DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

July 23, 2018

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: OSC File Nos. DI-17-4242 and DI-17-4331

Dear Mr. Kerner:

I am responding to your January 16, 2018, letter to the Secretary, regarding allegations made by whistleblowers at the Department of Veterans Affairs (VA), Greater Los Angeles Healthcare System (Los Angeles) in Los Angeles, California, that employees may have engaged in actions that constitute gross mismanagement and a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Executive in Charge directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. We partially substantiated the allegation that Los Angeles officials failed to investigate and remediate serious residential care concerns at California Villa, a VA-approved community residential care (CRC) facility and substantiated that there were VA-approved CRC facilities wherein the delivery of residential care to Veterans was compromised. We did not substantiate that Los Angeles officials failed to take action in response to reports that a management official engaged in improper relationships with VA patients nor that Los Angeles medical support assistants inappropriately accessed patient records. We made six recommendations to Los Angeles and one to Veterans Integrated Service Network 22.

Thank you for the opportunity to respond.

Sincerely,

Jacquelyn Hayes-Byrd
Acting Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Department of Veterans Affairs (VA) Report
to the
Office of Special Counsel
OSC File Numbers DI-17-4242 and DI-17-4331

West Los Angeles VA Healthcare System
Los Angeles, California

Report Date: June 7, 2018

TRIM 2018-D-466

Executive Summary

The Executive in Charge of the Office of the Under Secretary for Health requested that the Office of the Medical Inspector assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the VA Greater Los Angeles Healthcare System (Los Angeles) in Los Angeles, California. The whistleblowers, who chose to remain anonymous, alleged that employees are engaging in conduct that may constitute violations of law, rule, or regulation; and gross mismanagement, which may lead to a substantial and specific danger to public health. VA conducted a site visit to Los Angeles on February 8–11, 2018.

Specific Allegations of the Whistleblowers

1. *West LA officials failed to investigate and remediate serious patient care concerns at a number of approved Community Residential Care Facilities, in violation of state regulations and agency policy;*

2. *West LA officials failed to take action in response to reports that a management official engaged in improper relationships with VA patients in violation of state licensing requirements and agency policy;*

3. *West LA medical support assistants (MSAs) inappropriately accessed patient records in violation of federal law and agency policy; and*

4. *These actions resulted in compromised patient care, including patient neglect.*

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We were **not able to substantiate** allegations when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, we make the following conclusions and recommendations:

Conclusions for Allegation 1

- We **partially substantiate** that Los Angeles officials failed to investigate and remediate serious residential care concerns at California Villa, a VA-approved Community Residential Care (CRC) Facility, in violation of state regulations and VA policy. Although there are residential care concerns in at least one VA-approved CRC facility (California Villa), there are limited actions available to remedy these concerns. Additionally, these CRC facilities do not deliver direct care, with the exception of assisting Veteran-residents with the storage and self-administration of their medications. VA providers responsible for the clinical management of Veterans

through traditional outpatient care and, if enrolled/qualified, Home-Based Primary Care (HBPC), who reside in these CRC facilities may be under the false/erroneous impression that there is more medical capability on site than exists or is required by law. The VA CRC program staff notified the appropriate state agencies and stopped referring Veterans to California Villa pending other action. However, there are longstanding and well-known residential care issues with this facility and there is no evidence that these concerns were elevated to Los Angeles leadership or the Veterans Integrated Service Network (VISN) by the CRC Program Coordinator.

Recommendations to Los Angeles

1. Subject to VA's compliance with, and exhaustion of, the due process procedures available to the facility (including expedited procedures imposed when identified deficiencies pose a danger to life or safety of residents) and an outcome that supports revocation of VA approval, (1) notify the Veterans residing in California Villa (or their legal representatives) of the facility's disapproval and request permission to assist in their removal from the facility, and (2) cease referring Veterans to the facility. For Veterans who elect to remain at California Villa, ensure they are aligned with other Veterans Health Administration (VHA) programs such as HBPC or Mental Health Intensive Care Management (MHICM), as indicated based on their needs and eligibility.

2. Update Standard Operating Procedure 11-116A-10H5-31, *Community Care: Community Residential Care (CRC) Placements,* to include a mechanism to report inspection results of VA-approved CRC facilities to Los Angeles leadership through an existing standing committee, and include these discussions in formal meeting minutes on a monthly basis.

3. Provide training to VA providers regarding the capabilities and limitations of CRC facilities related to medication management.

4. Engage with California Department of Social Services (CDSS) investigations for recommendations related to medication management and share this with the VA-approved CRC facilities. Do not continue to recommend practices that place CRC facility staff at risk of violating the various state nurse practice acts.

5. With the permission of the Veterans (or their legal representatives), assist in the prompt transfer of Veterans, who reside on the locked ward/unit at California Villa, who suffer from dementia or other similar conditions requiring hospital or nursing home care, to such sites of care (either within or outside the VA system), as appropriately determined under the facts of each case. While these Veterans remain eligible for home care from VA even if the facility's VA-approval is revoked, we note that California law prohibits admission or retention of any resident in a residential care facility for the elderly if, among other things, the resident requires 24-hour, skilled nursing or intermediate care (Cal Health & Saf Code § 1569.72(a)). As

stated above, if these Veterans require nursing home care, action should be taken by VA to offer and provide it.

Conclusion for Allegation 2

- We **do not substantiate** that Los Angeles officials failed to take action in response to reports that a management official engaged in improper relationships with VA patients in violation of state licensing requirements and agency policy.

Recommendation to Los Angeles

None.

Conclusion for Allegation 3

- We **do not substantiate** that Los Angeles MSAs inappropriately accessed patient records in violation of Federal law and agency policy.

Recommendation to Los Angeles

None.

Conclusion for Allegation 4

- We **substantiate** that there were VA-approved CRC facilities wherein the delivery of residential care to Veterans was compromised. VA-approved CRC facilities should maintain the highest VA and state standards available. Despite efforts to provide Case Manager (CM) oversight by nurses and social workers, they have little influence and control over the conditions at a CRC facility and can only report incidents of noncompliance to the referring facility or state. Los Angeles should review the clinical status of Veterans residing in the locked ward at California Villa and assist with placement and transfer to appropriate levels of inpatient care as indicated by their medical conditions.

Recommendation to Los Angeles

6. The CRC Program Coordinator should conduct monthly site visits to all VA-approved CRC facilities, rather than delegating this task to the CM. The CRC Program Coordinator position should be a full-time appointment in accordance with VHA Handbook 1140.01.

Recommendation to VISN 22

1. The VISN Geriatrics and Extended Care Lead should conduct an independent review of all VA-approved CRC facilities, including reviewing all relevant CDSS inspection reports.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that Los Angeles may have violated law, rule, or regulation; engaged in gross mismanagement, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel has provided a legal review, VHA Human Resources has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VA and VHA policy, and note that a substantial and specific danger to public health and safety exists in some Los Angeles-approved CRC facilities.

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I. Introduction

The Executive in Charge of the Office of the Under Secretary for Health requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the VA Greater Los Angeles Healthcare System (Los Angeles) in Los Angeles, California. The whistleblowers, who chose to remain anonymous, alleged that employees are engaging in conduct that may constitute violations of law, rule, or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. VA conducted a site visit to Los Angeles on February 8–11, 2018.

II. Facility Profile

Los Angeles is the largest health care system within VA. It is one component of the VA Desert Pacific Healthcare Network (Veterans Integrated Service Network, or VISN, 22) offering services to Veterans residing in Southern California and Southern Nevada. Los Angeles consists of 3 ambulatory care centers, a tertiary care facility, and 10 community based outpatient clinics. It serves 1.4 million Veterans residing throughout five counties: Los Angeles, Ventura, Kern, Santa Barbara, and San Luis Obispo. It is affiliated with the David Geffen School of Medicine at UCLA and the University of Southern California School of Medicine, as well as more than 45 colleges, universities and vocational schools in 17 different medical, nursing, paramedical, and administrative programs. There are 33 VA-approved Community Residential Care (CRC) facilities in the Greater Los Angeles area.

III. Specific Allegations of the Whistleblowers

1. *West LA officials failed to investigate and remediate serious patient care concerns at a number of approved Community Residential Care Facilities, in violation of state regulations and agency policy;*

2. *West LA officials failed to take action in response to reports that a management official engaged in improper relationships with VA patients in violation of state licensing requirements and agency policy;*

3. *West LA medical support assistants (MSAs) inappropriately accessed patient records in violation of federal law and agency policy; and*

4. *These actions resulted in compromised patient care, including patient neglect.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of [redacted], M.D., Medical Inspector (an internist), [redacted], RN, MS, Clinical Program Manager, both of OMI, and [redacted] Licensed Clinical Social Worker (LCSW), Acting National Program Manager, Medical Foster Home/Community Residential Care. We reviewed relevant policies, procedures, professional standards, reports, memoranda, and other documents listed in Attachment A, and toured two CRC facilities in Van Nuys and Sunland, California. We held entrance and exit briefings with the following officials:

- [redacted], Healthcare System Director
- [redacted], M.D., Chief of Staff (CoS)
- [redacted] Associate Director, Patient Care Services (ADPCS)/Nurse Executive (NE)
- [redacted] Associate Director
- [redacted] Acting Assistant Director
- [redacted] M.D., Deputy CoS
- [redacted] Deputy NE
- [redacted] Deputy NE
- [redacted] Chief, Quality Management (QM)
- [redacted] Chief, Social Work (SW)
- [redacted] Acting Risk Manager
- [redacted] Quality Management Officer, VISN 22
- [redacted] Pharmacy Executive, VISN 22
- [redacted] Health Service Specialist (HSS) for ADPCS/NE

We were unable to interview the whistleblowers as they chose to remain anonymous. We also interviewed the following employees in person or by phone:

- [redacted] RN, Former Program Coordinator, CRC
- [redacted] LCSW, Acting Program Coordinator, CRC
- [redacted] M.D., VISN 22 Mental Health (MH) Lead
- [redacted] RN, ADPCS
- [redacted] Credentialing and Privileging
- [redacted] Nurse Practitioner (NP), Home Based Primary Care (HBPC)
- [redacted] Program Support Assistant (PSA) HBPC
- [redacted] Former Program Specialist, HBPC
- [redacted] RN, Nurse Manger, CRC
- [redacted] M.D., Medical Director, MH Intensive Care Management (MHICM)
- [redacted] M.D., Psychiatry
- [redacted] MSW, Chief, SW
- [redacted] RN, Case Manager (CM), CRC
- [redacted] M.D., Primary Care (PC)

- [redacted], MSW, Associate Chief, SW
- [redacted] LCSW, Adult Day Care Director
- [redacted] RN, VISN Geriatrics and Extended Care (GEC) Lead
- [redacted] LCSW, CM, Board and Care
- [redacted] RN, CM, CRC
- [redacted] LCSW, CM, CRC

VI. Findings, Conclusions, and Recommendations

Allegation 1

West LA officials failed to investigate and remediate serious patient care concerns at a number of approved Community Care Residential Facilities, in violation of state regulations and agency policy.

Background

Section 1730 of Title 38, Code of Federal Regulations (C.F.R.), authorizes VA to refer eligible Veterans for placement in a VA-approved CRC facility and to assist them in obtaining such placement. This law makes clear that payment for CRC charges are the responsibility of the individual, not that of the United States Government or VA.

A CRC may not be approved unless the Secretary determines it meets VA standards established in regulations codified at 38 C.F.R. §§ 17.61 *et seq.* Section 1730 requires these regulations to address: health and safety criteria, including a requirement of compliance with applicable state laws and local ordinances relating to health and safety; a requirement that the costs charged by the facility be reasonable (based on a number of specified factors); criteria for determining the resources that a facility needs, in order to provide an appropriate level of care to Veterans; and other criteria that VA has determined are needed to protect the welfare of Veterans placed in these facilities. That section further requires that VA regulations set forth not only the procedures related to approval and inspections, but also those related to notice of noncompliance, due process (for noncompliant facilities), and approval revocation.

As briefly alluded to above, VA conducts periodic inspections of VA-approved CRC facilities to ensure their continued compliance with VA's regulatory standards. Those found to be noncompliant receive written notice of which standards have not been met, the date by which they must be met to avoid revocation of VA approval, and their right to request a hearing before VA approval is revoked. In the event that approval is revoked, VA will cease referring Veterans to the facility, and may, with the permission of either the Veteran(s) or the person(s) or entity(ies) authorized by law to give permission on their behalf, assist in removing the Veteran(s) from the facility.

The State of California also has regulations regarding the licensing of residential care facilities for the elderly outlined in Chapter 8 of Title 22 of the California Code of Regulations.

Supplemental Security Income (SSI) and State Supplementary Payment (SSP) programs provide a guaranteed monthly income to single persons and couples aged 65 years and older, blind or disabled, with limited income and resources. In California, the combined rate for a single person is $1,173.37, of which $750 is SSI, and $423.37 is SSP[1]. California also sets a limit on how much individuals on SSI can be charged for nonmedical out-of-home care (NMOHC), which is $1,039.37 per month[2]. Facilities providing NMOHC and accepting SSI/SSP as payment must provide room, board, personal nonmedical care, and supervision of the individual[3].

Veterans Health Administration (VHA) Handbook 1140.01 outlines procedures for conducting the CRC program and establishes responsibility for oversight of VA-approved CRC facilities[4]. It defines CRC as follows:

> VA's Community Residential Care (CRC) is a form of enriched and supportive housing which provides health care supervision to eligible Veterans not in need of hospital or nursing home care, but who, because of medical, psychiatric and/or psychosocial limitations, are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. Examples of enriched housing may include, but are not limited to: Medical Foster Homes, Assisted Living Homes, Group Living Homes, Family Care Homes, and psychiatric CRC Homes. Care must consist of room, board, assistance with activities of daily living (ADLs), and supervision, as determined, on an individual basis. The cost of residential care is financed by the Veteran's own resources. Placement is made in residential settings inspected and approved by the appropriate VA facility, but chosen by the Veteran.

The CRC Program Coordinator is responsible for overall program development, management, operations, and participation in the evaluation of the CRC program in an interdisciplinary inspection team that must include a social worker, nurse, dietician, and a fire and safety specialist. The team must conduct inspections at least annually. Facilities that apply for participation in the VA CRC program must accept conditions of participation, including periodic inspection, but are not obligated to correct deficiencies. VA can remove noncompliant facilities from the approved list, and must stop referring Veterans to them. Because these facilities are not nursing homes, they have no licensed nurses, and therefore, medication administration is the responsibility of the Veteran: any necessary assistance with self-medication is provided by specially-trained technicians.

Findings

Although we received specific concerns related to only two VA-approved CRC facilities, California Villa and Sunland Manor, we reviewed the California Department of Social

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[1] https://www.ssa.gov/pubs/EN-05-11125.pdf.
[2] California Code of Regulations, Title 22, section 87464(e).
[3] http://www.cdss.ca.gov/shd/res/htm/13EAS.htm 46-140-Nonmedical Out of Home Care.
[4] VHA Handbook 1140.01, *Community Residential Care Program*, February 10, 2014.

Services (CDSS) Facility Visit Detail report to find facilities with a high number of complaints or visits for the calendar years (CY) 2014 to the present[5]. California Villa had the highest number of complaints (150 total, 70 substantiated) of the other 32 facilities reviewed, Sunland Manor had 10 (4 substantiated), over the same time. California Villa is a large facility, with approximately 120 beds, but other similar-sized facilities had fewer than one third as many complaints as it did. We toured both California Villa and Sunland Manor on unannounced visits, and found the California Villa facility to be in disrepair, and the medication room disorganized. Sunland Manor appeared to be the same age, but showed clear efforts to improve and upgrade the facility; the medication room and medication management system included appropriate documentation and medication-control processes[6]. We found the facility to be in fair shape. The administrator showed us the room upgrades he was making as money became available, including new flooring and furniture. We also witnessed residents requesting and receiving food from the kitchen well after meal hours.

Both California Villa and Sunland Manor accept SSI for NMOHC. Eleven of 32 VA-approved CRC facilities in the Greater Los Angeles area, as of February 5, 2018, accepted SSI as full payment. The average rent in the Los Angeles area for a studio apartment is approximately $1,604 per month[7]. The alternative to these facilities for Veterans on only SSI/SSP is either a shared apartment or homelessness.

We received concerns about six different Veterans who lived, before and/or at the time of, our site visit, at California Villa. Although we did not have specific names, we were able to discover four of their identities from interviewees and reviewing records in the Veterans Information Systems and Technology Architecture (VistA). We also reviewed all adverse event reports from CY 2015 to the present, and found three of the same Veterans in them. The first was a [redacted] year-old Veteran, admitted to a local hospital from [redacted], 2017, with a diagnosis of sepsis, and received intravenous antibiotics during the admission. He was discharged to California Villa with orders for two different oral antibiotics, Keflex and Clindamycin. He did not get the medications, however, as they were "not covered by Medicare." On [redacted] the Veteran was rehospitalized for the same condition. According to the Veteran's provider, the CRC assumed that Los Angeles would know about the medications and provide them, but had never contacted Los Angeles to check, even though it had the required physician's order from the hospital.

Another physician expressed similar concerns about medication management at California Villa. She visited the facility one evening to speak with the evening medication technician, after hearing from her patient many times that he had not gotten his evening medications. She asked to see his medications, and found that two she

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[5] https://secure.dss.ca.gov/CareFacilitySearch/FacDetail/191204117.

[6] During the site visit to Sunland Manor, we questioned the administrator about accepting patients with severe depression and suicidality. He indicated that they had an incident where one of their residents committed suicide on the grounds, and since that time, they will not accept residents with these types of conditions. Additionally, he indicated that they also do not accept residents from drug rehabilitation, as this potentially introduces a source of illicit drug use in the facility.

[7] https://www.rentcafe.com/average-rent-market-trends/us/ca/los-angeles/.

had discontinued 2 months before were still being administered. The two medications were identical, but the updated list included an increased dose, and a discontinuation of the lower dose. This change had not been implemented, and the Veteran received nearly twice the intended dosage for more than a week. He reported symptoms of lightheadedness, a side effect of this medication and an indication of potential overdose. This same error happened 4 months later, when he continued to get discontinued medications. The physician discontinued a medication and had the CM fax the new medication list to the facility (receipt of which California Villa confirmed), but when she visited the following week, the Veteran was still receiving the discontinued medication and the new medication list was not with his medications. CRC staff indicated that they couldn't locate the new order list.

We learned that California Villa was charging a current resident 5 dollars for every meal, in addition to his normal monthly fees, and that it was not providing his medications. We reviewed his record and found that the CM had visited the Veteran on February 14, 2018, and discovered that he had indeed been charged that, but the reason for this request was to eat in his room rather than go downstairs for meals, requiring staff to bring his meals to his room. As a result of the CM's visit, California Villa staff told the Veteran they would assist him downstairs for meals, and he decided that he would go to the dining room to eat instead of incurring the additional charges. The CM had also seen this Veteran the day before and had documented an extensive assessment that gave no indication of anyone withholding medications.

We found evidence of VA CRC program staff inspecting VA-approved CRC facilities and taking action in response to identified concerns. Interviewees indicated that they had a good working relationship with the state licensing board, and frequently reported concerns to them. We found evidence of timely licensing board complaint investigations in response to their concerns. We also found evidence of the CRC program ceasing to refer Veterans to facilities for various reasons, including care concerns. These actions stop any new referrals to the VA-approved facility until the concerns are appropriately resolved. Notably, Los Angeles ceased referring Veterans to California Villa m during our site visit for care concerns and continued noncompliance with recommendations. We questioned VA CRC program staff about how either periodic inspections or hold actions are communicated to higher level leadership; none could provide a clear answer. We interviewed the GEC Lead at the VISN who indicated that she only sees information related to community nursing homes (CNH) and the MHICM programs; VA, and not the Veteran, pays for both of these services.

We found continued concerns about California Villa and other VA-approved CRC facilities' administration and documentation of Veteran-resident prescriptions. Veterans living in CRC facilities are screened to ensure that they are competent to administer medications to themselves; however, due to concerns over their ability to understand and maintain medications in their rooms, CRCs collect all medications and store them in a medication room. Staff, trained under California-approved programs, retrieve Veteran-residents' medications from the secured room and provide them to each Veteran. There is no requirement for the facility to document these self-administered

medications except when the Veteran refuses to take one. For residents judged to be incapable of determining their needs for nonprescription, as-needed medications, such as over-the-counter pain medications, but able to communicate their symptoms clearly, the staff is required to document in the resident's record the date and time of each dose provided and the resident's responses[8]. For prescribed medications, the CRC must maintain both the medication and the provider's orders together; it is also a California best practice for CRC facilities to keep abreast of when medications are running out so that the Veteran-resident or CRC facility's medication technician can request refills[9]. When requested by either the prescribing physician or the CDSS, a record of dosages of centrally stored medications shall be maintained by the facility[10]. In addition, centrally-stored medicines are to be kept in a safe and locked place that is not accessible to persons other than employees responsible for the supervision of them[11]. As a detailed written order and label is required to be in place for each prescription and nonprescription medication given to a resident; related program medication guidance recommends that each CRC facility have a procedure in place to alert staff of any changes to medication orders[12].

Relevant California law also requires training for individuals assisting with medication self-administration[13]. It provides expressly that, "Nothing in this section authorizes unlicensed personnel to directly administer medications[14]." Both the California Board of Registered Nursing and the Vocational Nursing Practice Act identify administration of medication in the scope of practice for these disciplines.

In order to improve medication management by VA-approved CRC facilities, CRC program staff provided both guidance and training on what they described as best practices. We analyzed this guidance and training (that VA-approved CRC facilities are under no obligation to follow) and found that it included a recommendation that the medication technician at each should maintain a medication administration record documenting Veterans' taking their medications. As indicated earlier, this level of documentation is generally not required, except to document the provision of as-needed over-the-counter medications when administered to certain residents[15]. The use of such a record could potentially put at risk both the medication technician and the CRC facility, due to legal prohibitions against unlicensed personnel directly administering medications. Such a practice might also result in potential violations relative to both the Vocational Nursing Practice Act and the California Board of Registered Nursing. As indicated earlier, medication-trained personnel at the CRC facilities can *assist* Veteran-residents in taking their own medications. They are responsible for managing centrally-stored medications, but prohibited from *administering* them.

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[8] 22 California Code of Regulations (CCR) § 87465(c).
[9] http://ccld.ca.gov/res/pdf/MedicationsGuide.pdf.
[10] 22 CCR § 87465(a)(7).
[11] 22 CCR § 87465(h)(2).
[12] 22 CCR § 78465(e) and http://ccld.ca.gov/res/pdf/MedicationsGuide.pdf.
[13] Cal Health & Saf Code § 1569.69.
[14] Cal Health & Saf Code § 1569.69(h).
[15] 22 CCF § 87465 and 22 CCF § 87465(c)(3).

We also investigated the existence of a two-page note on a Veteran, indicating that a face-to-face visit had occurred at California Villa 2 days after he had died. On [redacted], 2017, the provider entered a note indicating that the Veteran died on [redacted] and an addendum of [redacted] stated that a report of death notification was sent to the appropriate agency. We found an [redacted] note by the CM describing a visit to this Veteran on that day. In a follow-up telephone encounter note of [redacted], the CM documented that she had been informed by a California Villa administrator that the Veteran had died [redacted] (this date is incorrect; he had died on [redacted]). In the note, she indicates that when she visited the facility on [redacted], she asked the staff to direct her to the Veteran. The staff confirmed that the resident identified was the Veteran in question. He was on the locked ward reserved for residents with Alzheimer's disease and dementia, and those at risk for wandering. She interviewed the resident, and assessed him as "usually confused." The staff had identified and confirmed the wrong resident as the Veteran. An addendum to the assessment note of [redacted], written [redacted], states: "Please delete, wrong Veteran." We are concerned that California Villa staff members were unable to properly identify a resident, particularly on a locked ward: this calls into question whether residents receive their correct medications.

Conclusion for Allegation 1

- We **partially substantiate** that Los Angeles officials failed to investigate and remediate serious residential care concerns at California Villa, a VA-approved CRC facility, in violation of state regulations and VA policy. Although there are residential care concerns in at least one VA-approved CRC facility (California Villa), there are limited actions available to remedy these concerns. Additionally, these CRC facilities do not deliver direct care, with the exception of assisting Veteran-residents with the storage and self-administration of their medications. VA providers responsible for the clinical management of Veterans through traditional outpatient care and, if enrolled/qualified, HBPC, who reside in these CRC facilities, may be under the false/erroneous impression that there is more medical capability on site than exists or is required by law. The VA CRC program staff notified the appropriate state agencies and stopped referring Veterans to California Villa pending other action. However, there are longstanding and well-known residential care issues with this facility and there is no evidence that these concerns were elevated to Los Angeles leadership or VISN 22 by the CRC Program Coordinator.

Recommendations to Los Angeles

1. Subject to VA's compliance with, and exhaustion of, the due process procedures available to the facility, including expedited procedures imposed when identified deficiencies pose a danger to life or safety of residents, and an outcome that supports revocation of VA approval, notify the Veterans residing in California Villa, or their legal representatives, of the suspension of VA approval of the facility, and request permission to assist in their removal from the facility. Ensure that Veterans

who elect to remain at California Villa, are aligned with other VHA programs such as HBPC or MHICM, for which they are eligible.

2. Update Standard Operating Procedure 11-116A-10H5-31, *Community Care: Community Residential Care (CRC) Placements*, to include a mechanism to report inspection results of VA-approved CRC facilities to Los Angeles leadership through an existing standing committee, and include these discussions in formal meeting minutes on a monthly basis.

3. Provide training to VA providers regarding the medication management capabilities and limitations of CRC facilities.

4. Engage with CDSS investigations for recommendations related to medication management and share this with the VA-approved CRC facilities. Do not continue to recommend practices that place CRC facility staff at risk of violating the various state nurse practice acts.

5. With the permission of the Veterans (or their legal representatives), assist in the prompt transfer of Veterans who reside on the locked ward at California Villa and suffer from dementia or other similar conditions requiring hospital or nursing home care to such sites of care (either within or outside the VA system), as appropriately determined under the facts of each case. While these Veterans remain eligible for home care from VA, even if the facility's VA-approval is revoked, we note that California law prohibits admission or retention of any resident in a residential care facility for the elderly if, among other things, the resident requires 24-hour, skilled nursing or intermediate care[16]. If these Veterans require nursing home care, action should be taken by VA to provide it.

Allegation 2

West LA officials failed to take action in response to reports that a management official engaged in improper relationships with VA patients in violation of state licensing requirements and agency policy.

Background

The California Board of Behavioral Science establishes regulations related to the practice of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, and Clinical Social work in accordance with state statutes. Unprofessional conduct is described in detail, and in the context of improper relationships, the regulations state that unprofessional conduct includes,"...sexual relations with a client, or who solicits sexual relations with a client, or who commits an act of sexual abuse, or who commits an act of sexual misconduct, or who commits an act punishable as a

[16] Cal Health & Saf Code § 1569.72(a).

sexual related crime if such act or solicitation is substantially related to the qualifications, functions or duties of an LCSW[17]."

Findings

We asked interviewees whether they had ever witnessed, or heard of management officials engaging in improper relationships with VA patients; only one responded in the affirmative. That interviewee volunteered information about another staff member's short relationship in 1998 with a fellow employee who was a Veteran and was neither a client nor in the same reporting chain. We reviewed this identified staff member's personnel records, state license report, and credentialing files, and found no adverse events. As a relationship between individuals not in a supervisor/subordinate relationship or a provider/client relationship is not a violation of policy, practice, or law, we found no areas of concern.

Conclusion for Allegation 2

- We **do not substantiate** that Los Angeles officials failed to take action in response to reports that a management official engaged in improper relationships with VA patients in violation of state licensing requirements and agency policy.

Recommendation to the Los Angeles

None.

Allegation 3

West LA medical support assistants (MSAs) inappropriately accessed patient records in violation of federal law and agency policy.

Background

VHA Handbook 1605.02 provides mandatory guidelines for the use and disclosure of patient's protected health information (PHI)[18]. It explains that VHA constitutes a covered entity, and, as such, is required to implement the "minimum necessary standard." This standard requires covered entities to establish policies to limit the use or disclosure of PHI to the minimum amount necessary. To accomplish the goal of limiting the use of PHI, the Handbook divides employees into functional categories, each with an appropriate level of minimum access.

Each position in Los Angeles has a position description relative to the position's duties and responsibilities. A PSA for the VA CRC program falls under the supervision of the Non-Institutional Care Administrative Officer, and is tasked to, "Obtain patient medical records from outside hospitals and other facilities. Manage HBPC severity list that

[17] http://www.bbs.ca.gov/pdf/publications/lawsregs.pdf Article 6, Section 1881.
[18] VHA Handbook 1605.02, *Minimum Necessary Standard for Protected Health Information*, January 23, 2013.

contains patient information, demographics, and risk category information." Additionally, the person: "Track[s] and process[es] all Home Health certification, plan of care and other physician orders from home health agencies and direct[s] the orders to the proper attending/primary care physician for signature." Finally, the PSA: "Protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, VA statutes and policy, and VHA policy."

The Sensitive Patient Access Report (SPAR) documents users' access to the electronic health record (EHR) of a sensitized patient record. A record is flagged as "sensitive" when a Veteran patient requests this status, is involved in a high profile incident, is a VA employee, or may have a health concern considered sensitive by the facility's leadership. Before a user can enter a sensitive record, he or she encounters a warning that the record is sensitive and that access to it is tracked, and he or she must be able to prove a need to know this information. The user must acknowledge this warning before accessing that record. The SPAR provides a definitive list of users who have accessed a sensitive record, as well as the software path through which they did so.

We defined impermissible access as falling into one of the following three subcategories:

- **Mistaken access**: The user mistakenly accessed the patient's EHR, while attempting to access another Veteran's record. In this instance, the second patient's last name or identifying information (the first letter of the last name along with the last four digits of the social security number) was identical or very similar to that of the other patient. Although we believe this subcategory of error to be an honest one, the employee did not have an official reason to be in the patient's record, and therefore, the access was impermissible.

- **Access for no apparent reason**: We were unable to find any documentation in the EHR or consistent testimony supporting the need for access. Without evidence of an official reason for access, we concluded that the minimum necessary standard was not met and access was impermissible.

- **Access for an unauthorized reason**: We found evidence that access was not permitted under the Privacy Act or the HIPAA Privacy Rule, and that there was no need to know in the performance of official job duties; therefore, the access was impermissible.

Findings

Staff we interviewed could not recall an instance of an MSA or PSA inappropriately accessing a record, or any reports of contact submitted for inappropriately accessing a record. We reviewed the SPAR reports from 2015 to present and could find no accesses by the individuals alleged to have violated policy. One interviewee indicated that a PSA (not an MSA) made a notation in a chart that they characterized as a "co-

signature" by the PSA, and questioned whether this was appropriate, both to us and in the record.

In the Computerized Patient Record System (a component of VistA), upon completion of a note, the writer can choose to "Identify Additional Signers," which is used as a communication tool between team members. When selected, the writer must choose who will receive the note for signature, and after selecting the individual, an alert is sent to that additional signer. This additional signer is not the same as a co-signer; co-signature implies either shared responsibility, or a supervisor/subordinate relationship such as an instructor/student. Only the original writer of the note can request additional signers.

We reviewed the chart and found the PSA's signature at the bottom of the note with a signature date of January 26, 2018, at 3:35 p.m. The signature was a receipt acknowledgement, not a co-signature (which would have been inappropriate), meaning that the writer requested acknowledgement of the note from the additional signer. In this specific example, the request included the PSA, the nurse CM, and the provider. Comparing this to the PSA's position description duties outlined in "Background," the note followed procedure as the PSA's duties include sending notes to the provider for review and signature, who signed the note on January 29, 2018, at 8:37 a.m. As the PSA had a need to know and appropriate training, we do not find any impermissible access. The fact that the only person who could have requested additional signatures was the original note writer, who claimed this was inappropriate access, we do not find any violation.

Conclusion for Allegation 3

- We **do not substantiate** that Los Angeles MSAs inappropriately accessed patient records in violation of federal law and agency policy.

Recommendation to Los Angeles

None.

Allegation 4

These actions resulted in compromised patient care, including patient neglect.

Findings

Because of the partial substantiation of Allegation 1, we do find that there were actions that resulted in compromised patient care. Los Angeles took actions, albeit at the level of the CRC Program Manager, but these actions failed to reach the level of either Los Angeles or VISN leadership. Contributing to the concerns are the long-standing reported issues with California Villa, including issues with medication management. There is a disconnect between VA CRC program staff's expectations of medication

administration by California Villa and potentially other CRC facilities, that is discordant with state law. We believe that VA providers and CMs involved with Veterans living at VA-approved CRC facilities tend to see such facilities as nursing home variants rather than as board and care facilities.

We also recognize the extreme difficulty of providing low-cost board and care for Veterans who have limited or no support and would otherwise be homeless in the absence of CRC facilities such as California Villa. Nevertheless, VA approval of a CRC facility means that the Secretary of Veterans Affairs has approved, and continues to approve, that facility for participation in VA's CRC program. A facility that continuously fails to meet state standards and displays disregard of these standards, as evidenced by repeat citations, should not be on the VA-approved CRC list.

We found a disparity in oversight by leadership at both Los Angeles and VISN 22, of the CRC and other similar programs. VA does not fund the CRC program, whereas it does fund the MHICM, HBPC, and CNH programs. This difference has contributed to a different level of oversight of these various programs to the detriment of the CRC program. Veterans residing in VA-approved CRC facilities are extremely vulnerable. In addition, CRC facilities that are not compliant with all of the requisite VA standards are free to opt out of the program rather than correct identified deficiencies. As such, the threshold for revoking VA approval should be low, recognizing that there is due process available to the CRC facility regarding its revocation, which provides a check on VA. In particular, we are very concerned about Veterans residing at California Villa in the locked ward. The lack of appropriate activities and interventions, evidence of poor medication management practices, and the fact that staff were unable to differentiate between two residents, calls into question the safety of these extremely vulnerable Veterans. Regardless of the frequency of visits by CM staff, there are other options available for these Veterans because of the higher level of their clinical needs.

Conclusion for Allegation 4

- We **substantiate** that there were VA-approved CRC facilities wherein the delivery of residential care to Veterans was compromised. VA-approved CRC facilities should maintain the highest VA and state standards available. Despite efforts to provide CM oversight by nurses and social workers, they have little influence and control over the conditions at a CRC facility and can only report incidents of non-compliance to the referring facility or state. Los Angeles should review the clinical status of Veterans residing in the locked ward at California Villa and assist with placement and transfer to appropriate levels of inpatient care as indicated by their medical conditions.

- Importantly, expedited due process procedures exist for cases where it has been determined that noncompliance threatens the lives of residents. Where the outcome of this process supports revocation of VA approval, such action needs to be taken promptly; frequently, the CRC facility will simply not appeal and revocation will thus occur expeditiously. Despite efforts of VA nurses and social workers to provide CM

oversight, they have little influence or control over the conditions at a CRC facility and can only report incidents of noncompliance to the facility or state, while VA moves to revoke its approval.

- Los Angeles should review the Veterans who reside in the locked ward at California Villa and who suffer from dementia or a similar condition to determine whether they now require hospital or nursing home care. Where such care is clinically indicated based on the residents' current medical status, Los Angeles should assist in their prompt placement and transfer to such sites of care, using whichever benefits the Veterans or their representatives elect to use to obtain such care. These Veteran-residents no longer qualify for placement in a facility that only provides board and care.

Recommendation to Los Angeles

6. The CRC Program Coordinator should conduct monthly site visits to all VA-approved CRC facilities, rather than delegating this task to CMs. The CRC Program Coordinator position should be a full-time appointment in accordance with VHA Handbook 1140.01.

Recommendation to VISN 22

1. The VISN GEC Lead should conduct an independent review of all VA-approved CRC facilities, including by reviewing all relevant CDSS inspection reports.

VI. Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that Los Angeles may have violated law, rule or regulation, engaged in gross mismanagement, an abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel has provided a legal review, VHA Human Resources has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VA and VHA policy, and note that a substantial and specific danger to public health and safety exists in some Los Angeles-approved CRC facilities.

Attachment A

Documents in addition to the Electronic Medical Records reviewed.

Privacy Act of 1974, 5 United States Code Section 552a.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 C.F.R. Parts 160 and 164.

VHA Handbook 1605.02, *Minimum Necessary Standard for Protected Health Information*, January 23, 2013.

VHA Handbook 1140.01, *Community Residential Care Program*, February 10, 2014.

California Department of Social Services, *Community Care Licensing Division Mediations Guide: Residential Care Facilities for the Elderly* TSP-2016-03 (9/30/2016).

Los Angeles Healthcare System, Standard Operating Procedure 11-116A-10H5-31, *Community Care: Community Residential Care (CRC) Placements.*

California Health and Safety Code – HSC Division 2. Licensing Provisions [1200 - 1797.8] (Division 2 enacted by Stats. 1939, Ch. 60.) Chapter 3.2. Residential Care Facilities for the Elderly [1569 - 1569.889] http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1569.69.

California Nursing Practice Act, California Board of Nursing www.rn.ca.gov.

California Vocational Nursing Practice Act, Board of Vocational Nursing www.bvnpt.ca.gov.

California state licensing reports from 2013 to present.

Annual VA Inspection reports for CRC facilities from 2015-present.

Action plans for CRC approved facilities from 2015 to present.

Monthly CRC visit reports by VA staff 2017 to present.

Adverse and Sentinel Events related to CRC from 2015 to present.

Greater Los Angeles Medical Center Standard Operating Procedure 11-116A-10H5-31, *Community Care: Community Residential Care (CRC) Placements*, March, 2013.

Sensitive Patient Access Reports (SPAR) from 2015 to present.