

Administrative Closure
Alleged Patient Abuse and Staff Issues
Tennessee Valley Healthcare System Alvin C.
York Campus (622)
Murfreesboro, Tennessee
MCI # 2012-04429-HI-0327

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to assess allegations made by an anonymous complainant concerning patient abuse by and complaints against a staff nurse at the Tennessee Valley Healthcare System Alvin C. York Campus (facility). Specifically, the complainant alleged that a Community Living Center (CLC) staff nurse (Nurse A) fed a hot sauce coated doughnut to a patient. The complainant further alleged that the patient refused to get out of bed for two weeks following the alleged incident causing the development of a deep vein thrombosis (DVT). The complainant also alleged facility managers did not address multiple complaints of mistreatment and intimidation of co-workers by the same staff nurse.

We conducted telephone interviews with the CLC Nurse Manager (NM), Acting NM, nursing, social work, housekeeping, and administrative staff. We also interviewed the CLC Quality Manager (QM) who had interviewed the patient. We reviewed relevant facility and VHA policies, procedures, directives, and the patient's electronic health record. Further, we reviewed the documents that the NM collected during a fact-finding review of the alleged patient abuse. The review did not support the allegations.

The patient is in [REDACTED] and has resided at the CLC [REDACTED]. His relevant medical history [REDACTED]

[REDACTED]

[REDACTED]

The patient has [REDACTED]

[REDACTED]

One of the nurses we interviewed (Nurse B) told us that on [REDACTED] the patient had soiled himself and was in need of personal hygiene. Nurse B assisted the patient to the shower area and began to prepare him for a shower. The patient resisted and was shouting loudly. Nurse A came to the shower area to assist. Upon assessing the situation, Nurse A gave the patient a doughnut, in an attempt to calm him down. The patient took a bite of the doughnut and then spit it out complaining that his mouth was hot. Nurse B gave the patient milk to help soothe the patient's mouth discomfort. While cleaning up the doughnut Nurse B noticed a smell similar to hot pepper sauce and threw the doughnut in the trash. Nurse B reported the alleged abuse to the CLC NM on [REDACTED]

[REDACTED]

There is no evidence to support the allegation of patient abuse. We interviewed 11 staff and reviewed multiple relevant documents and the patient's health record. Nurse A denied the allegation. Other than Nurse B, we found no witnesses to support the abuse allegation. However, there was a 14-day delay in reporting the alleged abuse, which does not comply with VHA¹ or facility policy. [REDACTED] and all CLC staff were reeducated regarding patient abuse reporting requirements.

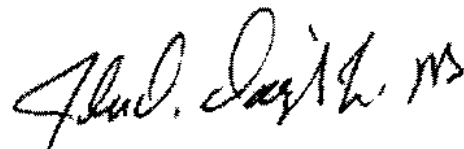
There is no evidence to support that the patient's activities were different after the alleged incident causing the patient to develop a DVT on June 18. The patient had a long history of refusing activity and participation in therapies. The patient had multiple risk factors for developing a DVT including, [REDACTED]

[REDACTED]

We did not substantiate that multiple complaints have been filed against Nurse A by other nurses, food service workers, and cleaning staff for mistreatment and intimidation of co-workers.

We found no documentation of formal or informal complaints against Nurse A. This was confirmed in interviews with the NM, the QM, and review of reports from the Patient Advocate. The CLC staff we interviewed were highly complementary of the care Nurse A provides to patients and did not report any mistreatment or intimidation.

Because the facility took appropriate action and reeducated staff in patient abuse reporting requirements, we made no recommendations.



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3/5/13

¹ VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011.