



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

Assistant Inspector General for Healthcare Inspections

Healthcare Inspection – Alleged Quality of Care Issues, Bay Pines VA
Healthcare System, Bay Pines, Florida

MCI # 2011-00530-HI-0170

At the request of Congressman Vern Buchanan, the VA Office of Inspector General's (OIG) Office of Healthcare Inspections reviewed a complaint from (b)(6) (b)(6)

The purpose of our inspection was to assess whether a previous review by the facility properly addressed the complaints and to determine if the complainant's allegations had merit.

The complainant alleged that:

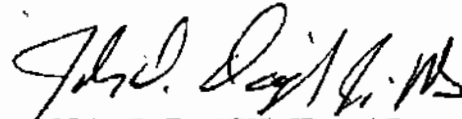
- (b)(6) received inappropriate or incorrect treatment.
- He suffered an adverse drug event.
- He was prematurely discharged to a community nursing home.
- Medical Center staff made insensitive remarks to (b)(6)

The complainant first contacted the OIG Hotline Division on November 8, 2010. The complaint was referred to the facility to review. The facility completed the review on November 15, 2010, and notified the complainant by letter of the results.

The Chief Hospitalist reviewed the medical records and found that the care was appropriate and consistent with the "standard of care." The facility completed an additional review and (b)(3):38 U.S.C. 5705

(b)(3):38 U.S.C. 5705 The facility took action regarding the allegation of insensitive remarks. An apology letter was sent to the (b)(6) and appropriate supervisors were informed of this situation. Staff members were reminded of the expectation that all veterans will receive compassionate and respectful care.

We found reviews by the facility to be thorough and (b)(3):38
U.S.C. 5705 to be reasonable. Our review also showed that the care was appropriate. At this time, the case does not warrant further review and may be closed without the issuance of a formal report.



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