Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Resident Care Issues
Northport VA Medical Center
Northport, New York

Report No. 11-01437-41

December 2, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of alleged poor quality of resident care on the community living center (CLC) 3.

An anonymous complainant alleged that residents on the CLC 3 unit were malnourished and abused, and staff supported residents' sexual activities in inappropriate ways. The complainant also alleged that staff removed confidential employee information from the medical center. An additional allegation included that the Nurse Manager was aware of these and other issues (determined to be outside the scope of this review) but did not take appropriate action.

We did not find evidence of poor resident care related to malnutrition, abuse, or other issues such as neglect. For example, staff appropriately assessed patients' nutritional status and conducted fact-finding on resident falls. We found no evidence that staff inappropriately supported residents in sexual activities; however, an unconventional treatment plan for one resident may have resulted in misperceptions by others unfamiliar with the plan. Although we did not find any evidence of pressure ulcer mismanagement among the CLC 3 residents we reviewed, we did find that the medical center had a rate of pressure ulcers that was higher than benchmarks.

We could not substantiate or refute the allegation that staff removed confidential employee information from the medical center or that the Nurse Manager had been aware of these issues, but did not take appropriate action because we were not provided specific information regarding these complaints.

During the course of our inspection, we were made aware of a breach of privacy related to resident identification bands and determined that medical center staff did not provide timely communication and follow-up after the privacy breach had occurred.

We recommended processes be strengthened to improve pressure ulcer management in the CLC units. We also recommended that privacy incidents be managed in accordance with VA policy related to timely follow-up and patient notification.

The Veterans Integrated Services Network 3 and Medical Center Directors agreed with our findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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

TO: Veterans Integrated Service Network 3 Director (10N3)

SUBJECT: Healthcare Inspection – Alleged Quality of Resident Care Issues, Northport VA Medical Center, Northport, New York

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by an anonymous complainant. The complainant alleged poor quality of resident care and inappropriate staff conduct in the community living center (CLC) 3. The purpose of the review was to determine whether the allegations had merit.

Background

The Northport VA Medical Center (medical center) is part of Veterans Integrated Services Network (VISN) 3 and serves veterans from the Nassau and Suffolk counties of Long Island and the surrounding five boroughs of New York. In addition, the medical center has three community-based outpatient clinics located in Plainview, Patchogue, and Westhampton, NY. The medical center provides medical and surgical care, primary care, extended care, and inpatient and outpatient mental health services. In 2011, the medical center had 506 operating beds, with 306 hospital beds, 170 CLC beds, and 30 domiciliary beds. The medical center is affiliated with the State University of New York at Stony Brook School of Medicine.

A complainant contacted the State of New York, Office of Inspector General in October 2010, and made the following allegations regarding the locked geriatric unit, CLC 3:

- Residents were malnourished and abused.
- Staff supported residents' sexual activities in inappropriate ways.
- Staff removed confidential employee information from the medical center grounds.
- The Nurse Manager (NM) was aware of these issues, but did not take appropriate action.

The State of New York forwarded these allegations to the VA Office of Inspector General (OIG), Office of Healthcare Inspections in January 2011.

In addition, the complainant made allegations related to diversion of narcotics, misuse of government issued credit cards, and stolen government supplies and money; however, those criminal allegations were outside the scope of this report.

Scope and Methodology

On May 23–26, 2011, we conducted a site visit to evaluate the complainant's allegations. We interviewed staff members and residents, and conducted meal rounds to observe residents dining. We reviewed policies and procedures, resident electronic medical records (EMRs), and incident reports. We also reviewed related findings of facts, pharmacy narcotics administration records, and nursing dashboards. In addition, we interviewed staff members from the VA Network and Security Operations Center (NSOC) and Incident Resolution Team (IRT).

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.

Inspection Results

Issue 1: Malnutrition and Abuse

We did not substantiate the allegation that residents were abused and malnourished. The allegation of abuse was non-specific. Therefore, we focused our inspection on the areas of fall prevention and pressure ulcer management. These two areas are good indicators of overall patient care and proactive interventions. We also reviewed the allegation of malnutrition.

Local policy requires that nurses assess residents for fall risk in a timely manner.[1] Although the complainant did not provide any specific resident information, we reviewed the EMRs of 15 residents on the CLC 3 unit for history of falls and documentation of nursing assessments. In addition, we reviewed the medical center data for falls. The medical center showed evidence of fall risk assessment per policy and fall rates below their established benchmark rate of seven falls per bed days of care. There was a slight peak in the fall of 2010. During our interviews, staff explained this was a result of construction and changes in traffic patterns for residents on the unit. We reviewed three falls and found completed fact-finding reports for these falls, with no indication of resident neglect. Therefore, we concluded that there was no resident abuse in relation to falls on the CLC 3 unit during the subject period, and made no recommendations.

[1] Northport VA Medical Center Nursing Memorandum, C-5 *Fall Prevention/Reduction Policy*, April 24, 2006.

Local policy provides guidance on timely assessments for pressure ulcer prevention and treatment.[2] While we did not have any specific resident information, we reviewed the EMRs of 15 residents for pressure ulcer incidence and documentation of care. We found two residents with evidence of pressure ulcers. In both cases, we found appropriate assessments, documentation, and pressure ulcer care. In addition, VHA requires the reporting and tracking of pressure ulcers.[3] We found evidence that the medical center had implemented processes to report and track pressure ulcers. However, the tracking data showed that the medical center's aggregated CLC pressure ulcer rates were consistently higher than those of VISN 3 and national averages. Therefore, we recommended that processes be strengthened to improve pressure ulcer management in the CLC units.

VHA requires that nutritional screenings, assessments, and reassessments be completed on a timely basis.[4] We reviewed the EMRs of 15 CLC 3 residents and found evidence that staff completed nutritional assessments according to policy. We did not find any evidence of malnourishment based on weight history and laboratory data. On the contrary, we found evidence of residents thriving in the environment, as evidenced by three residents gaining in excess of 10 percent body weight, while 4 residents showed modest gains. Five of the 15 residents generally maintained weight, and there was appropriate weight loss noted in 2 residents. Although one resident had significant unplanned weight loss, the resident's EMR showed that the weight change was due to the effects of his medication, which was later adjusted. We also found no evidence of resident neglect during unit rounds and surprise meal rounds. Therefore, we made no recommendations.

Issue 2: Inappropriate Sexual Assistance by Staff

We did not substantiate the allegation that staff inappropriately supported residents in sexual activities.

Because the complainant did not provide specific information regarding this allegation, we were unable to investigate specific incidents. However, during the course of our investigation, we found that the clinical treatment team had used unconventional therapeutic modalities in the care plan of one resident. VHA requires that extended care programs (such as CLC 3) develop interdisciplinary teams and treatment care plans for the care of residents.[5] We found evidence that the treatment team had carefully thought out this modality; and implemented it to safeguard the resident from physical harm, after the resident had demonstrated sexual behavior with potential for severe personal physical injury. During our investigation, we found that some staff members were uncomfortable

[2] Northport VA Medical Center Memorandum 118-02, *Prevention and Treatment of Pressure Ulcers* April 5, 2011.
[3] VHA Directive 2006-066, *Reporting and Tracking of Pressure Ulcers,* December 22, 2006.
[4] Northport VA Medical Center Memorandum 120-01, *Nutrition Care to Patients,* March 30, 2007.
[5] VHA Document M-5, *Part II Department of Medicine and Surgery,* July 19, 1988.

with this unconventional therapeutic modality. However, we did not find any evidence of staff members directly engaging in inappropriate sexual behavior with the residents on the unit. Based on the information provided, the use of this unconventional treatment plan may have created the perception of sexually inappropriate behavior by staff on the unit. We determined that staff actions were consistent with the clinician's approved plan of care for this resident. Therefore, we made no recommendations.

Issue 3: Confidential Information

We could not substantiate or refute the allegation that staff removed confidential employee information from the medical center because the complainant did not provide any specific information. However, during the course of our inspection, we were made aware of a privacy breach related to resident identification (ID) bands.

All residents are issued and should be wearing a barcode-readable ID band for purposes of identification and medication administration safety.[6] The computerized barcode medication administration (BCMA) system is used to administer medications to residents. BCMA reduces the chance of error through verification of the resident, time, medication, route, and dosage.[7] To start the verification process — and before administering any medication — staff scan the barcode on the resident's ID band. Scanning the resident's ID band, while worn on the resident wrist, positively identifies the resident and opens up the resident's BCMA record.

During the course of our investigation, we were told that on October 20, 2009, a Unit 34 (acute care) staff nurse, found 18 resident identification (ID) bands (duplicates of those worn by patients) in the hospital parking lot. The ID bands were stapled together with the residents' names, social security numbers, and barcodes still intact.

The nurse gave the ID bands to the Unit 34 NM who completed an incident report, identified the ID bands as belonging to CLC 3, and secured them until the CLC 3 NM returned from vacation. On October 29, 2009, the CLC 3 NM received the ID bands. The CLC 3 NM reported the privacy breach to the medical center's privacy officer and then gave the ID bands to a staff member in the performance improvement department. The privacy officer electronically reported the incident to the NSOC and IRT. According to VA policy, the IRT reviews privacy breach events, completes required risk assessments, and makes determinations on what actions to take to resolve each case.[8] The privacy officer received the completed assessment by the IRT on October 30, 2009, which advised the medical center to send letters offering credit protection services to all residents identified on the recovered ID bands. The CLC 3 NM completed an investigative report about the recovered resident ID bands and submitted it to the medical

[6] Northport VA Medical Center Memorandum 118-07, *Patient Wrist Identification Bands*, July 16, 2010.
[7] Department of Veterans Affairs. Barcode Medication Administration (BCMA) Technical Manual/Security Guide, Version 3.0, Accessed August 1, 2011.
[8] VA Handbook 6500.2, *Management of Security and Privacy Incidents*, June 17, 2008.

center's administrative leaders on November 4, 2009. The report stated that the, "use of alternate wrist bands to bypass BCMA was a frequent practice on unit CLC 3," and acknowledged that, "bypassing the process of scanning the wrist band that is on the resident, increases the potential for medication errors and caused resident information to be compromised." Further, the report stated all nursing staff were re-educated regarding the responsibilities for medication administration and privacy regulations, and the NM initiated a weekly monitor for medication administration safety compliance on all tours of duty.

On May 10, 2010, the medical center contacted the NSOC stating that the 18 bands, after being given to the performance improvement staff, were lost again; however, no new electronic ticket to the NSOC or investigation were launched. Further, the medical center requested an appeal to not offer credit protection services; because staff did not record the names of the 18 residents involved at the time of the October 2009 investigation and they could not be identified so long after the fact. The appeal was elevated through the IRT, to the Data Breach Core Team (DBCT) and approved on May 21, 2010. The DBCT decided, "Credit protection services are not required unless the ID bands are located."

VA requires that staff report suspected or actual breaches involving personally identifiable information to the VA NSOC, US-Computer Emergency Readiness Team (CERT), VA Privacy Service, appropriate privacy officer, and any other pertinent entity. [9] VA also requires that privacy officers will coordinate with the VA Privacy Service and their local information security officers to ensure that foreseeable privacy risks have been identified and documented in all privacy impact assessment submissions.[10] Communication with individuals directly affected by a privacy breach is a very important process and it is critical that information sent to these individuals be timely and accurate. This communication typically takes the form of either a notification letter or a letter offering credit protection services paid for by VA and prepared by the privacy officer or a Medical Center Director's designee.[11] We determined that staff appropriately reported the lost wristbands incident; however, they did not provide timely follow-up or communicate with the individuals directly affected by the privacy breach.

The primary goal of managing a privacy breach is to provide prompt and accurate notification and remediation to those individuals whose sensitive personal information (SPI) was lost or compromised.[12] Although the exact 18 resident names were unknown, the CLC 3 had a census of 30 residents at the time of the ID bands privacy breach. On June 9, 2011, we contacted the NSOC and the IRT for clarification on the appeal decision to not offer credit protection services to any residents, rather than sending letters to all residents. The IRT brought this issue back to the DBCT who agreed, on June 15, 2011,

[9] VA Directive 6502, *VA Enterprise Privacy Program*, May 5, 2008.
[10] VA Handbook 6508.1, *Privacy Impact Assessment*, November 16, 2010.
[11] VA Handbook 6500.2
[12] VA Handbook 6500.2

"to err on the side of caution" and notified the medical center to send letters to all 30 residents (or the next-of-kin), who resided on CLC 3 at the time of the breach.

We determined the staff did not provide timely follow-up or communicate with the individuals directly affected by the privacy breach.

Issue 4: NM's Response to Issues

We could not confirm or refute the allegation that the CLC 3 NM had been aware of the complainant's issues, but did not take appropriate action.

The complainant did not provide any specific incidents. However, staff told us that when issues were brought to the attention of the CLC 3 NM the issues were appropriately addressed and documented with reports of contact, fact-findings, and follow-up action plans. We made no recommendation.

Conclusions

Overall, we did not find evidence of poor resident care related to malnutrition, abuse, or other issues such as neglect. Staff appropriately assessed residents' nutritional status and conducted fact-finding on resident falls. We found that the facility had higher than average rates of pressure ulcers. We found no evidence that staff inappropriately supported residents in sexual activities; however, an unconventional treatment plan for one resident may have resulted in misperceptions by others unfamiliar with the plan.

Because the complainant did not provide details, we could not substantiate or refute the allegation that staff removed confidential employee information from the medical center. However, during the course of our inspection, we identified a breach of privacy related to resident ID bands and determined that medical center staff did not provide timely follow-up or communicate with the individuals involved in the privacy breach.

Without additional information from the complainant, we also could not confirm or refute the allegation that the NM had been aware of these issues, but did not take appropriate action.

Recommendation

Recommendation 1. We recommended that processes be strengthened to improve pressure ulcer management in the CLC units.

Recommendation 2. We recommended that the Medical Center Director ensure that management of privacy incidents be conducted in accordance with VA policy related to timely follow-up and patient notification.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations. The implementation plans area acceptable, and we will follow up on the planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 14, 2011

From: Michael A. Sabo, Director, VA NY/NJ Veterans Healthcare Network (10N3)

Subject: Healthcare Inspection – **Alleged Quality of Resident Care Issues, Northport VA Medical Center, Northport, New York**

To: Director, Baltimore Office of Health Inspections (54BA)

Thru: Director, Management Review (10A4A4)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding the Quality of Resident Care Issues, Northport VA Medical Center, in Northport, New York.

2. I concur with the recommendations and ensured that an action plan has been developed.

3. Should you have any questions, please do not hesitate to contact Pam Wright, RN MSN, VISN 3 QMO at telephone# 718-741-4135

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(*original signed by*:)
Michael A. Sabo, FACHE
Director, VA NY/NJ Veterans Healthcare Network (10N3)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: 11/9/11

From: Director, Northport VA Medical Center (632/00)

Subject: **Healthcare Inspection – Alleged Quality of Resident Care Issues, Northport VA Medical Center, Northport, New York**

To: Director, VA NY/NJ Veterans Healthcare Network - 10N3

Attached is the response as requested for the Alleged Quality of Resident Care Issues for Northport VAMC LTC. Please review and if approved forward to the Director, Baltimore Office of Health Inspections (54BA).

Philip C. Moschitta

Philip C. Moschitta
Director, Northport VAMC

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to improve pressure ulcer management in the CLC units.

Concur **Target Completion Date:** 2/15/2012

Facility's Response:

Based on the quality measure/ quality indicator report from April 2011 the facility's high-risk residents with pressure ulcers was 26.3% and low risk residents with pressure ulcers was 1.9%. The facility's most recent report from September 2011 indicates the high- risk residents with pressure ulcers is 19% and the low risk residents with pressure ulcers is 0.0%. The facility wants to continue to improve and strengthen the process of pressure ulcer management.

To improve and strengthen our current process of pressure ulcer management, we have initiated the following actions:

1. As of June 2011, an additional RN, who is certified in MDS 3.0, has been working with all the RNs responsible for documentation and education for proper pressure ulcer staging as well as identifying other wound types and skin injuries.
   Target Completion Date: 12/15/11

2. Wound Care Specialist and the RN certified in MDS 3.0 provided education to staff for skin assessment, documentation and education on proper pressure ulcer staging and identifying other wound types and skin injuries. Education of staff - 34 RNs to be educated/34 RNs total staff for 100% compliance.
   Target Completion Date: 12/15/11

3. Skin Champion's (Staff RNs) were identified for each CLC and will be developed as a unit resource by our Wound Care Specialist.
   Target Completion Date: 12/1/11

4. Implementation of a chart review focusing on the weekly skin assessment done timely by the staff in CLC. Twenty charts per month will be audited for 90 days until a 90% compliance rate is met (# charts with timely weekly skin assessment completed/total number of charts reviewed). This audit will be reported at the interdisciplinary LTC Clinical Executive Council Meeting and at the LTC PI Committee. Additionally, the Wound Care Specialist will chair a monthly meeting attended by the PI nurse, Acting ACNS for Extended Care, ACOS/Designee, the MDS Coordinator, the CLC Skin Care Champions and the Dietician to review this data.

Target Completion Date: 2/15/2012

Recommendation 2. We recommended that the Medical Center Director ensure that management of privacy incidents be conducted in accordance with VA policy related to timely follow-up and patient notification.

Concur **Target Completion Date:** 7/30/11

Facility's Response:

The Privacy Officer at the time of the initial loss of the wrist bands acted according to the Data Breach Core Team's (DBCT) direction and took no action to notify or provide remediation to the affected residents. Upon the re-opening of the case all 28 (incorrectly listed above as 30) of the affected residents (or the next of kin) were provided notification and remediation by the current Privacy Officer. There are currently no outstanding or unresolved privacy issues for the Northport VA Medical Center.

Status: Complete

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	Melanie Cool, MEd, LDN, Project Leader Sonia Whig, MS, LDN Donald Braman, RN, BSN Monika Gottlieb, MD Nelson Miranda

Appendix D

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