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The Special Counsel

August 8, 2019

The President
The White House
Washington, D.C. 20500

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

Dear Mr. President:

I am forwarding to you a report from the Department of Veterans Affairs (VA), based on disclosures of wrongdoing at the Greater Los Angeles Healthcare System (L.A.), Los Angeles, California. [redacted] and [redacted] who consented to be identified in the closure of this matter, disclosed that L.A. employees failed to take action on repeated allegations of patient care deficiencies and employee misconduct, resulting in compromised patient care. I have reviewed the agency report and whistleblower comments and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the reports, whistleblower comments, and my findings.[1]

The whistleblowers alleged that L.A. officials failed to investigate and remediate serious patient care concerns at a number of approved Community Residential Care Facilities (CRCs), in violation of state regulations and agency policy. The whistleblowers also alleged that West L.A. officials failed to take action in response to reports that a management official engaged in improper relationships with VA patients and that L.A. medical support assistants (MSAs) inappropriately accessed patient records in violation of federal law and agency policy.

The agency substantiated that L.A. officials compromised patient care by failing to properly investigate and correct serious resident care shortcomings at California Villa, a VA-approved CRC facility. According to the agency's report, California Department of Social Services (CDSS) received 150 complaints regarding California Villa, 70 of which were substantiated, between 2014 and 2018.[2] VA investigators observed California Villa's facilities in disrepair and a disorganized medicine room. Between 2015 and 2018, several veteran residents at California Villa experienced serious medication errors,

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[1]The whistleblowers' allegations were referred to former Veterans Affairs Secretary David J. Shulkin, M.D., for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The VA Office of the Medical Inspector (OMI) conducted the investigation. Former Acting Chief of Staff Jacquelyn Hayes-Byrd reviewed and signed the agency's report.

[2]OMI investigators also reviewed Sunland Manor, another VA-approved CRC. CDSS received 10 complaints—4 substantiated—regarding Sunland Manor between 2014 and 2018. However, investigators personally observed upgrades and improvements to Sunland Manor's facilities and medication administration processes.

including: failure to provide physician-prescribed antibiotics to a 100-year old veteran with sepsis; failure to update physician-canceled prescriptions resulting in a veteran receiving a double dose of medication on two occasions, despite intervention by the veteran's physician and case manager; and, failure to provide medication to a veteran who did not leave his room.[3]

The agency also discovered that California Villa staff were unable to correctly identify a veteran residing in a locked ward. On October 9, 2017, a VA physician entered a note that a veteran residing at California Villa died on October 8, 2017. The veteran's case manager entered a note on October 12, 2017 that she had an encounter with the veteran that day, four days after he died. On October 30, 2017, the case manager entered a note indicating that a California Villa administrator informed her the veteran died October 12, 2017, which was incorrect. The case manager indicated in her note that during her visit on October 12, California Villa staff directed her to a patient they confirmed was the veteran, who was residing in a locked ward. In fact, California Villa staff identified the wrong individual as the veteran, and the correct veteran had indeed died on October 8, 2017. The agency identified this error as one of concern, noting that if staff cannot properly identify residents, it could be an indication that veterans are not receiving their proper medications.

According to the agency, CRC staff appropriately inspect CRC facilities and have good relationships with state regulators, reporting concerns to the CDSS as required. However, there was no information showing that the CRC Program Manager raised staff concerns to L.A. management or Veterans Integrated Service Network (VISN) 22 officials for further action. The agency did acknowledge that L.A. officials suspended referrals to CRCs for various reasons, including care concerns; referrals to California Villa ceased during the OMI's site visit in this investigation.

The agency determined that the failure of the CRC Program Manager to report California Villa's ongoing shortcomings to L.A. management compromised patient care. The agency noted that a CRC that continuously fails to meet state standards and repeatedly disregards these requirements should not remain on the VA-approved CRC list. The agency acknowledged that, because VA does not pay CRCs—rather, veterans pay CRCs—L.A. officials did not oversee the CRC Program as rigorously as similar programs that the VA funds. Because of the vulnerability of the veteran population residing in CRCs, and the fact that CRCs can opt out of the CRC program instead of making improvements, the agency stated that the threshold for revoking VA approval should be low. And, the agency expressed serious concern for the wellbeing of veterans

[3]Investigators also discovered that, prior to intervention by the veteran's VA case manager, California Villa was charging this veteran $5 per meal because he chose to eat in his room instead of the cafeteria.

residing in California Villa's locked ward, noting that their safety was in question because of California Villa's critical failures.

In light of these findings, the agency recommended that L.A. officials notify all California Villa resident veterans that VA suspended its approval of the facility and request permission to have them moved or, for veterans who choose to remain, ensure they are aligned with other programs such as Home-Based Primary Care and Mental Health Intensive Case Management. Among other recommendations, the agency also advised L.A. officials to assist in the prompt transfer of veterans residing in California Villa's locked ward due to dementia or other conditions requiring hospital or nursing home care to an appropriate site that can provide the care required.

With respect to compromised care, the agency recommended that the L.A. CRC Program Coordinator conduct monthly visits to all VA-approved CRCs and that the position be made full-time. The agency also recommended that the VISN conduct an independent review of all VA-approved CRC facilities, including a review of all CDSS inspection reports. All of these recommendations were completed as of June 2019.

The agency did not substantiate the whistleblowers' allegations regarding L.A. officials conducting inappropriate or unethical relationships with patients or staff. The agency also did not find that MSAs accessed patient records without cause.

In comments, one of the whistleblowers reiterated the allegation that L.A. officials, specifically the CRC Program Coordinator, ignored serious shortcomings observed by case managers at VA-approved CRCs, including alleged bedbug infestations, decrepit facilities, and patient deaths. The whistleblower expressed the hope that an additional investigation would be conducted into patient safety matters.

I have reviewed the original disclosure, agency reports, and whistleblower comments. These whistleblowers highlighted a serious lapse in the care provided to our nation's veterans by VA-approved CRC facilities. The agency acknowledged that patient care was compromised by management's failure and substantiated the whistleblowers' concerns regarding the safety of veterans residing in VA-approved CRCs. In response, the agency acted to ensure that veterans were notified and relocated as required. L.A. officials have committed to active monitoring of the CRC Program to ensure that all enrolled CRCs are meeting requirements to maintain VA approval. The whistleblowers' insights into the shortcomings at VA-approved CRCs were invaluable, and their continuing concern for the safety of veterans is well-placed. I am shocked that such lax oversight of facilities providing critical care for vulnerable veterans ever occurred, and I commend these whistleblowers for coming forward to shine a light on this serious issue. I would also request that the VA follow-up with OSC in six months to ensure that veterans at California Villa have received proper care. Nevertheless, in light of the agency's

thorough investigation and proactive response, I have determined that the report appears reasonable and meets all statutory requirements.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, and the whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed redacted copies of these documents and the redacted § 1213(c) referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures