Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02437-117

Healthcare Inspection

Staffing and Quality of Care Issues in the Community Living Center Charlie Norwood VA Medical Center Augusta, Georgia

March 19, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by an anonymous complainant concerning staffing and quality of care issues resulting in patient harm and death in the community living center (CLC) at the Charlie Norwood VA Medical Center (facility), Augusta, GA.

We substantiated the allegation that the facility was without one of three registered nurse (RN) Certified Wound Care Specialists for over a year. We did not substantiate that several patients' wounds were neglected as a result of the vacancy and that management was aware of the issue but failed to take corrective action. The facility had attempted to fill the position but had difficulty recruiting a qualified candidate. We found that facility leaders expanded the services of the remaining two RN wound care specialists to cover all clinical areas including the CLC. In addition, wound care champions were implemented in the CLC to perform daily skin assessments on all CLC residents. While we found that one patient the complainant identified had several pressure wounds, we determined that the care for this patient's wounds was acceptable.

We did not substantiate the allegation that a patient's death occurred due to a primary care provider's (PCP) failure to address the patient's intestinal problems. We concluded that the PCP responded appropriately by sending the patient to the inpatient medical unit for evaluation. We found that surgery, gastroenterology, and psychiatry teams evaluated the patient and that the patient's unexplained weight loss was attributed to poor nutrition. We also found that the patient refused meals even after the dietitian made numerous meal adjustments.

We substantiated the allegation that a patient had a wound vacuum assisted closure (VAC) device that nurses and physicians failed to maintain. We did not substantiate that the sponge from the wound VAC "eviscerated" into the patient's abdominal wall. However, we did find that the sponge adhered to the wound and required removal. We determined that the wound VAC was not routinely used in the CLC, and nursing staff were not trained on the device prior to the patient's return to the CLC after having abdominal surgery. We concluded that the lack of training may have contributed to a delay in the CLC nurses identifying that a problem existed with the wound VAC system.

Although we found that a patient went into distress and had acute mental status changes, we did not substantiate the allegation that the PCP failed to send the patient to the inpatient medical unit earlier during the day, which resulted in a code being announced later that evening. We also did not find that the patient provided a written statement regarding the incident and that the facility failed to address it. We determined that the PCP advised the patient twice of the need to be evaluated in the emergency department for episodes of tremors, but the patient initially resisted the transfer. We also determined that prior to moving the patient, the Rapid Response Team was called due to an acute change in the patient's mental status. We reviewed Patient Advocate

Tracking System data and found no evidence that the patient provided a written statement regarding this incident.

We substantiated the allegation that a patient developed several wounds that needed debridement. However, we did not substantiate that due to the lack of an RN wound care specialist onsite, the patient's health deteriorated and he had to be moved to hospice. We found that one of the RN wound care specialists did see the patient and made appropriate recommendations for four pressure wounds that needed debridement. We also found that the PCP consulted podiatry and plastic surgery services. We further determined that the patient was diagnosed with osteomyelitis and his wounds continued to worsen, but the spouse did not want aggressive treatment. The PCP, therefore, transferred the patient to hospice where he expired.

We recommended that the Facility Director require that all nursing staff in the CLC receive the required training on the wound VAC device.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 10–12 for the Directors' comments.) We will follow up on the planned action for the open recommendation until it is completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by an anonymous complainant concerning staffing and quality of care issues resulting in patient harm and death in the community living center (CLC) at the Charlie Norwood VA Medical Center (facility), Augusta, GA.

Background

The facility is a two-division medical center in Veterans Integrated Service Network (VISN) 7. The facility has 278 acute inpatient beds, 60 domiciliary beds, and 132 CLC beds. Medicine, surgery, spinal cord injury, and emergency department (ED) services are provided at the downtown campus, and mental health and long-term care are provided at the uptown campus.

Allegations

In March 2014, the OIG's Hotline Division received allegations concerning staffing and quality of care issues in the CLC. Specifically, the complainant alleged that:

- The facility was without a Registered Nurse (RN) Certified Wound Care Specialist[1] for over a year, resulting in several incidents of pressure wounds (ulcers)[2] being neglected; management was aware of the issue but failed to take corrective action.
- A patient expired because a primary care physician (PCP) failed to address the patient's intestinal problems.
- A patient had a wound vacuum assisted closure (VAC)[3] device that nurses and physicians failed to maintain. As a result, a sponge [GranuFoam™][4] from the wound VAC "eviscerated"[5] into the patient's abdominal wall.

[1] A Certified Wound Care Specialist is a clinician certified by one of the nationally recognized wound care certification organizations (American Academy of Wound Management; the National Alliance of Wound Care; and the Wound, Ostomy, Continence Nursing Certification Board).
[2] Pressure wounds or ulcers, known as decubiti or bedsores, are localized injuries to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure or pressure in combination with shear and/or friction. The most common areas affected are the sacrum, coccyx, heels, and hips. Pressure ulcers most commonly develop in persons confined to bed or wheelchairs.
[3] A wound VAC device delivers negative pressure at the wound site through a patented dressing that is designed to draw wound edges together, remove infectious materials, and actively promote granulation. The negative pressure is achieved with the use of a sealed dressing and a vacuum pump.
[4] GranuFoam™ is a sponge-like dressing used with the wound VAC.
[5] The complainant used this terminology in the allegation. As the complainant was anonymous, we were unable to clarify this statement. Evisceration refers to the protrusion or removal of the contents of an organ. We determined that the complainant was referring to the adherence of the sponge to the wound bed.

- A patient went into distress and had drastic mental status changes. The PCP failed to send the patient downtown [inpatient medical unit] earlier during the day, which resulted in a code [notification of a medical emergency] being announced later that evening. The patient provided a written statement regarding the incident; however, the facility failed to address it.

- A patient developed several pressure ulcers that needed debridement;[6] however, due to the lack of an RN wound care specialist onsite, the patient's health drastically deteriorated, and he had to be moved to hospice.

Scope and Methodology

We conducted a site visit July 22–23, 2014. We interviewed the Associate Director for Patient Care Services, the Associate Nurse Executive for Geriatrics, clinical providers, CLC nurses, and other staff with knowledge of the allegations. We reviewed four patients' electronic health records (EHR), relevant VHA and facility policies, staff competency and training certificates, and other pertinent documents. In addition, we toured two of the CLC units.

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.

[6] Debridement is a process of removing unhealthy tissue from a wound to promote healing.

Case Summaries

Patient 1. The patient was a male veteran in his mid-sixties with multiple medical conditions, including dysphagia (difficulty swallowing) and a failure to thrive syndrome.[7] After a stroke in 2008, the patient was discharged to the CLC for permanent long-term care.

In early winter 2013, the PCP consulted the General Surgery Service for possible gallbladder surgery due to gallstones noted on a sonogram[8] performed in the fall. At that time, the PCP noted that the patient had a 30 pound weight loss over the last 2 months and appeared very ill. The following day, the PCP transferred the patient to the inpatient medical unit for further tests.

While on the medical unit, the general surgery team evaluated the patient and documented that he was a poor surgical candidate and did not appear to have symptoms related to the gallstones. They recommended conservative management. The gastroenterology team was also consulted. An esophagogastroduodenoscopy[9] was performed; the findings did not suggest an acute etiology for his weight loss. The medical resident wrote that the weight loss was, "likely due to poor nutrition." The patient was transferred back to the CLC.

About 6 weeks later, the PCP wrote that the patient had done better with meals; although, there was no increase in weight. Within a few weeks, the patient's nutritional status started to decline again. The dietitian documented that the patient's poor appetite was related to his medical issues. The PCP noted that the patient was again losing weight and requested double portions for the patient's breakfast meal along with supplemental nutritional drinks. The PCP also referred the patient to the psychiatry team to evaluate for depression as a contributing cause for the weight loss.

In late winter, the PCP transferred the patient to the ED for recurrence of not eating, continued weight loss, and hypotension. The patient was admitted to the inpatient medical unit with a diagnosis of renal failure, dehydration, and urosepsis.[10] The patient expired the following day.

Patient 2. At the time of our review, the patient was in his late fifties with multiple medical conditions, including hypertension and anemia (decrease in red blood cells).

In fall 2013, the patient was transferred from the CLC to the ED and admitted to the general surgery unit for abdominal distention. One month later, abdominal surgery through an open incision was performed. On post-operative day 6, the surgeon noted

[7] A 'failure to thrive' term is a descriptive, non-specific term that encompasses 'not doing well,' for example, malaise, weight loss, or poor self-care that can be seen in elderly individuals.
[8] A sonogram is a test that takes pictures of certain parts of the body by using sound waves.
[9] An esophagogastroduodenoscopy is a test to examine the lining of the esophagus, stomach, and first part of the small intestine.
[10] Urosepsis is a severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream.

that part of the wound was open and ordered wound care. In mid-fall, it was noted that the wound was infected, and a wound VAC device was placed onto the patient's lower midline abdominal incision. The patient was discharged back to the CLC a few weeks later. One of the CLC RNs documented that the patient arrived with the wound VAC to the mid-abdomen; it was intact with continuous suction.

On day 11 of the patient's return to the CLC, an RN noted that the wound VAC was not functioning well and showed blockage. The RN changed the wound VAC dressing, but the GranuFoam™ was stuck to the wound and a small wound area was exposed. The RN added a small GranuFoam™ but was unable to obtain a seal to the area. The RN applied an abdominal dressing over the wound area and documented, "continue to monitor drainage and reapply dressing when needed and refer to MD in a.m." Three days later (day 14 after returning to the CLC), the PCP documented that the wound VAC sponge was adherent to the wound base and could not be removed. An order was written to keep moist gauze on the abdominal surgical site to loosen the sponge and cover the area with an abdominal pad.

The PCP consulted the Surgical Service, and the patient was sent to the ED for evaluation. The surgeon examined the patient in the ED and removed the GranuFoam™ but noted that some remnants were left in the wound due to close adherence to the skin. The patient was transferred back to the CLC with instructions from the surgical team for three times a day wet to dry dressing changes to the wound site.

Patient 3. At the time of our review, the patient was in his early sixties with multiple medical conditions, including bilateral above-knee amputations, urinary tract infections, and hypertension.

One afternoon in late fall 2013, an RN in the CLC notified the patient's PCP that the patient had experienced a tremor.[11] The PCP evaluated the patient and documented that the patient was resistant to being transferred to the ED. Within 35 minutes, the PCP ordered labs, reviewed the results of the patient's recent urine cultures, and ordered an antibiotic. About 30 minutes later, the RN notified the PCP that they were unable to get the blood drawn and that the patient was vomiting. The PCP discussed with the patient again the importance of being transferred to the ED, as the patient was no longer able to reliably take medications orally. The patient agreed to the transfer. Before the transfer could be accomplished, the CLC RN called the Rapid Response Team[12] because "the patient was experiencing episodes of tremors, vomiting, body pain, and was febrile (temperature of 102.5) with an acute change in mental status." The patient was alert with some confusion when the team arrived. He was stabilized, transferred to the ED, and later admitted to an inpatient medical unit with a diagnosis of a urinary tract infection. The patient recovered and was transferred back to the CLC 7 days later.

[11] A tremor is an involuntary, somewhat rhythmic, muscle contraction and relaxation involving to and from movements of one or more body parts.
[12] A Rapid Response Team is a team of health care providers that responds to hospitalized patients with early signs of clinical deterioration on non-intensive care units to prevent respiratory or cardiac arrest.

Patient 4. At the time of our review, the patient was a male veteran in his early seventies and a resident in the CLC since fall 2011. The patient had multiple medical conditions, including hypertension and multiple cerebrovascular accidents with residual left sided hemiparesis.[13]

In mid-summer 2013, one of the CLC nurses documented, "patient has area on right side of buttocks from abscess [*sic*], area tissue is soft, some redness present. Interventions: frequent position changes, turn/reposition every 2 hours using pillows to separate areas, perform range of motion, maintain clean and dry skin, apply protective barrier ointment."

About 2 weeks later, the patient was transferred to the ED for an acute medical illness. An RN in the ED noted that the patient showed no signs of skin breakdown on his buttocks at that time. The patient was admitted to the inpatient medical unit with a diagnosis of sepsis, hyperglycemia, and dehydration.

The patient recovered and was transferred back to the CLC. One of the RNs in the CLC documented in the receiving note that the patient had a right heel deep tissue injury and a stage II[14] pressure wound on the buttocks. A few days after his return to the CLC, an RN wound care specialist responded to a consult from the patient's PCP and recommended a specialty bed, wound care as ordered, turn and reposition every 2–3 hours while in bed, and pressure releases every 15–20 minutes while up in the chair.

In winter 2014, a podiatrist was consulted, evaluated the patient, and made wound treatment recommendations. Four days after the podiatrist saw the patient, an RN wound care specialist re-evaluated the patient's wounds.

About 2 weeks later, the patient was admitted to Medicine Service for possible osteomyelitis (a bone infection most often caused by bacteria) of the right heel. During that admission, Podiatry Service and the Infectious Disease team were consulted. A bone biopsy was performed and was found to be positive for acute osteomyelitis that was treated with antibiotics and local wound care. The plastic surgery team was also consulted to evaluate the patient's bilateral hip and buttocks ulcers. The plastic surgeon made wound treatment recommendations including every 2 hours turning and nutritional supplements. The patient was transferred back to the CLC.

In late winter, the PCP wrote, "Patient continues to decline, oral intake had been consistently poor, and the ulcers continued to worsen." The PCP conferred with the patient's spouse to determine the family's treatment preferences and transferred the patient to hospice where he later expired.

[13] A cerebrovascular accident is the sudden death of some brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain; it is more commonly known as a stroke. Hemiparesis is a muscular weakness or partial paralysis restricted to one side of the body.
[14] Stage II pressure wound: the skin breaks open, tears away, or forms an ulcer, which is usually tender and painful. The sore extends into deeper layers of the skin.

Inspection Results

Issue 1: CLC Staffing

We substantiated the allegation that the facility was without an RN Certified Wound Care Specialist for over a year. We did not substantiate that several patients' wounds were neglected as a result of the vacancy and that management was aware of the issue but failed to take corrective action.

The facility had three RN Certified Wound Care Specialist positions. The Associate Director for Patient Care Services stated that one of the positions had been vacant since July 2013 due to difficulty recruiting a qualified candidate. In the interim, we found that facility leaders expanded the services of the two remaining RN wound care specialists to cover both the uptown and downtown campuses including the CLC. In addition, wound care champions (RNs trained in advanced wound care management) were implemented in the CLC to perform weekly skin assessments on all CLC residents.

Although one patient the complainant identified had several wounds, we found that the patient's PCP consulted one of the RN wound care specialists who made appropriate recommendations for the pressure wounds. In addition, we determined from the EHR review that the care of this patient's wounds was acceptable.

Issue 2: Quality of Care

Patient 1

We did not substantiate the allegation that a patient's death occurred due to a PCP's failure to address the patient's intestinal problem.

We determined that the PCP consulted the General Surgery Service due to the patient's unexplained weight loss and gallstones noted on a sonogram. The PCP transferred the patient to the inpatient medical unit for evaluation. We determined that a surgeon evaluated the patient and recommended conservative management, as the patient did not appear to have symptoms related to gallstones and was a poor surgery candidate. In addition, we found that a gastrointestinal evaluation was completed with no significant findings. We found documentation that indicated the unexplained weight loss was most likely due to poor nutrition. We also found evidence that the PCP consulted psychiatry to determine if depression was a contributing cause of the weight loss.

The dietitian we interviewed reported that the patient had continuous meal adjustments without significant changes in nutritional status. An RN told us that the patient often refused meals and fluids, which we validated during our EHR review.

Patient 2

We substantiated the allegation that a patient had a wound VAC that nurses and physicians failed to maintain. We did not substantiate that a sponge from the wound VAC "eviscerated" into the patient's abdominal wall; however, we did find that the wound VAC sponge became adherent to the wound.

We determined that 11 days after the patient returned to the CLC, an RN observed that the wound VAC system was not functioning. Other than the initial admission note indicating that the wound VAC was intact with continuous suction, we did not find documentation in the EHR addressing the functioning of the wound VAC prior to post-admission day 11. One of the CLC RNs told us that wound VAC device dressing changes were not routinely done on the unit, and training was not provided prior to the patient's return to the CLC. We found that the training was provided 28 days after the patient returned to the unit. However, according to the training sign-in sheets, 18 of 35 (51 percent) nursing staff did not receive the training. The Joint Commission requires that staff participate in ongoing education and training in regards to the needs of the patient population.[15]

In addition, we determined that 11 days elapsed after the patient's return to the CLC before staff documented the functioning of the patient's wound VAC. We found that the sponge from the wound VAC adhered to the patient's wound and was removed, but not all of the sponge could be removed due to close adherence to the skin. The patient was informed that the sponge remnants will slowly separate and detach from the base of the wound as part of the natural healing process. In spring 2014, the facility did an Institutional Disclosure of an Adverse Event.[16]

Patient 3

We substantiated the allegation that a patient went into distress and had acute mental status changes. We did not substantiate that a PCP failed to send the patient to the inpatient medical unit earlier during the day, which resulted in a code being announced later that evening. We did not substantiate that the patient provided a written statement regarding the incident and the facility failed to address it.

We found that the RN notified the PCP of the patient's episode of tremors. We also found that the PCP saw the patient and advised the patient of the need for an evaluation in the ED; however, the patient resisted the move. We determined that the PCP initiated appropriate treatment while the patient remained on the unit. In addition, we found that the RN notified the PCP of the patient's declining condition, and the PCP further advised the patient of the importance of an evaluation in the ED. We determined that when the patient agreed to the ED transfer, more than an hour had passed since

[15] The Joint Commission; HR.01.05.03.

[16] An Institutional Disclosure of Adverse Events is a formal process by which facility leader(s) together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

the PCP's initial visit. We found that the Rapid Response Team was called prior to moving the patient due to an acute change in the patient's mental status.

We reviewed the Patient Advocate Tracking System[17] data from November 2013 to February 2014 and did not find any complaints specific to this allegation.

Patient 4

We substantiated the allegation that the patient developed several wounds that needed debridement. However, we did not find that due to the lack of an RN wound care specialist onsite, the patient's health deteriorated and he had to be moved to hospice.

We found that the patient had multiple health care issues including advanced pressure wounds. We determined that the RN wound care specialist and a podiatrist were involved in the patient's care and made appropriate recommendations for the pressure wounds. We found that while the patient was hospitalized in February 2014, the infectious disease and plastic surgery teams evaluated the patient. A bone biopsy was done that confirmed the diagnosis of osteomyelitis. The patient's condition continued to decline, but the patient's spouse did not want aggressive treatment. The PCP, therefore, transferred the patient to hospice where he expired.

Conclusions

We substantiated the allegation that the facility was without a RN Certified Wound Care Specialist for over a year. We did not substantiate that several patients' wounds were neglected as a result of the vacancy and management was aware of the issue but failed to take corrective action. We found that the facility had three RN Certified Wound Care Specialist positions; however, one position had been vacant for over a year due to difficulty recruiting a qualified candidate. We also found that facility leaders expanded the services of the remaining two RN wound care specialists to cover all clinical areas including the CLC. In addition, managers implemented wound care champions in the CLC to perform daily skin assessments on all CLC residents. While we found that one of the patients the complainant identified had several pressure wounds, we determined that the care for this patient's wounds was acceptable.

We did not substantiate the allegation that a patient's death occurred due to a PCP's failure to address the patient's intestinal problem. We concluded that the PCP responded appropriately by sending the patient to the inpatient medical unit for evaluation. We found that surgery, gastroenterology, and psychiatry teams evaluated the patient and that the patient's unexplained weight loss was attributed to poor nutrition. We determined that the patient refused meals even after the dietitian made numerous meal adjustments.

[17] The Patient Advocate Tracking System is a program that tracks patient complaints and compliments at each medical center.

We substantiated the allegation that a patient had a wound VAC device that nurses and physicians failed to maintain. While we did not substantiate that the sponge from the wound VAC "eviscerated" into the patient's abdominal wall, we did find that the sponge adhered to the wound and required removal. The wound VAC was not routinely used in the CLC, and the nurses were not trained on the device prior to the patient's return to the CLC after having abdominal surgery. We concluded that the lack of training may have contributed to a delay in the CLC nurses identifying that a problem existed with the wound VAC system. We found that the facility did an Institutional Disclosure of an Adverse Event because the sponge from the wound VAC adhered to the abdominal wound and was removed. However, the surgeon was unable to remove the sponge completely. The patient was told that the remnants of the sponge will slowly separate and detach as part of the natural healing process.

We substantiated the allegation that a patient went into distress and had acute mental status changes. We did not substantiate that the PCP failed to send the patient to the inpatient medical unit earlier during the day, which resulted in a code being announced later that evening. We also did not substantiate that the patient provided a written statement regarding the incident and that the facility failed to address it. We determined that the PCP advised the patient of the need to be evaluated in the ED for episodes of tremors. In addition, the PCP initiated the appropriate care while the patient remained in the CLC. We concluded that the patient's resistance to the transfer may have contributed to a delay in the ED transport; subsequently, the Rapid Response Team was called due to an acute change in the patient's mental status. We reviewed Patient Advocate Tracking System data and found no evidence that the patient provided a written statement regarding this incident.

We substantiated the allegation that a patient developed several wounds that needed debridement. We did not substantiate that due to the lack of an RN wound care specialist onsite, the patient's health deteriorated and the patient had to be moved to hospice. One of the RN wound care specialists did see the patient and made appropriate recommendations for four pressure wounds that needed debridement. The PCP consulted podiatry and plastic surgery services. We further determined that the patient was diagnosed with osteomyelitis and his wounds continued to worsen, but the spouse did not want aggressive treatment. The PCP, therefore, transferred the patient to hospice where he expired.

Recommendation

Recommendation 1. We recommended that the Facility Director require that all nursing staff in the Community Living Center receive the required training on the use of the wound vacuum assisted closure device.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 5, 2015

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Inspection—Staffing and Quality of Care Issues in the Community Living Center, Charlie Norwood VA Medical Center, Augusta, Georgia

To: Director, San Diego Office of Healthcare Inspections (54SD)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Thank you for the opportunity to review your findings and the draft report. I concur with both the resolved complaints and the identified recommendation and the thoroughly completed response provided by the Augusta leadership which I hope will close this report.

Charles E. Sepich, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 31, 2014

From: Acting Director, Charlie Norwood VAMC, Augusta, GA (509/00)

Subj: Healthcare Inspection—Staffing and Quality of Care Issues in the Community Living Center, Charlie Norwood VA Medical Center, Augusta, Georgia

To: Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review the draft report. I concur with the identified recommendation.

2. Attached is associated action plan for the recommendation. Please feel free to contact Mary A. Hill, Acting Chief, Quality Management Service for questions at 706-733-0188, extension 3638.

Michelle Cox-Henley

Michelle Cox-Henley

Acting Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendation in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the Facility Director require that all nursing staff in the Community Living Center receive the required training on the use of the wound vacuum assisted closure device.

Concur

Target date for completion: December 15, 2014

Facility response: The facility developed the following action plan in response to the above recommendation.

- Wound Care Nurses and assigned Nurse Educators will provide Wound Vac training for all CLC RNs/LPNs. Documentation of training will include:
    - Signed attendance rosters
    - Completed competency forms

  By October 10, 2014, 74/75 staff completed the Wound Vac training. The remaining RN is on emergency leave and is expected to complete training on January 2, 2015.

Appendix C

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Judy Montano, MS, Team Leader Deborah Howard, RN, BSN, MSN Julie Kroviak, MD Glen Pickens, RN, BSN, MHSM Derrick Hudson, Program Support Assistant

Appendix D

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