5/17/06

Administrative Closure Summary
May 2, 2006
Hotline Inspection MCI# 2006-01671-HI-0329
VA Medical Center, Bay Pines, FL

VA Office of Inspector General (OIG) Hotline Section received a letter from the Tampa Office of the Florida State Office of Attorney General (OAG), Office of Medicaid Fraud, alleging poor care provided to a veteran patient residing at a community nursing home (CNH) after transfer from and readmission to the VA Medical Center (516) at Bay Pines, Florida (BPVAMC) during the period January 6-20, 2006.

The OAG allegation described a patient readmitted to the BPVAMC from a CNH with open pressure sores on his heel, open skin abrasions on his lips with bleeding gums, and acute build-up of mucus in his mouth and nose. The OAG conducted an independent investigation of the CNH and determined that "there is no evidence to indicate the facility staff (CNH) failed to provide sufficient care for the patient on an ongoing basis." The OAG office recommended referral to the VA-OIG for investigations and closed the case.

The BPVAMC had no contractual relationship with the CNH. The patient was referred to the CNH for routine placement under Medicare coverage.

The patient is a 78-year-old, African-American male veteran receiving a Non-service Connected (NSC) pension, and is well known to the BPVAMC staff from several clinical disciplines, including Neurology, Geropsychiatry, Geriatric Rehabilitation, Physical Medicine & Rehabilitation, Plastic Surgery, ENT, and Nursing.

The St. Petersburg Office of Healthcare Inspections (54SP) reviewed progress notes, consult summaries, and diagnostic testing reports contained in the Computer Patient Record Systems (CPRS) at BPVAMC beginning with the patient's initial entry into the VA healthcare system on October 19, 2005, and continuing through his readmission from the CNH on January 20, 2006. A review of his medical record disclosed the following;

The patient was admitted to BPVAMC three times: October 19, December 8, 2005, and January 20, 2006. Following his second BPVAMC admission, he was discharged to the CNH on January 6, 2006, where he stayed until his readmission to BPVAMC on January 20, 2006.

Prior to discharging the patient to the CNH on January 6, 2006, BPVAMC staff completed all required clinical summaries and provided copies to the receiving CNH. The summaries adequately described the patient's condition, diagnoses, and treatment while at the BPVAMC. Where appropriate, the summaries identified skin condition and pressure sores, mouth breathing, and other aspects of care requiring more diligent attention and oversight by CNH staff. For example, nursing assessment program notes

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dated December 22-23, 2005, identified skin lesions on the patient's elbows and necrosis on his heels and documented that specific skin integrity actions were initiated to address his skin problems. Skin integrity actions were documented in the patient's treatment plan. These notes were representative of the medical records we reviewed that documented BPVAMC's identification of the patient's skin problems and treatment through application of pads and interventions.

The St. Petersburg Office did not have access to CNH patient records directly. The OAG, in the letter sent to OIG Hotline Section, contained very brief synopses of progress notes form the CNH. The CNH discharge documents sent with the patient during transfer back to BPVAMC were obtained and reviewed. The CNH discharge documents sent with the patient did not provide information on the patient's mouth breathing status or existence of potentially compromising pressure sores.

The St. Petersburg Office did not substantiate any issues performed or not performed by BPVAMC staff that could have or would have contributed to the patient's change in physical status while receiving treatment external to the BPVAMC facility.

We found the care provided to the patient at BPVAMC appropriate and have no recommendations.