THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 24, 2013

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-12-4027

Dear Ms. Lerner:

I am responding to your letter regarding allegations of misconduct made by a whistleblower at the Department of Veterans Affairs Caribbean Healthcare System, Community Living Center, in San Juan, Puerto Rico. You asked me to investigate the whistleblower's allegations and identify any conduct that constituted a violation of law, rule or regulation, gross management, or a substantial and specific danger to public health.

I asked the Under Secretary for Health to review this matter and conduct an investigation for purposes of providing your office a report as required under 5 United States Code § 1213(c) and (d). He, in turn, referred the matter to the Veterans Health Administration's Office of the Deputy Under Secretary for Health for Operations and Management.

The investigation substantiated one of the two allegations related to standards of nursing care. Based on the findings, a number of recommendations were also made. The enclosed final report and action plan is submitted for your review.

I have reviewed the report and concur with the findings, conclusions, and recommendations. Thank you for the opportunity to respond to this issue.

Sincerely,

Eric K. Shinseki

Enclosures

# OFFICE OF GERIATRICS AND EXTENDED CARE OPERATIONS

Report to the

Office of Special Counsel

OSC File Number DI-12-4027

Department of Veterans Affairs

VA Caribbean Healthcare System

San Juan, Puerto Rico

Veterans Health Administration

Washington, DC

Report Date: March 21, 2013

## Executive Summary

The Under Secretary for Health requested that the Office of Geriatrics and Extended Care Operations (GEC) investigate complaints submitted to the Office of Special Counsel (OSC) by a whistleblower (a former nursing assistant) at the Department of Veterans Affairs (VA) Caribbean Healthcare System, Community Living Center (CLC), in San Juan, Puerto Rico, hereafter, the Medical Center. The whistleblower alleged that the CLC is engaging in conduct that may constitute violations of law, rule or regulation, gross mismanagement, and substantial and specific danger to public health. In brief, the allegations were:

- Nursing staff at the CLC neglected the elderly residents at the facility by failing to assist with essential activities of daily living.
- Nursing staff failed to record and report adverse events, namely patient falls, as required.

**Conclusions**

- The Veterans Health Administration (VHA) team substantiated the allegation of nursing staff at the CLC neglecting the elderly residents at the facility by failing to assist with essential activities of daily living.
- The CLC has 120 operating beds and consists of CLC 1, CLC 2, and CLC 3. CLC 1 is located on the first floor within the main Medical Center building and CLC 2 is located on the second floor of the main Medical Center building. San Sebastian (CLC 3) is located in a separate section of the Medical Center.
    - There are numerous resident care issues on CLC 2 including the nursing staff failing to provide residents the required assistance with essential activities of daily living, such as bathing, toileting, eating and drinking.
    - No significant resident care issues were identified on CLC 1 and 3.
- The neglect of the residents at the CLC 2 poses a serious and significant issue. The neglect of residents at the facility amounts to violations of the following: 38 Code of Federal Regulations (C.F.R.) 17.33 - Patient's Rights, VHA Handbook 1142.01 *Criteria and Standards for VA Community Living Centers (CLC)*, and of Memorandum No. 00-08-43, *Identification and Reporting of Possible Victims of Abuse/Neglect and Exploitation Cases*, VA Caribbean Healthcare System, January 2008.
- The Medical Center took immediate actions to address the allegations substantiated by the VHA review team.
- The fall rate at the CLC was found higher than the Veterans Integrated Service Network (VISN) and VHA comparisons.
- The VHA team did not substantiate the allegation that the CLC failed to record and report adverse events, namely patient falls, as required.

**Recommendations**

**The Medical Center should:**

1. Not tolerate any substantiated resident abuse and/or neglect.
2. Take resident and/or family complaints of care issues seriously, and take immediate and appropriate action.
3. Investigate any occurrences of failure to report resident and/or family complaints, and take appropriate action.
4. Implement a plan to observe direct care staff to ensure each resident is provided assistance with assigned care and activities of daily living as needed.
5. Implement a plan to ensure ongoing education, competency validation and observation of direct care staff.
6. Take any additional appropriate actions with regards to the neglect of the CLC 2 residents, based on internal reviews and recommendations.
7. Take appropriate actions as necessary, based on recommendations of the Administrative Investigative Board findings.
8. Ensure the Quality Improvement Committee evaluates each resident with documented weight change on the form CMS-802 to determine each resident's nutritional needs.
9. Continue carrying out the action plans identified through the Falls Prevention Collaborative.
10. Monitor status of progress to the Performance Improvement Committee and provide updates to leadership until resolution of corrective actions is reached and improved performance is evident.

**Summary Statement**

The VHA team substantiated one of the whistleblower's allegations, and agrees that these are significant issues that must be corrected. The investigation found that the standard of nursing care was not met and this constituted a violation of law, rule, or regulation. However, the investigation did not find that the CLC's actions constituted gross financial mismanagement, or a substantial and specific danger to public health.

## I. Summary

The Under Secretary for Health requested GEC investigate complaints submitted to OSC by a whistleblower (a former nursing assistant) at the VA Caribbean Healthcare System, CLC, in San Juan, Puerto Rico, hereafter, the Medical Center. The whistleblower alleged that the CLC was engaging in conduct that may constitute violations of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public health. In brief, the allegations were:

- Nursing staff at the CLC neglected the elderly residents at the facility by failing to assist with essential activities of daily living.
- Nursing staff failed to record and report adverse events, namely patient falls, as required.

## II. Facility Profile

The VA Caribbean Healthcare System consists of the main Medical Center located in San Juan, Puerto Rico, with satellite clinics located in Ponce, the southern part of the Island, and Mayagüez, the western coast. There are Community-Based Outpatient Clinics (CBOC) in St. Thomas and St. Croix (U.S. Virgin Islands), Arecibo (northwest Puerto Rico), and Guayama (southeast Puerto Rico). The Medical Center includes multi-disciplinary ambulatory facilities, 348 authorized hospital beds, 12 blind rehabilitation beds and 120 CLC Beds. The VA Caribbean Healthcare System is part of VISN 8.

CLC 1 consists of three hallways (staff refers to the hallways as neighborhoods) where staff provides skilled care, rehabilitation, respite, and care for residents with spinal cord injury; one hallway within CLC 1 continues to be closed due to renovation. CLC 1 has a capacity for 42 residents; at the time of the visit there was a census of 29. CLC 2 also consists of three hallways where staff provides long-term, skilled care and rehabilitation services for the residents. CLC 2 has a capacity for 60 residents; at the time of the visit the census was 56. San Sebastian (CLC 3) provides hospice/palliative care and has a capacity for 29 residents. To afford each resident a private room, the staff attempts to limit the census to 20; the census at the time of the visit was 19.

## III. Summary of the VHA Review

A VHA team consisting of (b) (6) RN, MS, Chief, Facility Based Programs, GEC, (b) (6), M.D., Medical Investigator, Office of the Medical Inspector, (b) (6) MSN, RN, VISN 2 GEC Care Line Director, and (b) (6) MSW, VISN 3 GEC Coordinator, conducted the site visit. The team toured all three CLC areas, interviewed individuals, and reviewed policies, procedures, and reports related to the care of residents who reside there. A full list of the documents reviewed by the VHA team is in Attachment A. The team held an entrance and exit briefing with Medical Center leadership including:

Entrance Briefing:

- (b) (6) RN, Acting Associate Chief Nurse for CLC
- (b) (6) M.D., CLC Medical Director
- (b) (6) RN, Deputy Associate Director for Patient Care Services
- (b) (6) M.D., Acting Chief of Staff (ACOS), GEC
- (b) (6) M.D., Chief Operating Officer/Chief of Staff (COS)
- (b) (6) Deputy COS
- (b) (6) RN, Associate Director for Patient Care Services
- (b) (6) Director, Tennessee Valley Healthcare System
- (b) (6) Acting Medical Center Director
- (b) (6) Associate Director

Exit Briefing:

- (b) (6) M.D., CLC Medical Director
- RN, Deputy Associate Director for Patient Care Services
- (b) (6) M.D., ACOS, GEC
- N, Associate Director for Patient Care Services
- Acting Medical Center Director
- M.D., COS
- (b) (6) M.D., VISN 8 GEC (via telephone)
- (b) (6) M.D., VISN 8 Chief Medical Officer (via telephone)
- (b) (6), Associate Director

During the site visit, the VHA team interviewed the following individuals in person:

- (b) (6), LPN, CLC 2
- RN, Acting Nurse Manager CLC 2
- (b) (6) RN, Acting Chief Nurse for CLC
- (b) (6) RN, Associate Director for Patient Care Services
- (b) (6) RN, Deputy Associate Director for Patient Care Services
- (b) (6) RD, Clinical Dietitian CLC 1 and CLC 2
- (b) (6) RN, CLC 2
- (b) (6) M.D., CLC Medical Director
- (b) (6) Patient Safety Officer
- (b) (6), RN, Nurse Manager CLC 1
- RN, Acting Nurse Manager CLC 3
- (b) (6) RN, CLC 2
- (b) (6) RN, CLC 2
- (b) (6) LPN, CLC 2
- (b) (6) RN, Wound Care Nurse on CLC 1 and CLC 2
- (b) (6) LPN, CLC 2
- CNA, CLC 2

The VHA team was able to interview the whistleblower, (b) (6) as he consented to the disclosure of his name. The whistleblower was employed at the CLC from June 2011 until May 2012. This interview was conducted in person on November 26, 2012. The whistleblower provided additional information to assist the investigation in identifying specific quality of care concerns.

The VHA team reviewed all allegations including the facts and findings related to the alleged events or actions reported by OSC.

The Office of General Counsel reviewed the findings to determine if there was any violation of law, rule, or regulation.

The VHA team substantiated allegations when the facts and findings supported that the alleged events or actions took place. The VHA team did not substantiate allegations when the facts showed that the allegations were unfounded. The VHA team could not substantiate allegations when there was no conclusive evidence to either sustain or refute the allegations.

**IV. Findings, Conclusions, and Recommendations**

**A. Allegation:**

Nursing staff at the CLC neglect the elderly residents at the facility by failing to assist with essential activities of daily living. The whistleblower indicated that upon arriving for his shift, he frequently observed that the nursing staff failed to provide residents the required assistance with essential activities of daily living, such as bathing, toileting, eating and drinking. The whistleblower presented as an example that nursing staff failed to bathe immobile residents who had urinated or defecated in their beds upon being called by the residents, or in an otherwise timely manner.

**Findings:**

During the tour of the CLC on November 27, 2012, between 10:00 a.m. and 10:30 a.m., several residents were observed to be in bed in their bedrooms in CLC 2. Observation was also made of a tray left at a resident's bedside. It appeared that the resident needed assistance with feeding as he was a frail elderly male who did not respond to knocking on the door or verbal cues. The liquids were unopened and most of the pureed food was still present in the dishes. The VHA team also noted a strong fecal odor while touring CLC 2.

During interviews, the CLC Medical Director discussed the need to order intravenous fluids for residents with clinical evidence of dehydration. She reported that this occurs approximately twice per month, which, in her opinion, was excessive.

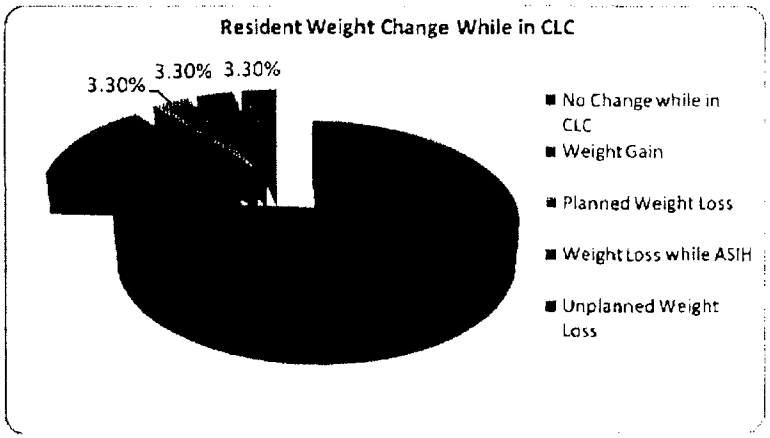
The registered dietitian discussed her concerns about regularly observing uneaten food on the meal trays at the resident's bedside between 1:30 p.m. to 2:00 p.m. Lunch is scheduled at

12 noon. She stated that this was observed 50 percent of the time when she made rounds on the CLCs. During her interview, she informed the VHA team that she spoke with the CLC 2 Nurse Manager about her concerns; however, she did not know if any measures were taken to assist Veterans at meal time.

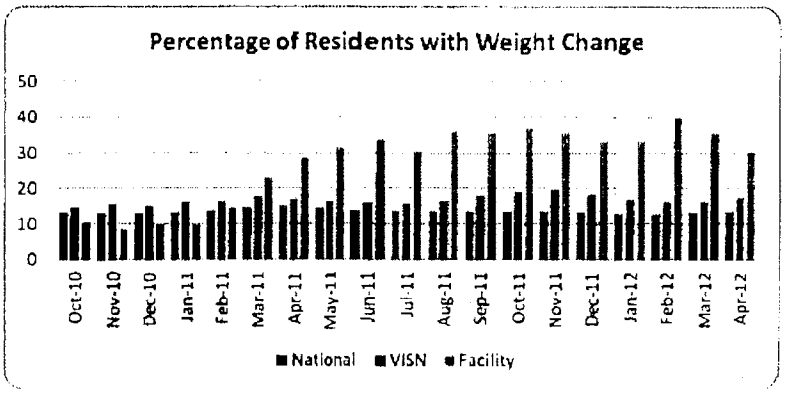
Findings from the document review included the following:

- The Roster/Sample Matrix form (CMS-802) is used by the facility to list all current residents (including residents who are absent sick in the hospital (ASIH)) and to note pertinent care categories. This report was requested and reviewed by the team. The following information was obtained from this report:

- Weight Change was defined on form CMS-802 to mean that the resident has shown unintended weight loss/gain of 5 percent in 1 month or 10 percent in 6 months, or had chronic insidious weight loss or was at nutritional risk. It was noted on the CMS-802 report that the facility showed 27 percent of the residents had weight change marked. They were asked to provide data regarding this finding. The following information was provided after the facility's review of the residents who were on the report and noted to have had a weight change. This monitor is not being continuously followed by the Quality Improvement Committee.




The following graph is the historical performance of the facility compared to the VISN and national performance on weight change. There were residents within the CLC that had an unintended weight loss/gain of 5 percent in 1 month, or 10 percent in 6 months, or had chronic insidious weight loss, or were at nutritional risk. Weight loss and the evaluation of any resident who may trigger on the CMS-802 report was expected to be completed by the CLC Quality Improvement Committee.




- During fiscal year (FY) 2012 while the whistleblower was an employee on CLC 2, seven resident and/or family complaints were documented in Reports of Contact, Patient Advocate Reports, and a letter written to a physician from a family member.[1] During her interview, the Nurse Manager on CLC 2 reported having received and reviewed these complaints throughout the course of the FY, and reported counseling the staff involved in the care. When asked for documentation of the corrective actions, none was provided to the VHA team. When asked if nursing or Medical Center leadership was informed of the complaints, the Nurse Manager informed us that they were not informed.

- The VHA team reviewed each of the complaints, identifying that they were all related to allegations of the failure of the nursing staff to assist residents with essential activities of daily living, specifically: bathing, toileting, getting in/out of bed, and diet. Four of the seven complaints were regarding multiple issues that included: bathing, toileting, wound care, and availability of supplies. The documents contained complaints in the following categories of essential activities of daily living:

    - Bathing
        - A resident complained that he did not get a bath.
        - A resident stated he wanted a shower but the staff member assisting him could not find a shower chair/commode.
        - A resident was incontinent of urine and feces - the excrement had dried on the resident.
        - A resident had not been cleaned after he vomited.

[1] The dates of these complaints were: 08/09/2011, 11/08/2011, 01/29/2012, 07/30/2012, 09/13/2012, 10/09/2012 and 10/27/2012.

- Toileting
  - A resident stated he needed help with a urinal but did not get the assistance he needed.
  - A resident complained that he wore the same diaper for 24 hours.
  - A resident was incontinent of urine and feces - the excrement had dried on the resident.

- Wound Care
  - One complaint states a resident's wound care was not done.
  - A complaint stated colostomy supplies were not available.

- Diet
  - A complaint was made regarding diet and dehydration.
  - A complaint was made that a resident had urinary tract infections and dehydration.
  - A complaint was made that the resident didn't get any food.

- Activity (getting in/out of bed)
  - A resident complained that he did not get out of bed.
  - A resident stated he had to wait "hours" to go to bed.

- The VHA team reviewed all transfers from the CLC to the acute care units at the Medical Center between June 2012 and November 2012. A total of 60 transfers occurred. A review of the treatment diagnoses showed 13 (22 percent) admissions for manifestations of dehydration.

- According to Memorandum No. 00-08-43, *Identification and Reporting of Possible Victims of Abuse/Neglect and Exploitation Cases*, VA Caribbean Healthcare System, January 2008, the definition of elderly abuse/neglect is "any act or conduct that results in physical, mental or psychological harm toward a person 60 years of age or older." The Memorandum further defines neglect as "any act of omission or failure to adequately provide food clothing, shelter, and healthcare for an elderly person or failure to provide adequate provision by the person's guardian or caregiver."

The Medical Center took immediate actions to address the allegations. These were the following:

- Nurse Leader for CLC 2 was reassigned.
- Re-education of CLC staff on reporting allegations of abuse and/or neglect.
- An Administrative Investigative Board was chartered to evaluate the leadership and oversight of the CLC.
- Re-education was provided to all CLC 2 staff on proper alignment during feeding, responsiveness to call bells and assisted daily living needs of the resident, and monitoring meal intake.

- Validation of expectations and staff competencies was conducted by daily rounds by leadership, including Nurse Managers, Associate Chief Nurse for CLC, Dietary and Medical Director.
- All education, observations and random audits were incorporated into the Medical Center's performance improvement committee reporting structure and are reported monthly.

**Conclusions**

- The VHA team substantiated the allegation that nursing staff in CLC 2 neglected the elderly residents by failing to assist with essential activities of daily living.
    - There were numerous resident care issues on CLC 2 including the nursing staff failing to provide residents the required assistance with essential activities of daily living, such as bathing, toileting, eating and drinking.
    - No significant resident care issues were identified on CLC 1 and 3.

- The neglect of residents on CLC 2 posed a significant serious issue for those residents living there. The neglect of residents at the facility reflected to violations of the following: 38 C.F.R. 17.33 – Patient's Rights, VHA Handbook 1142.01 Criteria and Standards for VA Community Living Centers (CLC) and of Memorandum No. 00-08-43, *Identification and Reporting of Possible Victims of Abuse/Neglect and Exploitation Cases,* VA Caribbean Healthcare System, January 2008 and VHA Directive 2012-022, *Reporting Cases of Abuse and Neglect*, September 4, 2012.

- When events such as abuse and neglect occur, Medical Center staff are required to provide written documentation, counsel staff, and report the events to leadership.

**Recommendations**

**The Medical Center should:**

1. Not tolerate any substantiated resident abuse and/or neglect.

2. Take resident and/or family complaints of care issues seriously, and follow up with appropriate administrative action.

3. Investigate any occurrences of failure to report resident and/or family complaints, and take appropriate action.

4. Implement a plan to observe direct care staff to ensure each resident is provided assistance with assigned care and activities of daily living as needed.

5. Implement a plan to ensure ongoing education, competency validation and observation of direct care staff.

6. Take any additional appropriate actions with regards to the neglect of CLC 2 residents, based on internal reviews and recommendations.

7. Take appropriate actions as necessary, based on recommendations of the Administrative Investigative Board findings.

8. Ensure the Quality Improvement Committee evaluates each resident with documented weight change on the CMS-802 to determine each resident's nutritional needs.

**B. Allegation**

The CLC failed to record and report adverse events, namely resident falls, as required. The whistleblower indicated that at least on two occasions between March and May 2012, he arrived at work to discover two residents on the floor who had fallen from their beds. He was instructed by his shift supervisor, (b) (6) not to record or report resident falls because it required too much paperwork.

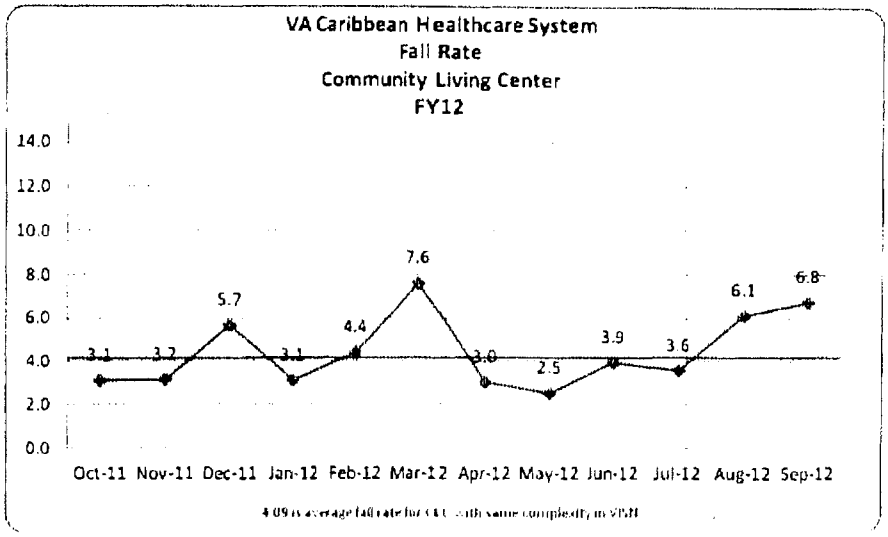
**Findings**

During interviews, all levels of staff denied having been told by any supervisor not to report adverse events to include falls. All levels of staff were able to articulate the adverse event reporting process.

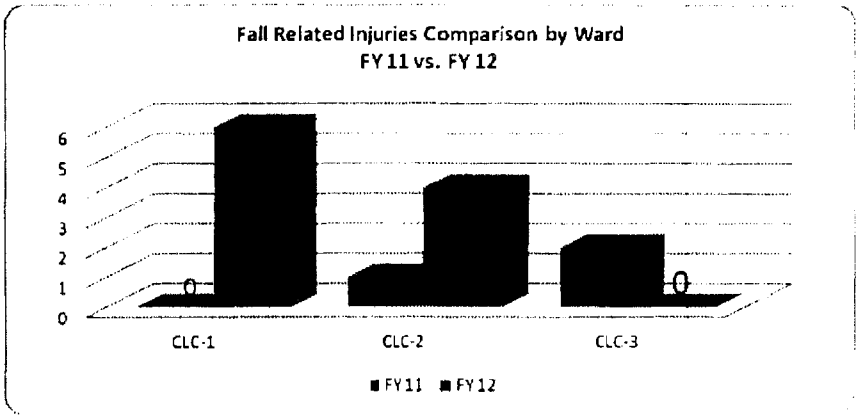
Findings from the document review included the following: At full census, CLC 2 houses 46 percent of the entire CLC population of residents, and at the time of the VHA team site visit, CLC 2 housed 54 percent of the CLC residents.

During fiscal year (FY) 2012, the entire CLC reported 174 falls. Of these, 94 (55 percent) occurred in CLC 2. Of the 94 falls that occurred on CLC 2, 50 (52 percent) occurred during the 7:30 a.m. to 4:00 p.m. shift. Of the reported 174 CLC falls, there were 18 unique Veterans that had repeated falls.

The following graph depicts the CLC's fall rate for FY 2012. Fall rate is defined as the number of falls per 1,000 bed days of care.




The facility noted that they had an increase in the number of CLC fall related injuries from FY 2011 to FY 2012.




The Medical Center completed a root cause analysis related to falls over the past FY. Actions taken included the following:

- The Medical Center is participating in a Falls Prevention Collaborative (a VHA-wide focus group working on fall prevention).

- Falls are a part of the CLC's Performance Improvement activities and are being monitored on a monthly basis.
- The Medical Center has implemented an interdisciplinary, post-fall, huddle team.
- The Medical Center has implemented a Partners in Preventing Patients/Residents Falls/Injuries Program (Fall Contract).
- The Medical Center is exploring the use of protective equipment.

**Conclusions**

- The VHA team did not substantiate the allegation that the CLC failed to record and report adverse events, namely patient falls, as required. However, the fall rate at the CLC is higher than the VISN and VHA comparisons.

**Summary Statement**

The VHA team substantiated one of the whistleblower's allegations, and agrees that these are significant issues that must be corrected. The investigation found that the neglect of residents at the facility reflected to violations of the following: 38 C.F.R. 17.33 – Patient's Rights, VHA Handbook 1142.01 *Criteria and Standards for VA Community Living Centers (CLC)*, and of Memorandum No. 00-08-43, *Identification and Reporting of Possible Victims of Abuse/Neglect and Exploitation Cases*, VA Caribbean Healthcare System, January 2008, and VHA Directive 2012-022, *Reporting Cases of Abuse and Neglect*, September 4, 2012. The Medical Center took immediate actions to address the allegation that was substantiated by the VHA team.

**Attachment A**

The following documents were reviewed in preparation of the report:

- *Long Term Care Institute Survey,* October 30-November 1, 2012
- VHA Handbook 1050.01, *National Patient Safety Improvement Handbook,* March 4, 2011
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers,* August 13, 2008
- VHA Directive 2012-022, *Reporting Cases of Abuse and Neglect*, September 4, 2012
- RAI/MDS 802 report, November 27, 2012
- CLC Quality Improvement Minutes, FY 2012
- Data regarding weight loss tracking/trending for FY 2012
- Death Occurrence Screens, CLC, June 2012 through November 2012
- Data on transfers to the Medical Center from CLC, FY 2012
- FY 2012 Facility Falls Data at the VA Caribbean Healthcare System CLC
- Incident Reports, CLC, FY 2012
- Staffing/Assignment Sheets for November 5-16, 2012
- Resident Council Minutes, September through November 2012
- Patient Advocate Reports, CLC 2, for FY 2012
- Memorandum No. 11G-12-18, *Guidelines for the Monitoring of Weight Loss and Gain in Long Term Care Residents,* VA Caribbean Healthcare System, August 18, 2012
- Memorandum No. 00-08-43, *Identification and Reporting of Possible Victims of Abuse/Neglect and Exploitation Cases,* VA Caribbean Healthcare System, January 2008
- Reports of Contact for Care Issues at the CLC, FY12
- 38 C.F.R. 17.33 – Patient's Rights

Attachment A

**Veterans Administration Caribbean Healthcare System (VACHS)**
**Community Living Center (CLC)**
**Immediate Actions Taken in Response to the Veterans Health Administration (VHA) Team Recommendations**

**The Medical Center should:**

1. Not tolerate any substantiated resident abuse and/or neglect.

   **Immediately** – CLC 2 staff are being re-educated on signs/symptoms and the reporting of resident abuse and/or neglect. Training began on December 2012. Training is being offered on a daily basis and it is expected that 100 percent of staff will be trained no later than May 31, 2013.

2. Take resident and/or family complaints of care issues seriously, and take immediate and appropriate action.

   **Immediately** – On December 4, 2012, all Nurse Managers were re-educated on the process of investigating and reporting complaints of care issues. Since the time of the original site visit, there has been one complaint received regarding care (on CLC 3). That complaint was investigated properly with appropriate follow up. In addition, immediate communication was held with the Chief, Patient and Community Relations to assure that all resident/family complaints received at the Patient Representative office are sent to the CLC Medical Director and Chief Nurse, CLC for investigation. Complaints made to the patient representative are tracked through the Patient Advocate Tracking System. On December 10, 2012, follow up to this communication was completed; it was determined that a process was already in place. Any complaints raised at the service level (nurse manager, providers, associate chief nurse) are tracked utilizing a tracking grid to assure resolution and identify patterns/trends. Any complaints voiced at the Resident Council meetings are tracked through the minutes until resolution.

3. Investigate any occurrences of failure to report resident and/or family complaints, and take appropriate action.

   **Immediately** – Effective December 2012, the Acting Chief Nurse, CLC has a meeting with the CLC Nurse Managers daily from 4:00 – 5:00 pm to discuss various care issues including the responsibility of the nursing staff to address resident/family/staff complaints. The importance of notifying the Chief Nurse, CLC of any and all resident/family complaints was reinforced with the Nurse Managers. Appropriate follow up actions are completed. In addition, the Acting

Chief Nurse performs rounds in the units, including during off tours. No occurrences of failure to report have been detected since these actions have been in place.

4. Implement a plan to observe direct care staff to ensure each resident is provided assistance with assigned care and activities of daily living as needed.

   **Immediately** – Effective December 2012, the Acting Chief Nurse, CLC has a daily meeting with the CLC Nurse Managers from 4:00 – 5:00 pm. The daily meeting includes a discussion of food consumption, residents taken out of bed, residents taken to the dining room, special/unusual incidents, repositioning bed bound residents, oral care, nail care, and other resident care issues. A form to track observations of resident care was developed for use by the nurse leaders (Charge Nurse/Nurse Manager) performing rounds during their shift to ensure nursing care is given timely and appropriately. The results of this tracking tool are discussed with the Acting Chief Nurse, CLC at the daily meetings.

5. Implement a plan to ensure ongoing education, competency validation and observation of direct care staff.

   **Immediately** – Plan to re-educate 100 percent of staff was developed to include two sessions of a 3-day Registered Nurse (RN) Educational Training Session and three sessions of a 2-day Licensed Practical Nurse (LPN) Educational Training Session. These trainings were coordinated with the Nurse Managers (NM) to assure that all staff members are scheduled to attend. Topics covered include: Fall Prevention, Prevention of Medication Errors, Prevention of Aspiration, Grooming Essentials, Monitoring Food Consumption, Monitoring Weight Loss, Liberalize Diets, Principles of Dignity, Respect and Privacy, Restorative Program, Infection Control, Care Planning, Team Nursing as the Model of Care Delivery, Prevention, Assessment and Management of Pressure Ulcers, Management of Contractures, Orthotic/prosthetic Devices, Psychotropic Medications, Nursing Assessments, Pain Management and Management/Screening of Dysphagia. Trainings started on March 20-21, 2013 and are scheduled until 100% of employees re-educated (mid-May). Parallel to the educational training, the Clinical Nurse Specialists are validating 100 percent of the staff's competency in assisting residents with eating, pain management, suctioning, use of Protective Personnel Equipment with Methicillin-Resistant Staphylococcus aureus (MRSA) Positive High Risk and Head to Toe Skin Inspections; currently 114/115 (99 percent) of staff members have had competency validation in the above areas. The ongoing plan includes monthly education in conjunction with competency validation and daily rounds by the NMs to observe resident care.

6. Take any additional appropriate actions with regards to the neglect of the CLC 2 residents, based on internal reviews and recommendations.

   **Immediately** – A total of six (6) incidents regarding CLC-2 resident/family complaints from August 1, 2011 through November 30 , 2012 were analyzed and it was found that actions were taken either by the NMs, providers, social worker or CLC Medical Director. In some cases, the investigations and actions taken were not of the depth required of such serious complaints. An internal Administrative Investigative Board of Investigation (AIB) was requested to 1) review and address resident/family complaints regarding care on CLC 2, 2) review the timeliness of the resolution of complaints received by CLC, and 3) evaluate the leadership oversight and involvement in the daily operations of the CLC. In addition, the Acting Chief Nurse met with the resident's daughter who submitted a written complaint and had not received feedback on actions taken. The daughter received feedback and follow up was provided to her on a daily basis until she expressed satisfaction with the services Veteran is receiving.

7. Take appropriate actions as necessary, based on recommendations of the Administrative Investigative Board findings

   **Immediately** – The AIB was chartered on January 3, 2013, and conducted on January 7-8, 2013. Pending the results of that investigation, the following actions were taken:
   a) The Acting Nurse Manager for CLC 2 was re-assigned to a non-patient care area effective December 4, 2012.
   b) The Associate Chief of Staff for Geriatrics and Extended Care (ACOS/GEC) was detailed out of the ACOS CLC position on November 6, 2012; she later requested voluntarily reassignment out of her position of ACOS/GEC on January 10, 2013. She was reassigned to Physical Medicine and Rehabilitation on January 27, 2013. Currently, candidates are being interviewed for the ACOS/GEC position.
   c) On February 8, 2012, the Associate Chief Nurse requested a voluntary reassignment out of her position; she was reassigned as Caregiver Coordinator on February 26, 2012.

   The final AIB report was received on April 16, 2013. As a result, personnel actions are being evaluated to determine next steps.

8. Assure that the Quality Improvement committee evaluates each resident with documented weight change on the CMS-802 to determine each resident's nutritional needs.

   **Immediately** – The CLC Resident Assessment Instrument/Minimum Data Set Coordinator is evaluating each resident's documented weight change on the CMS 802; results are discussed in the CLC Performance Improvement Committee. One of the findings was that the weight at times has been coded

incorrectly, therefore this aspect the Minimum Data Set will be included in the Minimum Data Set Inter-Rater report.

9. Continue carrying out the action plans identified through the Falls Prevention Collaborative.

   **Immediately** – Fall prevention actions are part of the CLC Unannounced Survey Corrective Action Plan (CAP) and are discussed with VA Central Office (VACO) /Veterans Integrated Service Network (VISN) on a monthly basis. The CLC is monitoring falls on a daily basis and performs a post fall safety huddle to evaluate what went wrong and what can be done to avoid a future fall. In addition, residents with more than one fall are discussed in the interdisciplinary care planning meeting and their plan of care revised accordingly. The CLC has had only one fall with injury this fiscal year (FY), a marked decreased from the four falls with injury at this same time in FY 2012.

10. Monitor status of progress to the Performance Improvement Committee and provide updates to leadership until resolution of corrective actions is reached and improved performance is evident.

    **Immediately** – The care issues assessed during the VHA investigative site visit conducted November 26-29, 2012 were cited during the CLC Unannounced Survey visit and a Corrective Action Plan was developed and included over 14 weekly performance improvement monitors that were discussed with the VISN on a weekly basis and with VACO on a monthly basis. We are in the process of establishing the mechanism to report to the VACHS Performance Improvement Board. The anticipated date of incorporation into VACHS Performance Improvement Board meetings is June 2013.