Administrative Closure
Alleged Quality of Care Issues
Rhode Island State Veterans Home
Providence, Rhode Island
2009-01858-HI-0107

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The VA Office of Inspector General (OIG), Office of Healthcare Inspections received allegations regarding quality of care issues at the Rhode Island State Veterans Home, Bristol, RI (the home). The purpose of this review was to determine if the allegations had merit.

The State of Rhode Island Department of Health (DOH) and the Providence VA Medical Center, Providence, RI (medical center) have conducted several announced and unannounced visits to the home. The VA OIG has not conducted a site visit.

State homes are established by a state for veterans disabled by age or disease, and who are incapable of earning a living. The homes provide care for eligible veterans in need of domiciliary, nursing home, hospital, and adult day health care. VA participates in two grant-in-aid programs for states. VA may pay up to 65 percent of the cost of construction or acquisition of state nursing homes or domiciliary, or for renovations to existing state homes. VA also provides per diem payments to states for the care of eligible veterans in state homes. The Secretary of Veterans Affairs may adjust the per diem rates each year.

When a state home accepts VA construction grant assistance, at least 75 percent of the bed occupants at the facility must be veterans. VA pays at least a 33 1/3 percent share of the states' cost for the provision of such care.

A state home is owned and operated by the state. The state is responsible for performing annual inspections of the home to ensure the safety and quality of the care provided. In addition, the state home's VA medical center of jurisdiction performs an annual inspection, audit and record review to assure that VA standards for quality of care are met, and to assure congress of the same. The VA medical center of jurisdiction is responsible for ongoing quality monitoring. The state home is required to meet VA standards in order to continue to receive per diem payments from VA.

The home is a 110 acre complex located in Bristol, RI. Veterans are eligible for care if they served in the military for a period of 90 days or more, which began or ended during any foreign war or conflict in which the United States was involved, or in any expedition or campaign for which the United States issued a campaign medal. The applicant must have been honorably discharged and deemed in need of the care and services provided at the home. Social, medical, nursing and rehabilitative services are

also provided to veterans and their survivors and/or dependents to improve their physical, emotional and economic well-being.

The home consists of 260 nursing care beds in three skilled and semiskilled units and two ambulatory care units with 79 beds. The home provides nursing, rehabilitation services, and Alzheimer's care in a fully certified unit. In addition the Transitional Supportive Program provides services to homeless veterans. These services include substance abuse treatment, work therapy, case management, individual and group counseling, medical and psychiatric follow-up and after-care planning.

The VA medical center of jurisdiction for the home is the Providence VA Medical Center, Providence, RI. Staff at the medical center are responsible for performing annual inspections to ensure patient safety and quality of care. These inspections are reported to VHA leadership and Congress.

In April 2009, the VA OIG received the following complaints:

- Five to seven veterans' sustained serious falls and three of these died within one month of their falls. One other veteran died as a direct result of a fall.
- Medication errors have increased with an increase in the use of agency nursing staff.
- The home does not have a licensed administrator as required by state law.
- Inadequate management of patient's pain and lack of a pain management effectiveness committee.

The DOH review stated that seven veterans had fallen. Two of the patients sustained fractures as a result of their falls. DOH did not substantiate that any patient died as a result of a fall. The DOH and medical center inspections identified a failure to track and trend falls and to identify measures to prevent and reduce the severity of falls sustained by the home's residents.

Neither the medical center nor DOH reported a correlation between increased use of contract/agency staffing and medication errors at the home. Both reports confirmed that the home failed to identify and address medication error concerns. The DOH report identified that home "continues to fail to administer drugs in accordance with the attending physician's written order on 5 out of 6 units and in 17 of 39 charts reviewed." Most of the medication errors were due to a failure to follow the provider's written orders. The home tracks medication errors but has no system to trend the errors or develop action plans when negative trends are identified.

The DOH and medical center reports confirmed that the home administrator was unlicensed. However, the DOH provided a waiver for the current administrator to allow time for completion of his licensure exam. There is a former licensed administrator assigned to the home on a full time basis. This arrangement meets the DOH requirement.

The DOH found that 1 out of 35 patient charts reviewed revealed that the patient's pain was not properly managed. The facility did not have any quality improvement program to monitor all aspects of care provided to the residents at the home; nor were policies regarding patient care reviewed in accordance with VA and state regulations. The DOH required the home to conduct a root cause analysis of nursing services and to complete the following:

- Assess medication administration, medication error tracking and reporting, and nurse training.
- Enter into a contract with a Patient Safety Organization to monitor medication errors. Implement a quality improvement program.
- Establish and maintain full compliance with state regulations.

Both the DOH and the medical center reports found an absence of quality management and patient safety programs leading less than optimal care for veterans. The DOH has entered into a consent agreement with the home to ensure that the problems identified in both the DOH and VA inspections are resolved. The quality management and patient safety consultants hired by the home will submit progress reports to the DOH.

Given the oversight provided by the DOH and the medical center, the Hotline has been administratively closed.

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