



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Alleged Resident Abuse and
Abuse Reporting Irregularities at the
Pueblo Community Living Center,
VA Eastern Colorado Healthcare System,
Denver, Colorado**

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection of the Pueblo Community Living Center (CLC), in Pueblo, CO, which is operated by the VA Eastern Colorado Health Care System, located in Denver, CO. The purpose of the inspection was to determine the validity of allegations regarding CLC resident abuse and reporting irregularities.

We did not substantiate the allegation of resident abuse. We did not substantiate the allegation that staff attempted to cover up an allegation of abuse or that staff who report potential abuse are retaliated against; however, we found staff did not report allegations of abuse as required by VHA and local policies, and did not track or trend incidents such as bruises and skin tears of unknown origin in order to identify potential abuse patterns. We recommended that the system Director ensures all Associate Chiefs of Nursing and CLC staff are retrained on the requirements for reporting allegations of abuse and that procedures to report, log, track, trend, and analyze injuries of unknown origin at the CLC are developed.



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

TO: Director, VA Rocky Mountain Network (10N19)

SUBJECT: Healthcare Inspection – Alleged Resident Abuse and Abuse Reporting Irregularities at the Pueblo Community Living Center, Pueblo, Colorado

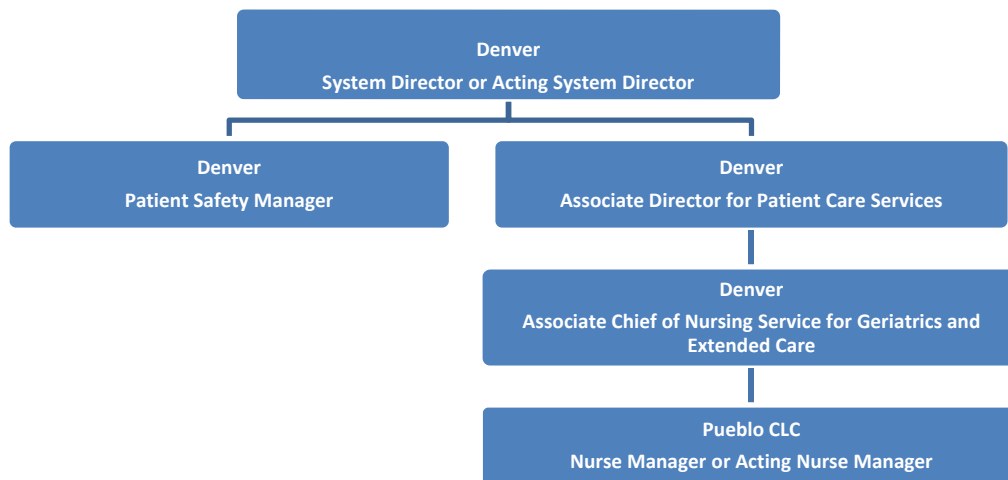
Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection of the Pueblo Community Living Center (CLC), in Pueblo, CO, which is operated by the VA Eastern Colorado Health Care System (system), located in Denver, CO. The purpose of the inspection was to determine the validity of allegations regarding CLC resident abuse and abuse reporting irregularities.

Background

Pueblo CLC

The Pueblo CLC is one of two CLCs operated by the system, and is part of Veterans Integrated Service Network (VISN) 19. The 40 bed CLC offers residents rehabilitation, nursing care, long-term care, palliative care, and respite care. Residents at the CLC are most often admitted for long-term care. The system and CLC supervisory reporting structure is illustrated below.



Allegations

In July 2012, the OIG's Hotline Division received allegations from a complainant concerning the CLC. Specifically, the complainant alleged a staff member (Staff A) abused a resident while performing personal care and that CLC management and supervisors were aware of the incident and covered it up. The complainant further alleged CLC staff are discouraged from reporting possible abuse due to fear of upper management retaliation.

Scope and Methodology

We conducted a CLC site visit on August 2. We observed care provided to residents at the CLC and interviewed the Nurse Manager, Assistant Nurse Manager, staff members, the resident and other residents, visitors, and the Chaplain. Additionally, we interviewed the system Director, the complainant, and a provider familiar with the resident by telephone, and we interviewed the Associate Director for Patient Care Services (Associate Director), Associate Chief of Nursing Service for Geriatrics and Extended Care (Associate Chief Nurse), and Patient Safety Manager at the system in Denver. We reviewed the resident's and other selected CLC residents' electronic health records, CLC Resident Council meeting minutes, system documentation related to this complaint, VHA and local policies related to abuse reporting, and other pertinent documents.

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

Case Summary and Summary of Events

The resident is in his 60s and has resided at the CLC for three years. His relevant medical history includes acute stroke with significant left side weakness. His usual mode of locomotion is a wheelchair; however, he is able to stand and walk briefly with a left ankle brace and assistance. He requires assistance with bathing and dressing.

On the day of the alleged abuse, Staff A assisted the resident with personal care and dressing. Soon after, the resident told the Charge Nurse that Staff A was rough with him that morning. The Charge Nurse reported the allegation to the Nurse Manager during the daily morning staff meeting. Later, the resident reported the incident to the Assistant Nurse Manager and stated that he did not want Staff A to provide care for him in the future. Specifically, the resident told the Assistant Nurse Manager that Staff A was rough while wiping his buttocks and genitals when he changed the resident's incontinence pad. The Assistant Nurse Manager discussed the resident's allegation with Staff A, who denied being rough with the resident that morning.

The next day, the resident again approached the Assistant Nurse Manager and asked her what she was going to do about his complaint to her the day before. That evening, the Assistant Nurse Manager sent e-mails to the Nurse Manager, a human resources (HR) staff, the union president, and an employee relations staff titled "Abuse?" The Assistant Nurse Manager thought she had attached a report of contact (ROC) concerning the resident's allegation to each e-mail recipient; however, only the employee relations staff received the ROC.

Two days after the allegation the Assistant Nurse Manager instructed a Charge Nurse that Staff A was not to provide care to the resident until further notice.

Four days after the allegation the employee relations staff who received the ROC instructed the Assistant Nurse Manager to send the ROC up through the chain of command immediately to let them know about the allegation of patient abuse.

Five days after the allegation the Assistant Nurse Manager forwarded an e-mail regarding the allegation of abuse with the ROC attached to the Nurse Manager. The Nurse Manager forwarded the e-mail and ROC to the Associate Chief Nurse and wrote, "Have you seen this? I just got this from (Assistant Nurse Manager)." The Associate Chief Nurse forwarded the e-mail to the Associate Director and wrote, "This was reported to me this afternoon...I have requested a patient safety¹ report be completed."

That same day, the Nurse Manager also spoke to the employee relations staff and stated she would conduct a fact-finding review. The employee relations staff advised the Nurse Manager not to conduct a fact-finding review because the allegation had to be elevated to the Convening Authority to determine if an Administrative Investigation Board should be convened.² Despite the employee relations staff's instruction, the Nurse Manager interviewed Staff A and the resident regarding the allegation.

The Associate Director and Associate Chief Nurse told us they discussed the allegation with the Acting Director during the daily morning report on day 6 and 7 after the allegation.

Eight days after the allegation, the Patient Safety Manager, who was not aware of the allegation, received an anonymous call on the system's Patient Safety Hotline regarding the allegation. The Patient Safety Manager immediately called the Associate Director and the Director, and the three met in the Director's office to discuss the allegation.

¹ Events involving alleged or suspected patient abuse of any kind must be reported via the VHA Patient Safety Information System (PSIS). VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

² It is VA policy that significant incidents occurring and issues arising within VA facilities or staff offices, or as a result of VA activities, shall be reported and investigated as necessary to meet the informational and decision-making needs of VA. VA Directive 0700, *Administrative Investigations*, March 25, 2001.

Nine days after the allegation, the Associate Director received a patient safety report regarding the allegation, which was authored by the Assistant Nurse Manager. On August 2, the OIG Office of Healthcare Inspections conducted an onsite review at the CLC. On August 3, the Associate Chief Nurse conducted onsite fact finding at the CLC.

Inspection Results

On August 2, we entered the CLC at 8:00 a.m. and found it clean, and welcoming. Residents in the dining room were dressed in street clothes and eating breakfast. Resident rooms and common areas were neat and clean, and there were no offensive odors. We observed staff assisting residents in the dining room, in the halls, and in resident rooms.

We interviewed many CLC staff in the halls and in private. Although some verbalized fear of reprisal if they reported safety concerns (see Issue 2), all told us they would remove residents from danger and immediately report abuse to their supervisor.

We also interviewed residents, visitors, and the Chaplain. All believed the care provided at the CLC was safe and voiced no concerns related to abuse. All verbalized they could report allegations of abuse without fear of reprisal. All believed staff were caring and responsive to residents' needs.

Issue 1: Alleged Resident Abuse

We did not substantiate the allegation that the resident was abused at the Pueblo CLC in July 2012.

The resident was well groomed and in clean street clothes during our interview. His room was clean and homelike, with his personal belongings and photographs displayed. He told us he was the CLC Resident Council president. He was a good historian of events and recounted the events surrounding the July 2012 incident to us. The resident told us he believed Staff A was in a hurry that day and rushed while providing him personal care; however, he did not believe Staff A deliberately hurt him. The resident told us Staff A no longer provided personal care for him and that he and Staff A had "worked out" their differences. The resident told us he felt safe at the CLC and he believed he and the other CLC residents received safe care. He said he would not hesitate to report abuse and he would not fear reprisal if he did.

Staff A remembered providing personal care for the resident in July. Staff A denied the allegation of abuse. Staff A's competency folder indicated Staff A possessed the required training and skills to perform assigned CLC duties and CLC supervisors told us they did not believe Staff A provided abusive or unsafe care.

Issue 2: Abuse Reporting

We did not substantiate the allegation that staff attempted to cover up the allegation of abuse or that staff who report potential abuse are retaliated against; however, we found staff did not fully understand their reporting obligations and the reporting process.

Staff did not report the allegation of abuse to supervisors and the Executive Leadership Team or initiate a patient safety report as required by VHA Handbook 1050.01 and local policies. VHA Handbook 1050.01 states events involving alleged or suspected patient abuse of any kind must be reported (patient safety report) via the VHA Patient Safety Information System. The system's local policies for reporting alleged or suspected abuse direct staff to initiate a patient safety report and to notify a supervisor within 1 hour of awareness of the event. The policies direct supervisors to notify the Executive Leadership Team (Chief of Staff, Nurse Executive,³ Quality Manager, and Director, in that order), within 2 hours regardless of the day of week or time of day. After notification, the Director is tasked with initiating an inquiry or investigation.

Although the Nurse Manager, the Assistant Nurse Manager, and other CLC staff were aware of the resident's allegation on the day of the alleged abuse, the Associate Chief Nurse (supervisor) was not notified until five days later, and the Patient Safety Manager did not receive a patient safety report until eight days later. Additionally, the Associate Chief Nurse did not notify the Executive Leadership Team as required. While we found a breakdown of the abuse reporting system occurred, we did not find staff attempted to cover up the resident's allegation. CLC staff and the Assistant Nurse Manager believed they were required to follow a chain of command and that reporting the allegation to the Nurse Manager satisfied that requirement. The Nurse Manager believed the duty to report the allegation to a supervisor (Associate Chief Nurse) and to initiate a patient safety report was predicated upon preliminary fact finding and determination of the allegation's merit.

While our review of staff competency folders and interviews revealed all staff received required abuse and neglect reporting policy education, most staff could not fully describe their reporting obligations. Most staff told us they were to follow a chain of command; some were not aware of their duty to report any incidents that caused residents injury, or placed them at risk of harm; and some were not aware of the system's Patient Safety Hotline.

During interviews, we learned some staff feared retribution if they reported patient safety concerns and that senior leaders did not support a culture of safety. Although we did not find evidence of retaliation, we did find the belief about senior management not promoting a culture of safety is not unique to CLC staff. Results of a 2011 "Patient Safety Culture Questionnaire" sent to all VA medical center employees revealed system

³ The Associate Director of Patient Care Services is commonly referred to as the Nurse Executive.

staff responded two standard deviations⁴ below overall VHA scores in areas related to education, training, resources, and staff perceptions of senior management's promotion of patient safety. In the spring and summer of 2012, the system developed and implemented action plans to address these concerns.

Issue 3: Reporting and Tracking Injuries of Unknown Origin

During this review, we identified one other aspect of care in need of improvement. We found CLC managers did not report, track, trend, or analyze un-witnessed injuries such as skin tears and bruises to residents who could not tell staff how the injury occurred.

During our onsite visit, we identified three total-care residents (residents who require assistance to meet their daily needs) with skin tears of unknown origin. Two residents had a skin tear on their hand, and one had a skin tear on his lower leg. The injuries were being treated appropriately, but had not been reported nor had the causes been analyzed. For example, the resident with the leg injury required a wheelchair for locomotion and stated a nurse accidentally pushed him into a wall. The resident was unable to identify the nurse and CLC management did not document efforts to identify the nurse to ascertain further details of the incident to track, trend and analyze the event.

Conclusions

We did not substantiate the allegations of resident abuse, staff attempts to cover up an allegation of abuse, or retaliation against staff who report allegations of abuse. However, we found CLC supervisors and staff did not fully understand their reporting obligations and the reporting process. Staff did not report an allegation of abuse to supervisors and the Executive Leadership Team or initiate a patient safety report as required by VHA Handbook 1050.01 and local policies. We also found CLC managers did not report, log, track, trend, and analyze bruises and skin tears of unknown origin to identify potential abuse patterns.

Recommendations

Recommendation 1. We recommended that the system Director ensure all Associate Chiefs of Nursing and Community Living Center staff receive retraining on the requirements for reporting allegations of abuse.

Recommendation 2. We recommended that the system Director ensures procedures to report, log, track, trend, and analyze injuries of unknown origin at the Community Living Center are developed.

⁴ Standard deviation is a descriptive statistic that is used to understand the distribution of a dataset. A sample with a large standard deviation below or above the mean tends to have cases that are more widely spread-out.

Comments

The VISN Director and system Director concurred with the inspection results (see Appendixes A and B, pages 8–10, for the full text of their comments and completed actions). The actions taken are acceptable and we will follow up on the planned actions until they are completed.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 7, 2012

From: Director, VA Rocky Mountain Network (10N19)

Subject: **Healthcare Inspection – Alleged Resident Abuse and Abuse Reporting Irregularities at the Pueblo Community Living Center, Pueblo, Colorado**

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

Thru: Director, Management Review Service (VHA 10AR MRS)

Attached is the response from VA Eastern Colorado Health Care System to OIG Health Care Inspection – Alleged CLC Resident Abuse and Abuse Reporting Irregularities. The facility acted upon the opportunities for improvement immediately following the review. All education interventions will be completed by November 30, 2012.

(original signed by:)
Ralph T. Gigliotti, FACHE
Director, Rocky Mountain Network (10N19)

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 8, 2012

From: Director, VA Eastern Colorado Health Care System (554/00)

Subject: **Healthcare Inspection – Alleged Resident Abuse and Abuse Reporting Irregularities at the Pueblo Community Living Center, Pueblo, Colorado**

To: Director, VA Rocky VISN Mountain Network (10N19)

I concur with the recommendations from the Healthcare Inspection conducted on August 2, 2012. The recommendations cover areas of opportunities for improvement as well as educational reinforcement. Actions taken in response follow this letter.

Eastern Colorado Health Care System (ECHCS) leadership continues to monitor processes and outcomes and take action when indicated to strengthen patient abuse reporting awareness and policy compliance.

For additional information please contact Keith Harmon, Chief, Organizational Improvement at 720-857-5906 or keith.harmon@va.gov.

(original signed by:)

Lynette A. Roff

Director, Eastern Colorado Health Care System (554/00)

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

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

OIG Recommendations

Recommendation 1. We recommended that the system Director ensure all Associate Chiefs of Nursing and Community Living Center staff receive retraining on the requirements for reporting allegations of abuse.

Concur

Target Completion Date: Completed

Facility's Response:

Based on the actions taken to date by the health system, I respectfully request that OIG Recommendation #1 be closed. Training for all Pueblo Community Living Center employees was completed on 9/30/12. The Associate Chiefs of Nursing received retraining on the requirements for reporting on 11/2/12.

Status: Complete

Recommendation 2. We recommended that the system Director ensures procedures to report, log, track, trend, and analyze injuries of unknown origin at the Community Living Center are developed.

Concur

Target Completion Date: 11/30/12

Facility's Response:

Community Living Center Operational Guideline, OG-118B-10 Injuries of Unknown Origin Reporting, Tracking, and Evaluation Guidelines for the Denver and Pueblo Community Living Centers have been developed. Staff education on the procedures for reporting, tracking and evaluation of injuries of unknown origin is in progress. I further respectfully request that OIG Recommendation #2 be closed at such time.

Status: In Progress

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Stephanie Hensel, RN, JD, Project Leader Cheryl Walker, APNP, MBA, Team Leader Michael Bishop, MSW Michael Shepherd, MD

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