Administrative Closure
Alleged Dental Provider Issues at the
Pueblo Community Based Outpatient Clinic
VA Eastern Colorado Health Care System (554/00)
Denver, Colorado
MCI #2013-03862-HI-0373

I. Background

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received allegations from a [redacted] (complainant)[1] at the Pueblo Community Based Outpatient Clinic (CBOC), Pueblo, CO, regarding a [redacted] ([redacted]).[2] The CBOC is part of the VA Eastern Colorado Health Care System (system), Denver, CO.

After unsuccessful attempts to resolve his concerns through [redacted] the complainant submitted clinical and non-clinical allegations in two letters to OIG, dated 9 days apart.[4]

Initially, OHI's Hotline Working Group (HWG) referred the following summarized allegations to the system for review and response:

1. Because of his negligence, the [redacted] endangered a patient when he used an improper [redacted] procedure that led to a patient's discomfort and extreme coughing.
2. During the same incident, the [redacted] panicked without rendering aide and departed the treatment area.
3. The [redacted]'s unprofessional behavior included the use of profanity and frequent outbursts in the clinic caused numerous patients to refuse to be treated by him. [redacted]

The non-clinical allegations did not fall within the purview of OHI; therefore, we did not pursue them further.[5]

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[1] [redacted]
[2] [redacted]
[3] [redacted]
[4] May 29 and June 7, 2013
[5] [redacted]
[redacted]

On November 14, 2013, the HWG reviewed the system's response dated September 26.[6]

The HWG noted the system's response did not substantiate the allegations and attributed many of the behaviors alleged against the (b)(3):5 U.S.C. App 3 (b)(6) to the complainant. The HWG also noted the system's response did not provide data to support its conclusion or address the alleged incompetence of the (b)(3):5 U.S.C. App 3 (IG Act):(b)(6) (b)(6).[7] Finally, the HWG noted that the (b)(6) was a reviewer for the system's response, thereby raising possible conflict of interest concerns. Therefore, the HWG decided to open a hotline.

On November 22, we contacted the complainant to clarify the allegations and to discuss the uncertainty of ensuring requested confidentiality based on the nature of the allegations and parties involved. The complainant explained that (b)(3):5 U.S.C. App 3 (IG Act):(b)(6), retained an attorney, and requested to rescind his allegations. After discussion with our medical consultant, it was determined that we would convert the hotline to an Administrative Closure. The reason the inspection was continued was to review the facility's inspection data, to determine the competence of the (b)(6), and to identify any conflict of interest concerns stemming from the (b)(6) participating in the facility's internal review.

II. Inspection Results

During the system's scheduled Combined Assessment Program review during the week of January 13, 2014, we reviewed internal review documents that formed the basis of the system's response to the HWG. We interviewed key managers including the system's Director, (b)(6) Chief of Staff, Chief of Quality Management, and other staff knowledgeable about the allegations cited and other reviews of the system's (b)(6). We reviewed staff interviews, (b)(6) complaints, adverse event reports, personnel memoranda, Morbidity & Mortality (M&M) Meeting reports specific to the (b)(6), an external (b)(6) program review report, and a patient's electronic health record.

A search of the Computerized Patient Record System was unable to locate the patient named by the complainant. However, system managers knew of an incident similar to that described by the complainant. This incident, which occurred on February 23, 2012, did not involve the patient named by the complainant, but it did

(b)(3):5 U.S.C. App 3 (IG Act):(b)(6)

[6] The delay between the OIG's receipt of the system's response and OHI's review of it is attributed to a Federal Government furlough from October 1, 2013 - October 17, 2014.

[7] OHI considered that a partial response may have been provided because the complainant had requested confidentiality, and honoring this request resulted in only part of his allegations being forwarded to the system.

involve the [redacted]. We confirmed that the [redacted] had interviewed the [redacted] who was present during the patient procedure. The [redacted] stated that at the time of the incident, he was aware that a [redacted] was missing when he was operating on a patient. However, the patient was talking and in no respiratory distress. The [redacted] informed the patient that Emergency Medical Service (EMS) would transport him to a local, non-VA emergency department to remove the [redacted]. After calling EMS, the [redacted] stayed with the patient and the [redacted] went to his office. The patient continued to try to dislodge [redacted] by drinking water, coughing, and gagging. At one point, the [redacted] called for the nearest person, the complainant, to assist. Soon afterward, EMS transported the patient to a non-VA emergency department where the [redacted] was retrieved. The patient was discharged to home later that day in good condition. The following week, the patient returned to the CBOC for a follow-up [redacted] appointment with no complaints.

We validated that the [redacted] presented the incident at an M&M meeting. [redacted]

We found that the [redacted] and a Human Resources representative had interviewed five CBOC [redacted] who reported that the complainant was the [redacted]. We identified documents in which that CBOC [redacted] staff repudiated assertions of [redacted] by the [redacted]. We found that the system Director requested a program review of the facility's [redacted], including the CBOC. [redacted] from Veterans Integrated Service Networks (VISN) 15 and 19 conducted the program review. This program review did not identify issues consistent with the complainant's allegations.

Based on further clarification and validation of system internal review data, interviews with system managers, and the VISN's program review, we concluded that the complainant's allegations were not substantiated. Therefore, I am administratively closing this case.

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Healthcare Inspections

5/27/14