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

TO: Assistant Inspector General for Healthcare Inspections

SUBJECT: Healthcare Inspection – Patient Neglect in Community Living Center, Hunter Holmes McGuire VA Medical Center, Richmond, Virginia

MCI # 2011-01057-HI-0056

Recommendation for Administrative Closure

We recommend administrative closure of this inspection for the following reason: Preliminary research did not support any allegations. No merit.

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations regarding a veteran treated at the Hunter Holmes McGuire VA Medical Center (the facility), Richmond, VA. A confidential complainant alleged that:

- Practitioners failed to provide proper oral care.
- The veteran had an offensive body odor indicating that he is not receiving routine baths.
- The veteran's hair was extremely filthy with an excessive amount of dandruff.
- The veteran was left lying in feces for hours.
- The medical staff has also been remiss in providing the alleged victim with clean clothes. Instead, the same dirty clothes were placed on the veteran the following day.
- Six complaints were filed concerning the above allegations between December 2009 and April 2010.

Background

The facility provides a full range of acute and long-term care services, with a 98 bed Community Living Center (CLC), for approximately 209, 072 veterans. The facility is part of the Veterans Integrated Service Network (VISN) 6. The facility is also a regional referral center for traumatic brain injury and spinal cord injuries.

The veteran is a 38-year old male, who was involved in a motor vehicle accident in December 2003. He sustained a traumatic brain injury, spinal cord injury with quadriplegia[1], broken eye sockets, and a bruised lung. At the time of our visit, he was unable to speak but was able to follow simple commands. In addition, he had limited use of his right hand. He requires total care and is not able to assist with any activities of daily living.

Scope and Methodology

We conducted an onsite inspection February 22–23, 2011, reviewed pertinent documents, including Veterans Health Administration and facility policies and procedures, and the veteran's medical record. We conducted interviews with the veteran's spouse and mother, the facility director, relevant clinical staff, the patient advocate, dental staff and an oral surgeon. We toured the unit, including the veteran's room, and observed his interactions with staff.

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.

Case Summary

The veteran was seen in the dental clinic on July 1, 2004, and staff documented that he had difficulty opening his mouth. He had considerable debris on his teeth and was diagnosed with generalized gingivitis and periodontitis.

On September 22, 2004, the veteran was discharged from the facility's traumatic brain injury unit and transferred to the CLC. At the time of the transfer, the veteran was able to follow simple commands. His motor coordination was limited by a combination of spasticity[2] and athetoid movements.[3] He required assistance with all activities of daily living. The veteran was not allowed to have anything by mouth because he was a chocking risk due to his inability to swallow. He was being fed through a Percutaneous Endoscopic Gastrostomy Tube. The veteran was unable to participate in his rehabilitation.

[1] Quadriplegia is a paralysis of all four limbs or of the entire body.
[2] Spasticity is an involuntary, velocity-dependent, increase in muscle tone that results in resistance to movement.
[3] Athethoid movements consists of involuntary, purposeless weaving motions of the body or its extremities

On October 21, 2005, the veteran was seen again in the dental clinic and had gingival inflammation, generalized plaque, and calculus on all tooth surfaces.

On May 30, 2007, the veteran had severe gingivitis with possible periodontal disease and calculus buildup on his dental crowns. Dental staff were unable to take dental x-rays because of the difficulty the veteran had opening his mouth.

The veteran was seen by the dental hygienist on February 27, 2008, and had a cavity, moderate plaque, and gingival inflammation.

By April 2009, the veteran was able to eat, and his endoscopy tube was removed.

On January 20, 2011, the veteran was taken to the operating room for multiple restorations while under anesthesia on his maxillary teeth, including three root canals and removal of gingival tissue from his lower teeth.

On March 25, 2011, the veteran was taken to the operating room again, and 14 teeth with cavities were excavated and filled. Overgrown gingival tissue was removed from both sides of the lower jaw teeth.

Inspection Results

Issue 1: Dental Care

We did not substantiate the allegation that practitioners failed to provide proper oral care. We reviewed daily oral hygiene records, dental records, and interviewed staff. We found that reasonable attempts were made to provide oral care to the veteran. We noted that the veteran frequently refused oral care, or he only allowed limited care to be done. .

The oral surgeon we spoke to stated that the gingival hyperplasia was from the anti-seizure medications, decreased saliva, the resumption of oral feedings with high sugar, as well as the challenges faced in providing oral care. These conditions have led to accelerated and severe tooth decay with periodontal disease. The surgeon also stated that they stabilized the veteran's oral condition, but the underlying causes are not resolved, and the veteran's future prognosis for oral health remains poor.

Issue 2: Veteran's Bathing

We did not substantiate the allegation that the veteran has an offensive body odor indicating that he is not receiving routine baths. We inspected the CLC, observed the veteran, and reviewed policies and bathing documentation. We found that the veteran was either showered or given a bed bath daily.

Issue 3: Veteran's Hair Hygiene

We did not substantiate the allegation that the veteran's hair is extremely filthy with an excessive amount of dandruff. The veteran has seborrheic dermatitis, which contributes to dandruff production. The veteran's hair was washed with a medicated shampoo during daily showers or bed baths.

Issue 4: Veteran's Body Hygiene

We did not substantiate the allegation that the veteran is left lying in feces for hours. The veteran's injuries left him incontinent of stool and urine. We reviewed medical records and interviewed staff. We found that the veteran has not had any skin breakdown since his admission to the CLC. After each episode of incontinence, he receives proper skin care and his clothing and bedding are changed.

Issue 5: Veteran's Dirty Clothing

We did not substantiate the allegation that the medical staff has also been remiss in providing the alleged victim with clean clothes, and the same dirty clothes are placed on the veteran the following day. The veteran's spouse comes in to the facility two or more times per week to bring clean clothes for the veteran, which are used when dressing him.

Issue 6: Multiple Allegations Filed

We did not substantiate the allegation that six complaints were filed concerning the above allegations between December 2009 and April 2010. We reviewed the Patient Advocate Tracking System patient complaint records from December 2009 to April 2010. We found three complaints, and all were resolved within 7 days or less. Staff also told us that complaints are handled at the lowest level that can best affect a resolution.

Conclusion

We made no recommendations. Our review indicated that the veteran received acceptable care and complaints were resolved quickly. At this time, the case does not warrant further review and may be closed without the issuance of a formal report.

Comments

Concur with recommendation for administrative closure of this inspection.

6/8/11

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