulants. The patient was admitted to a hospice due to continued loss of physical functioning and weight loss.

We did not substantiate the allegation of inadequate community nursing home oversight. We reviewed the facility's investigation of the complaint and found they conducted a thorough investigation within 3 working days of the allegations. At the time of the abuse allegation, the patient had already transferred to a Veterans Home and there were no other provider agreement patients at the community nursing home. The Oklahoma City VA Medical Center did not substantiate abuse. In addition, we reviewed the Adult Protective Services report that did not substantiate the abuse. We agreed with the Oklahoma City VA Medical Center's determination that it was appropriate to place patients in the community nursing home. We found that the Oklahoma City VA Medical Center provided appropriate oversight to the community nursing home.

We made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, South Central VA Health Care Network (10N16)

SUBJECT: Healthcare Inspection – Alleged Patient Abuse and Inadequate Community Nursing Home Program Oversight, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of patient abuse at a community nursing home (CNH) and inadequate CNH oversight provided by the Oklahoma City VA Medical Center (the facility), Oklahoma City, OK. The purpose of the inspection was to determine if the allegations had merit.

Background

The facility, a tertiary care medical center, is part of Veterans Integrated Service Network (VISN) 16. It has 159 acute care beds and 33 community living center beds. It serves approximately 199,244 veterans and is affiliated with the University of Oklahoma Medical School.

VA's nursing home health system programs include VA-operated community living centers and CNH placement. The facility has provider agreements with 20 nursing homes within the community to provide nursing home care for eligible veterans. It is responsible for overseeing the care patients receive at CNHs through the provider agreements.[1]

An anonymous complainant contacted the OIG Hotline Division with allegations that a patient was abused at a CNH the facility has a provider agreement[2] with, and that the facility provided inadequate oversight of the CNH. Specifically, the complainant alleged patient abuse and that the facility did not provide adequate oversight to remaining patients after being made aware of unsafe conditions.

[1] Veterans Health Administration (VHA) Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
[2] The Pilot Provider Agreement Directive is undergoing VHA approval.

Scope and Methodology

We reviewed the patient's medical record, relevant policies and procedures, and other related documents. We conducted an onsite review April 22–25, 2011. We interviewed facility leadership, facility Community Nursing Home Program (CNHP) staff, and CNH and Clinton Veterans Center (Veterans Home), Clinton, OK, staff familiar with the patient's care. We also reviewed the Oklahoma State Adult Protective Service (APS) final report and the Centers for Medicare and Medicaid (CMS) independent inspection.[3] Multiple attempts to contact the patient's family were unsuccessful.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient was a male in his 80s with a medical history that included multiple myeloma,[4] coronary artery disease, macular degeneration, degenerative joint disease, hearing loss, and benign prostatic hypertrophy[5] with urinary incontinence.

Prior to the patient's CNH admission, he was admitted to a non-VA hospital where he received treatment for a viral illness. He returned home, but fell several times. In November 2010, he moved to the CNH as a private pay resident. Admission documentation indicated the family reported that the patient had a poor appetite and felt depressed. Documentation also indicated the patient's long-term plan was to move to the Veterans Home. In early December, VA approved funding for his nursing home care. He remained at the CNH while his family arranged the Veterans Home placement.

In late December, the facility's CNHP Licensed Clinical Social Worker (LCSW) conducted an oversight visit. The patient's room was found to be neat and clean, and his belongings were observed in the room. The LCSW noted the patient appeared sad, reclusive, and did not want to answer questions. The LCSW also noted the following about the patient:

- He required a wheelchair and staff assistance for locomotion.
- He had recently lost 10 pounds and was receiving nutritional health shakes at every meal.
- His right buttock had an area of skin breakdown that was approximately 1–1.5 centimeters in size.

[3] The Centers for Medicare and Medicaid Services (CMS) conducts nursing home health and fire safety inspections. CMS also investigates complaints related to nursing home care.
[4] Multiple Myeloma is a cancer of the plasma cells in bone marrow.
[5] Hypertrophy is an enlargement or overgrowth of an organ or part of the body.

In early January 2011, the patient was placed in hospice care due to a decline in physical functioning and weight loss. In mid January, the patient was transferred to the Veterans Home.

The patient's Veterans Home admitting physician documented that the patient had multiple pressure ulcers and bruises all over his body. Veterans Home social worker admission notes indicated the patient's family member was concerned about his weight loss, poor hygiene, and skin breakdown. The social worker also noted the patient:

- Acted and looked fearful when staff approached him.
- Stated he was "slammed around," verbally abused, and did not receive good care at the CNH.
- Stated he did not share his concerns with anyone until then because he feared retaliation against his family member as well as himself.

The Veterans Home social worker reported concerns regarding the care the patient received at the CNH to the facility and to APS.

In late January, the patient developed a fever, his heart rate increased, and his oxygen levels and blood pressure decreased. He was treated with antibiotics, intravenous fluids, and oxygen. The patient had an Advance Directive,[6] a Do Not Resuscitate[7] order, was receiving hospice care, and staff provided comfort care as directed. However, these treatments were not successful, and the patient died.

Inspection Results

Issue 1: Patient Abuse

We did not substantiate the allegation that the CNH abused the patient.

The patient voluntarily admitted himself to the CNH on November 20, 2010, where he had been a private pay patient on a previous occasion. A request for VA assistance was approved and VA accepted oversight responsibility in December 2010. From the time the patient was admitted at the CNH, the patient's family voiced his wish to transfer to the Veterans Home. The family requested VA assistance with the transfer procedures. The admission assessment indicated the patient had several skin tears and pressure ulcers. Wound care was provided according to doctors orders. Weight loss was treated with health shakes and appetite stimulant medications. Due to declining physical functioning and weight loss, the patient was placed on hospice care in early January 2011.

[6] An Advance Directive is a written statement by a person who has decision-making capacity regarding preference about future health care decisions in the event that an individual becomes unable to make those decisions.
[7] Do Not Resuscitate orders may be placed in a medical record to indicate whether or not a patient should be resuscitated in the event of a cardiopulmonary arrest.

According to documentation and interviews with the CNH staff, the patient and family did not voice concerns during his admission, and the family was involved in the patient's treatment. Weight loss and pressure ulcers were treated appropriately.

The Oklahoma State Department of Health, Long Term Care Division of APS, conducted an unannounced inspection in March 2011, and did not substantiate the allegation of abuse. CMS performed a standard health inspection in December 2010 and the facility received an overall rating of 5 (the highest rating). The facility CNHP staff conducted an inspection following the alleged abuse and did not substantiate the complaint.

Issue 2: VA Oversight of CNH Care

We did not substantiate the allegation that the facility provided inadequate CNH oversight.

VHA Handbook 1143.2 defines guidelines for facility oversight requirements for community nursing home patients. Prior to the abuse allegation, CNHP staff conducted scheduled oversight nursing and social work visits as required. At the time of the abuse allegation, the patient had already transferred to the Veterans Home and there were no other provider agreement patients at the CNH. We reviewed the facility's investigation of the complaint and determined that it conducted a thorough investigation of the allegation of patient abuse within 3 working days after it was reported. APS also conducted an investigation of the complaint. The facility and APS investigators did not substantiate the abuse allegation. Consequently, the facility determined that it was appropriate to place patients in the CNH. Subsequent social work and nursing visits with current CNH patients reflect their satisfaction with their care.

Conclusions

We did not substantiate the allegations of patient abuse or that the facility provided inadequate oversight at the CNH. We made no recommendations.

Comments

The VISN and facility Directors concurred with our findings and there are no recommendations (see Appendixes A–B, pages 5–6, for the full text of their comments).

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 2, 2011

From: Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Alleged Patient Abuse and Inadequate Community Nursing Home Program Oversight, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma**

To: Director, Denver Office of Healthcare Inspections (54DV)

Thru: Director, VHA Management Review Service (10A4A4)

I have reviewed the results of the Healthcare Inspection of the Oklahoma City VA Medical Center and concur with the findings.

Thank you for this comprehensive review.

George H. Gray, Jr.
Director, South Central VA Health Care Network (10N16)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 2, 2011

From: Director, Oklahoma City VA Medical Center (635/00)

Subject: **Healthcare Inspection – Alleged Patient Abuse and Inadequate Community Nursing Home Program Oversight, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma**

To: Director, South Central VA Health Care Network (10N16)

I concur with the findings of Healthcare Inspection review team.

We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

David Wood

David P. Wood, MHA, FACHE'
Director, Oklahoma City VA Medical Center (635/00)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Virginia Solana, RN, Regional Director, Team Leader Laura Dulcie, BS Stephanie Hensel, RN, JD Ann Ver Linden, RN

Appendix D

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