March 30, 2006

4/7/06

**Memorandum to the File**
**Case Closure**

Patient Treatment Issues
VA Medical Center, Bay Pines, FL

(2006-01214-HI-0287)

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) received a complaint from a veteran treated at the Bay Pines VA Medical Center. The complainant alleged that:

- He broke his leg in a fall while hospitalized, yet did not receive treatment for the fracture for a week.
- He suffered heart failure as a result of severe fluid imbalance due to improper hemodialysis (HD) and inadequate monitoring of his weight.
- He was hurriedly and inappropriately discharged from the facility without any notification.
- He was left alone in his front yard by the transportation service as his family was not notified of his discharge.
- The facility misplaced his prosthetic leg for 10 days.

We planned a site visit to interview the complainant, his family, and medical center staff involved in the patient's care. We reviewed the patient's medical record and the Root Cause Analysis (RCA) completed by the facility when they learned of the patient's concerns. The purpose of our inspection was to assess whether the RCA properly addressed the complaints and recommended appropriate corrective actions, and to determine if the complainant's allegations had merit.

*Case History*

The patient is a 79-year old male with a medical history that included end stage renal disease (ESRD), diabetes (IDDM), hypertension (HTN), coronary artery disease (CAD), stroke (CVA), and a right below the knee amputation (BKA). He was admitted to the medical center on December 6, 2005 for gait training with his new prosthesis. He received HD three times a week. During this admission, he suffered a leg fracture and heart failure. He was discharged home via Sarasota County Access Transport bus on December 28, 2005 and left alone in his front yard. The next day he was admitted to a local hospital and had considerable fluid drained from his body over the course of a few days.

The facility conducted an RCA after learning of the patient's complaints. The RCA team (b)(6) 38 U.S.C. 5705

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6-5

March 30, 2006

(b)(3) 38 U.S.C. 5705

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The facility also performed a peer review of the patient's care.

We found that the RCA was thorough and its findings were reasonable. The recommendations (b)(3) 38 U.S.C. 5705

(b)(3) 38 U.S.C. 5705

The complainant's son informed us a few days prior to our site visit that the family had obtained legal counsel and planned to file a tort claim against the Bay Pines VA Medical Center related to this patient's care. The lawyer advised them not to speak to us. Therefore, in view of the medical center's RCA, which was acceptable, and the pending legal action, we will not open a formal investigation at this time.

Prepared by: Christa Sisterhen
Christa Sisterhen
Health Systems Specialist
Office of Healthcare Inspections

Approved by: _____
Victoria Coates
Director, Atlanta Region
Office of Healthcare Inspections