Administrative Closure
Quality of Care and Credentialing Issues
VA North Texas Health Care System (549/00)
Dallas, TX
MCI # 2012-01236-HI-0335

The VA Office of Inspector General Office of Healthcare Inspections received allegations from an anonymous complainant regarding quality of care in the Community Living Center and credentialing issues at VA North Texas Health Care System, Dallas, TX.

We conducted an onsite inspection on January 17–19, 2012. We interviewed management and staff, conducted medical record reviews, and reviewed all incident reports and relevant documents pertaining to the allegations. We did not find that critically ill patients were admitted to a CLC unit. Staff agreed that, while patients often had multiple medical issues, they met admission criteria. Further, staff was comfortable with the patient screening process and the screening committee's decisions. Medical record documentation supports that all patients admitted to a CLC unit during August 2011 met admission criteria.

We did not find a relationship between codes (resuscitation efforts) and nursing staff for any of the 10 CLC unit codes that occurred in FY 2011 through January 17, 2012. Medical staff and management felt CLC unit nurses were proficient during codes and the code team responsiveness (average 5-7 minutes) was appropriate given the distance staff had to travel from the main clinical building to the CLC.

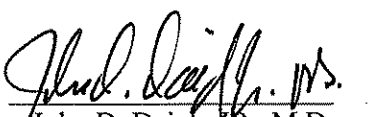
The details provided regarding an alleged CLC unit patient death on November 12, 2011, were not accurate. The complainant stated time, date, and cause of death in the allegation that did not match what was found in the medical record. The patient had a history of stroke and had been an inpatient since September 2011. The patient had a cardiac arrest on November 13, 2011, shortly after eating breakfast; he was revived in the CLC and transferred to the ICU. The patient's medical record documents that the exact cause of the cardiac arrest and subsequent death was unclear; a seizure or aspiration was suggested as possibilities.

We identified the patient who allegedly received inappropriate oxygen administration but did not find any evidence of inappropriate therapy. We identified the female patient who allegedly did not receive methadone on at least one occasion and also suffered an uninvestigated narcotic overdose. We reviewed the patient's medical record and found documentation describing the possible overdose: however, there was no evidence to support missed methadone dosages.

We found no incident reports concerning missing medications in the CLC. The CLC nurse manager and staff nurses did not report nor were they aware of any issues with missing medications taken from medication carts in the CLC by other staff.

We did not find that nurses are allowed to work with expired licenses. The facility has a system in place to track nursing license expiration dates. This system alerts nurse managers of upcoming license expirations so that the subject nurses can be notified and update their license prior to expiration. Nurses without an active unrestricted license are terminated.

We recommend administrative closure.

Approved by: 
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