



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-04401-416

**Healthcare Inspection
Staff and Management
Concerns at the
Jacksonville Outpatient Clinic
Jacksonville, Florida**

July 8, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to an anonymous complaint to Congressman Mike Coffman, Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, regarding multiple allegations about the staff and management of the Jacksonville Outpatient Clinic (OPC) in Jacksonville, FL. The purpose of the review was to determine whether the allegations had merit.

We substantiated that VA maintenance and engineering employees at the Lake City facility provide repair and installation services for VA equipment at the OPC, but this was reasonable. We substantiated that female veterans were not able to obtain mammography imaging services until June 2014, which was the planned opening date for the mammography suite. We also substantiated that the waiting area carpets were heavily stained.

We did not substantiate allegations that:

1. Veterans who presented for walk-in appointments were turned away without being seen.
2. During the second week of June 2014, 19 primary care providers at the OPC treated only 145 veterans.
3. The specialty clinic manager did not make rounds and was unaware of providers not complying with tours of duty or lunch and break times.
4. OPC leadership did not address complaints about managers bullying staff members.
5. The anesthesiologist and operating room (OR) staff members do nothing because the OR air system has to be fixed.
6. Dietary staff saw only 20 veterans during the second week of June 2014.
7. Dieticians made an onsite community garden.
8. Mammography equipment had ongoing technical problems resulting in denials of non-VA mammography requests.
9. Individuals who were referred for non-VA medical care mammography services during the first week of June 2014 were denied care.
10. Wi-Fi access was not available to clinic staff.
11. The OPC clinic was dirty, and environmental service staff were not trained.
12. The security staff did not follow up on an event where a veteran was reported to have been carrying a prohibited weapon in the clinic.
13. The administrative area access was blocked, and staff members were advised to stay out of that area altogether.

We recommended that the System Director take action to improve the cleanliness and appearance of the carpeted waiting room areas at the Jacksonville Outpatient Clinic.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 12–14 for the Directors' comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to an anonymous complaint to Congressman Mike Coffman, Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, regarding multiple allegations about the staff and management of the Jacksonville Outpatient Clinic (OPC) in Jacksonville, FL. The purpose of the review was to determine whether the allegations had merit.

Background

The OPC is a part of the North Florida/South Georgia Veterans Health System (system), which includes the Lake City and Gainesville VA Medical Centers (VAMCs), 10 community based outpatient clinics, 1 outpatient clinic, and 5 other specialty locations of care. The OPC is part of Veterans Integrated Service Network (VISN) 8.

Opened in the spring of 2013, the OPC serves over 38,000 unique veterans, with 309,000 outpatient visits in fiscal year 2014. The OPC offers medical, dental, surgical, psychiatric, nursing, and ancillary services to acute and chronically ill veterans, while referring those in need of specialty care to system inpatient facilities.

Allegations

The multiple allegations involved a number of services within the OPC. The allegations addressed by the OIG Office of Healthcare Inspections were:

- Veterans who presented for walk-in appointments were turned away without seeing a provider, even though there were open slots in providers' schedules.
- During the second week of June 2014, 19 primary care providers at the OPC treated about 145 veterans, averaging less than 7.5 visits in an 8-hour shift.
- Since his arrival a year ago, the specialty clinic manager has only made rounds approximately three times, and providers in the specialty clinics were sleeping on duty, took excessively long lunch breaks, and came in late and left early.
- OPC leadership did not address complaints about managers bullying staff members.
- The anesthesiologist and operating room (OR) staff members do "virtually nothing" because the OR air system has to be fixed.
- Two dietitians at the OPC saw only 20 veterans during the second week of June 2014, an average of 1 patient per dietitian per day. In addition, dietitians were paid to shop for groceries, give cooking demonstrations to veterans, and had permission to make an onsite community garden.

- Female veterans were not able to obtain mammograms at the OPC until June 2014, and mammography technicians reported for duty months earlier and were paid without the ability to perform their duties.
- The new mammography unit continued to have technical problems, causing female veterans to experience cancellations and rescheduling, while non-VA medical care mammogram consults were denied.
- Access to clinic wireless internet services (Wi-Fi) was not available to clinic staff and veterans.
- The OPC was dirty, and housekeeping supervisors did not train or supervise the housekeeping staff.
- Maintenance work at the OPC requires submission of a work order to the Lake City VAMC, whereupon a Lake City crew drives to the OPC to perform the work. If they do not have the correct tools, they may need to drive again to the OPC the following day.
- Security staff remained at the entry area of the OPC and did not follow up on a complaint that a veteran was carrying a prohibited weapon.
- OPC staff members were told that access to the administrative area was blocked, and an email advised staff to stay out of that area altogether.

We categorized the allegations above according to areas of concern: Primary Care, Specialty Care, Nutrition Services, Mammography, Environment of Care, and Security.

We did not address allegations related to labor relations and human resource issues or allegations that we were unable to clarify and/or for which we were unable to obtain specific information.

Scope and Methodology

The period of our review was October 2014 to March 2015. We conducted a site visit at the OPC from October 28–30, 2014. We interviewed OPC clinical and administrative staff, including the Chief Medical Officer; Administrative Officer; Assistant Chief Nurse; Chief, Specialty Care Clinic; Primary Care supervising physician; Radiology Department Manager; Women’s Health Manager; Housekeeping Supervisor; Police Captain; Biomedical Engineering Specialist; Information Technology Specialist; a staff dietician; and a primary care registered nurse (RN). We also interviewed the System Director, the Associate Director for Patient Care Services, and the system’s Contracting Officer Representative (COR) for Leased Properties. We inspected the physical layout of the OPC, toured the administrative suite, and reviewed Veterans Health Administration (VHA) and facility policies related to the allegations.

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.

Inspection Results

Issue 1: Primary Care

Walk-in Appointments. We did not substantiate the allegation that veterans who presented for walk-in appointments were turned away without seeing providers even though there were open slots in provider schedules. Specific dates and times were not provided by the complainant, so we evaluated the overall process for walk-in patients.

VHA policy directs that primary care for veterans be accessible and timely and that veterans should be able to obtain medical advice when they need it, whether during business or non-business hours.¹ Access may be through telephone triage or, when clinically indicated, through the primary care team for a face-to-face visit.

The appearance of open slots in a provider's daily schedule may coincide with time allocated for administrative duties, education, and research, in contrast to direct patient care time.²

We learned that the process for triaging³ all patients presenting to the walk-in clinic is dependent on whether the patient is new to the clinic or already established with a provider. All walk-in patients are evaluated by an RN to determine their immediate need to be seen. New patients with a need to be seen that day are sent to Evaluation Clinic, where they are seen by a nurse or provider. The Evaluation Clinic is open weekdays from 6:30 a.m. to 6:00 p.m. New patients not needing immediate care are assigned a provider and a future appointment. Patients not new to the clinic are triaged to their assigned Patient Aligned Care Team (PACT)⁴ for evaluation by their PACT RN or provider. They are managed according to their level of need, as they may be seeking medication refills, health guidance, or care for an illness. If they need to be seen by a provider, and their assigned provider is not available, they are referred to an available provider.

We reviewed 166 patient advocate⁵ encounters from October 1, 2013, to September 30, 2014, and did not find complaints specific to the walk-in clinic.

Primary Care Visits. We did not substantiate the allegation that during the second week of June 2014, 19 primary care providers at the OPC treated about 145 veterans,

¹ VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012. This Directive that was current at the time of the events discussed in this report, was rescinded March 26, 2015 and replaced by VHA Handbook 1101.10 *VHA Patient Aligned Care Team (PACT) Handbook*.

² VHA Directive 2011-009, *Physician and Dentist Labor Mapping*, February 28, 2011.

³ Triage is the process of assigning a level of urgency to wounded or ill patients.

⁴ PACT: Patient Aligned Care Teams are an approach to improving access and health care continuity. VHA Handbook 1101.10, *VHA Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

⁵ A patient advocate assists or advocates for patients or families to facilitate their healthcare experience.

averaging less than 7.5 visits in an 8-hour shift. The data source the complainant used in the allegation was not provided.

A provider's panel size (number of assigned patients) is determined by the facility and managed through the Primary Care Management Module,⁶ an information technology application, with guidance from VHA policy on PACT.⁷ VHA policy states that direct patient care time also includes the time "...to prepare for, provide, and follow-up on the clinical care needs of patients" and may be spent reviewing patient data and medical literature, consulting with colleagues, and speaking to caregivers and families.⁸

According to Veterans Support Service Center⁹ data, 23 Primary Care providers saw a total of 810 patients at the OPC the week of June 9–13, 2014. The number of patients seen by an individual provider ranged from 3 to 14 per day, with an average of 8.03 visits per provider per day. Not every provider saw patients every day (they may have been on leave or engaged in other duties). Furthermore, this data does not include additional time spent on non-traditional methods of patient care, such as phone calls and secure messaging between providers and patients.

Issue 2: Specialty Care

Employee Tours of Duty. We did not substantiate that the specialty clinic manager did not make rounds and was unaware of providers not complying with tours of duty or lunch and break times. Specific instances of employee non-compliance with arrival and departure times or excessive break times were not provided by the complainant.

The Chief of Specialty Clinics told us that he makes rounds weekly, sees patients in the specialty clinic areas regularly, and participates in monthly training activities for specialty clinic providers. He described an issue with a provider who was reported to be sleeping at her desk. As it was not clear to others whether the individual was on her lunch break, she was advised to rest in her car if she chose to nap during her lunch break.

System policy on hours of duty describes time allotted for tours of duty, lunch and breaks, and types of scheduling. While we were onsite, facility managers told us about other instances of noncompliance with hours of duty. When facility managers learned that staff members of a specific clinic were leaving early, a lead staff member was appointed to provide oversight to ensure compliance with system policy. In addition, OR managers modified scheduled OR employee arrival times to ensure that surgical start times aligned with employee work arrival times.

⁶ VHA Handbook 1101.02, *Primary Care Management Module*, April 21, 2009. PCCM is a Veterans Health Information Systems and Technology Architecture (VistA) application that allows input of panel specific data with national roll up of this data for tracking, case finding, and comparison purposes. This Handbook was scheduled for recertification by March 2014 but has not yet been recertified.

⁷ VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

⁸ VHA Handbook 1101.02, *Primary Care Management Module*, April 21, 2009, p.3.

⁹ Refers to a data repository and analysis site available to VHA.

Management Issues. We did not substantiate the allegation that OPC leadership did not address complaints about managers bullying staff members.

While we were onsite, we learned that there were instances in three clinics where nursing staff complained that physician providers behaved or spoke inappropriately. The cases were reviewed and discussed with employees and clinic leaders. Leadership used different approaches to seek resolution, including group discussions, mentoring, policy development, facilitation, and relocation of staff. Leaders, managers, and staff worked to mitigate differences, and in some cases, the facilitation process continues.

OR Staff Utilization. We did not substantiate that an anesthesiologist and OR staff members do “virtually nothing” because the OR air system has to be fixed.

The OPC clinic was opened in 2013 with plans to provide outpatient surgical services. The clinic has six procedure rooms and two sterile OR suites. At the time of our site visit, the ORs were not in use because of a defect in the air handling systems. The intake and exhaust for the OR and sterile supply air handlers are less than 25 feet apart and require correction before the two sterile ORs can be used. Because the clinic is leased space, the issue requires coordination between VA contracting officers and the non-VA building manager and contractor. The COR for Leased Spaces reported that funding is approved, and detailed construction plans are awaiting building management and contractor action to correct the problem.

The OPC hired an anesthesiologist as part of a staffing plan to provide broader surgical services; however, the lack of a functioning sterile OR has limited the types of surgery available for patients. At the time of our visit, the anesthesiologist traveled to the Lake City or Gainesville facilities 1–2 days per week to provide services and worked at the OPC providing anesthesia for patients in the six clinic procedure rooms. To maintain their skills and share workload, the OR nurses cross-trained to the endoscopy unit,¹⁰ worked in post-anesthesia care, conducted pre-anesthesia evaluations for cataract surgery scheduled at the Lake City VAMC, attended twice-weekly skills training, and conducted mock OR scenarios with the anesthesiologist.

Issue 3: Nutrition Service

We did not substantiate that two dietitians at the OPC saw only 20 veterans during the second week of June 2014, for an average of 1 patient per dietitian per day. We substantiated that dietitians were paid to shop for groceries and give cooking demonstrations to patients and others; however, this was part of a successful education program initiated by nutrition service staff.

Nutrition staff activity reported for the week of June 9–14, 2014, included 28 individual nutrition encounters, 32 nutrition group meetings, 34 diabetes patient appointments, and

¹⁰ The endoscopy unit is an outpatient unit where gastrointestinal procedures are done.

35 MOVE¹¹ group meetings. As a result of these encounters with individual patients and groups, 22 electronic nutrition consults, 6 MOVE consults, and 10 diabetes consults were completed during that week.

In addition to the nutritional assessments, care, and education provided for patients in individual and group settings, OPC dieticians took advantage of audiences in the OPC waiting rooms and gave cooking demonstrations and instructions on preparing meals to patients and others. The dietician and the OPC Administrative Officer reported that feedback on the cooking classes in the waiting room was positive.

We did not substantiate that the dieticians were given permission to make an onsite community garden. A volunteer began efforts to create a garden for veterans on the OPC grounds. Ground was broken for the garden, but the volunteer spearheading the initiative left, so the effort was disbanded.

Issue 4: Mammography

We substantiated that female veterans were not able to obtain mammograms at the OPC until June 2014; however, that was the planned opening date of the OPC's mammography suite. While mammography technicians reported for duty months earlier, we did not substantiate that they were paid without the ability to perform their duties.

Mammography Program Set-Up. The American College of Radiology requires a complex and lengthy process for accreditation of a new mammography unit, taking anywhere from 6–13 months to complete. Critical to this process are quality assurance testing and staff training. Radiologic technologists performing mammography must be certified, licensed, and receive extensive mammography training in order to perform mammograms. They also must perform supervised mammograms as part of program certification.¹²

To achieve approval for the program, the technicians must be part of the mammography unit set-up process. The new employees were needed on-site at least 90 days prior to initiation of services. One mammography technician began work in December 2013, and another arrived in February 2014. They assisted with the necessary paperwork, policy development, equipment orientation, quality assurance process, and digital mammography unit training. In addition, they supported front desk activities and provided assistance with routine imaging and bone density evaluations.

The OPC mammography equipment was scheduled for activation in June 2014. While the plan was to begin performing mammograms on June 3, 2014, a problem with the

¹¹ "MOVE" is a VHA program that encourages weight loss and healthy lifestyles

¹² ACR®, Mammography Accreditation Program Requirements, updated January 15, 2014, retrieved on February 19, 2015, from <http://www.acr.org/~media/ACR/Documents/Accreditation/Mammography/Requirements.pdf>.

Computer Aided Design¹³ system required correction by an applications service person, and the start date was moved to June 10, 2014. We reviewed mammography requests from June 3 through 10, 2014, and found 18 requests for non-VA medical care mammograms. Seventeen patients received non-VA care appointments for their mammography. The remaining patient was not reachable by the non-VA medical care site, and the consult was cancelled, although the patient later presented to the clinic requesting a new consult.

On June 9, 2014, the Food and Drug Administration approved the OPC digital mammography system for clinical use on patients although continued quality control testing was a required part of achieving final certification. On June 10, 2014, the Chief Consultant, Diagnostic Services, VHA, authorized use of the digital mammography equipment for patients at the OPC and on September 10, 2014, provided a 3-year certification to the mammography unit for meeting congressionally mandated mammography quality standards and accreditation by the American College of Radiology.

Mammography Equipment and Scheduling Issues. We did not substantiate that the new mammography unit continues to have technical problems causing female veterans to experience cancellations and rescheduling, while non-VA medical care mammogram consults were denied.

We reviewed all invoices for testing and repairs on the facility's mammography system from April through October 2014. Repairs were required on two instances following the unit opening on June 10, 2014. On June 30, 2014, and August 26, 2014, the mammography machine was being repaired and not available for patient use.

In fiscal year 2014, the OPC had 1,010 mammograms for non-VA medical care requested and authorized. We reviewed all of the requests and did not find any "denied" mammogram requests.

Issue 5: Environment of Care

Wi-Fi Availability. We did not substantiate that access to clinic Wi-Fi was not available to clinic staff. We substantiated that Wi-Fi was not available to patients (the general public). The OPC at Jacksonville has Wi-Fi for use by employees using VA government provided equipment in the performance of their work duties on site.¹⁴ Wi-Fi is not required to be available to the public at the facility.

¹³ Computer Aided Design (CAD) refers to an application required for the functioning of the mammography equipment.

¹⁴ Wi-Fi is a system of accessing the internet from remote machines such as laptop computers that have wireless connections, accessed March 23, 2015, from <http://dictionary.reference.com/browse/wi-fi>.

Facility Cleanliness. We did not substantiate that the OPC was dirty, and housekeeping (Environmental Services) supervisors did not train or supervise the housekeeping staff.

At the time of our visit, Environmental Services at the OPC were provided by two shifts of employees, from 7:00 a.m. through 12:00 a.m. (midnight). The waiting area floors were waxed every 90 days by a contract service. The supervisor performed spot checks, and the Lake City VAMC Environmental Management Services team conducted routine environment of care inspections every quarter. We reviewed the OPC inspection reports for May and August 2014 and found no housekeeping deficiencies.

We were told that the number of visitors to the clinic has increased fourfold, producing a greater need for services in high traffic areas. As a result of complaints about the lack of cleanliness of the 60 clinic-area bathrooms, the supervisor assigned 2 to 3 employees to clean the bathrooms.

Training for Environmental Services staff is by apprenticeship. New employees worked with trained employees, and the supervisor monitored their progress. If performance was unsatisfactory, employees were counseled. The supervisor reported a high employee turnover, because once hired, employees quickly moved to other positions within the system.

We toured the OPC, including clinics, waiting areas, and bathrooms. All areas appeared clean and free of dust and debris, although there was notable staining on all observed waiting area carpets.

We substantiated that some maintenance work at the OPC requires submission of a work order to the Lake City facility, whereupon a Lake City crew drives to the OPC to perform the work. However, we found that this process was evaluated by the facility Chief Medical Officer who determined that a full-time maintenance person was not justified.

The building housing the OPC is leased, and the building owner is responsible for much of the maintenance, including repairs to walls, tiles, carpet squares, plumbing, and electrical work. Work orders for building repairs are submitted electronically¹⁵ to the property management company. During our site visit there were no outstanding work orders beyond 30 days. For non-medical equipment repairs of VA-owned equipment, or to have items hung on clinic walls, VA staff must place an electronic request to the facility maintenance staff at the Lake City facility, which is 64 miles away.¹⁶ A maintenance team is then dispatched from the Lake City facility to the OPC to perform requested services. While some equipment is taken to Lake City for repairs,

¹⁵ Workspeed™ is a web-based communication hub for property managers, tenants, engineers and vendors to submit and complete real-time requests. Retrieved on February 20, 2015, from http://www.mrisoftware.com/Workspeed_Property_Operations_Home_Page.

¹⁶ Distance and time retrieved from <https://maps.google.com/maps?output=classic&dg=brw>.

occasionally, after evaluation of the extent of the requested repair or task, the maintenance team must return for more appropriate tools or equipment. The OPC has two biomedical engineering employees on-site for repairs and maintenance of medical equipment.

Issue 6: Security

Report of Patient with Weapon. We did not substantiate that security staff remained at the front of the OPC and did not follow up on a complaint that a patient was carrying a prohibited weapon.

Security at the OPC is provided by a contracted security agency and VA police. Contracted security services provide coverage onsite 24 hours per day, 7 days per week. VA police are onsite during the day shift from Monday through Saturday. The security service employees wear brown uniforms; VA police wear black uniforms, have badges, and carry weapons. The security service employees do not respond to calls involving deadly weapons. VA police have jurisdiction on the OPC property and grounds but may not respond to issues off-site.¹⁷ VA police speak at OPC monthly training days to educate OPC staff on security staff and VA police role differences.

When queried about an event where a “staff member called to report a patient had spoken about another patient having a gun,” the VA Chief of Police provided recollection of an event, occurring more than 6 months earlier, where VA police followed up when an employee telephoned the front desk and spoke to a security service member, alerting him to a patient who was thought to have a gun. The employee hung up without providing personal identification, his/her location, or a description of the individual with a gun. The security service member at the front desk alerted VA police, and VA police attempted to track down the patient with the gun and the employee who made the call. VA police could not locate the caller, any witnesses, victims, or an individual with a weapon. VA police did not file a report of the incident but did assign VA police to cover the front desk and building entry space after that.

Access to Administrative Area. We did not substantiate the allegation that OPC staff were told that access to the administrative area was blocked, and an email advised staff to stay out of that area altogether.

OPC leadership and administrative staff maintain a suite of offices that has controlled access to the suite entrance. Because the OPC is located in an area of the city where personal safety may be threatened and the administrative area is not located in a main part of the facility, OPC leadership decided to require an access code to enter the area. The access code is programmed into the identification badge of employees and managers who work in the administrative suite, as well as other OPC staff as needed. Other employees may seek admission from someone with access, call someone in the

¹⁷ Security Management Plan, Memorandum No. 132-09, January 1, 2014, North Florida/South Georgia Veterans Health System.

administrative suite for entry, or present to the administrative suite entry door and ring the doorbell. Access to the area is limited but not prohibited.

We found that on June 25, 2014, a nurse manager sent an email to her staff reminding them that the “administrative suite is a restricted access area where a high volume of private and time sensitive information is processed” and advised that individuals should contact their “nurse manager or the Assistant Chief Nurse for assistance if any needs arise that are located within this area.” According to the nurse manager, this email was sent to make sure that employees had an actual need to be in the area. We observed fluid access to the administrative suite via identification badges or doorbell by clinic staff while we were onsite.

Conclusions

We did not substantiate that veterans who presented for walk-in appointments were turned away without being seen. Processes were in place to evaluate and make appropriate arrangements for care for all veterans without a scheduled appointment.

We did not substantiate that, during the second week of June 2014, 19 primary care providers at the OPC treated 145 veterans, averaging 7.5 visits in an 8-hour shift. The 23 primary care providers saw from 3 to 14 patients per day the week of June 9–13 and averaged 8.03 visits per day for a total of 810 patient visits that week. This data did not include other activities involved in performing patient care duties.

We did not substantiate that the specialty clinic manager did not make rounds and was unaware of providers not complying with tours of duty or lunch and break times.

We did not substantiate that OPC leadership did not address complaints about managers bullying staff members. Instances of problems between some providers and staff were addressed by managers.

We did not substantiate the allegation that the anesthesiologist and OR staff members do nothing because the OR air system has to be fixed. All OR staff, including the anesthesiologist, have been utilized in other areas of the OPC and other facilities in the system and will continue to be utilized until the OR is functional.

We did not substantiate the allegation that dietary staff saw only 20 veterans during the second week of June 2014. Nutrition staff activity reported for the week of June 9–14, 2014, included 28 individual nutrition encounters, 32 nutrition group encounters, 34 diabetes encounters, and 35 MOVE group encounters. We substantiated that dietitians were paid to shop for groceries and give cooking demonstrations to veterans; however, this was part of planned nutrition education programs. We did not substantiate that the dietitians made an onsite community garden.

We substantiated that female veterans were not able to obtain mammography imaging services until June 2014; however, June 10, 2014, was the planned opening date for the

mammography suite. Prior to the opening date, mammography services were provided through non-VA care services.

We did not substantiate that the mammography equipment experienced ongoing technical problems, resulting in denials of non-VA mammography requests.

We did not substantiate that individuals who were referred for non-VA medical care mammography services during the first week of June 2014 were denied care.

We did not substantiate that Wi-Fi access was not available to clinic staff. We did substantiate that Wi-Fi is not available to veterans [the general public]. The OPC Wi-Fi is not a public system, and is available only to VA employees using VA equipment in the performance of their clinical and administrative duties.

We did not substantiate the allegation that the OPC clinic was dirty and environmental service staff were not trained, although we did find that the waiting area carpets were heavily stained.

We substantiated that VA maintenance and engineering employees at the Lake City facility provide repair and installation services for VA equipment at the OPC, which we found to be reasonable. VA biomedical engineering employees provide on-site support for medical equipment. The building owner is responsible for servicing building maintenance requests, and they are fulfilled within 30 days.

We did not substantiate that the security staff did not follow up on an event where a patient was reportedly carrying a prohibited weapon in the clinic.

We did not substantiate that the administrative area was blocked or that staff members were advised to stay out of that area altogether.

Recommendation

1. We recommended that the System Director take action to improve the cleanliness and appearance of the carpeted waiting room areas at the Jacksonville Outpatient Clinic.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 29, 2015

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Draft report - Healthcare Inspection—Staff and Management Concerns at the Jacksonville Outpatient Clinic, Jacksonville, Florida

To: Director, Bay Pines Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

Thank you for your onsite review and evaluation. I have reviewed our report and concur with the findings and recommendations.

Corrective action plans have been established with outlined completion dates as detailed in the attached report.

(original signed by:)

David Wittmer for Paul Bockelman, MBA, FACHE
Acting Network Director, VISN 8

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 20, 2015
From: Director, North Florida/South Georgia Veterans Health System (573/00)
Subj: Healthcare Inspection—Staff and Management Concerns at the Jacksonville Outpatient Clinic, Jacksonville, Florida
To: Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed the draft report Healthcare Inspection – Staff and Management Concerns at the Jacksonville Outpatient Clinic. I concur with the findings and recommendation in the report.
2. A corrective action plan has been established with planned completion dates, as detailed in the attached report.



Thomas Wisnieski, MPA, FACHE
Health System Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director take action to improve the cleanliness and appearance of the carpeted waiting room areas at the Jacksonville Outpatient Clinic.

Concur

Target date for completion: December 31, 2015

Facility response: The carpets were deep cleaned early in November 2014, in early February 2015, and again in April 2015. The short term plan is to clean the carpets at least quarterly, or as needed, using contracted services. A long term plan is in place to replace carpets with a material more suitable to high traffic areas. Carpet replacement will be complete by December 31, 2015.

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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