Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-03860-100

Healthcare Inspection

Medical Foster Home Program Concerns Chalmers P. Wylie VA Ambulatory Care Center Columbus, Ohio

February 13, 2018

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection to assess concerns about possible abuse, neglect, and/or financial exploitation of veterans residing in three medical foster homes (MFH) under the purview of the Chalmers P. Wylie VA Ambulatory Care Center (facility) in Columbus, OH. The purpose of this review was to determine whether current residents of the subject MFHs were at risk and whether MFH program managers assured compliance with VA policy and took appropriate actions when program deficits were identified.

On May 23, 2017, facility staff notified the OIG of concerns involving possible abuse, neglect, and/or financial exploitation of veterans residing in MFHs operated by Mr. and Mrs. X, and of other apparent violations of VA policy. MFH managers had already taken action to discontinue admissions to all three of the MFHs in question and offered the veterans (or their surrogates) the option to move to alternate care settings. While one veteran relocated immediately, the remaining veterans elected to stay in their respective MFHs.

During site visits in July 2017, the OIG did not substantiate that the veterans residing in MFH-1 (no veterans resided in Mr. and Mrs. X's other two MFHs at the time) were at imminent risk for abuse or neglect. The OIG found the veterans still residing in MFH-1 to be clean and well-groomed and the home environment pleasant. None of the veterans (and/or their family members/guardians) voiced concerns about the care they received and all declined relocation to an alternate MFH.

The OIG could not substantiate that these veterans were at imminent risk for financial exploitation. Although Veterans Health Administration (VHA) policy discourages MFH owners/caregivers from managing the financial affairs of their residents, the two veterans who designated the MFH owners/caregivers as their financial power of attorney (POA) appeared to have decision-making capacity and were satisfied with this designation.

MFH program managers took appropriate action after determining that the subject MFHs were in violation of VHA policy. Specifically, managers suspended new admissions; provided verbal and written notification to Mr. and Mrs. X regarding the suspension of new admissions; offered residents and/or their family members/guardians the option of transfer to alternate settings; and followed due process guidelines including notification of appeal rights. The facility subsequently revoked VA's approval for all three of Mr. and Mrs. X's MFHs.

While the facility generally met selected VHA requirements pertaining to MFH enrollment, monitoring for abuse and neglect, and caregiver selection, the facility's MFH coordinator did not consistently facilitate appropriate communication, collaboration, and follow-up. The coordinator's documentation did not always reflect actions taken in response to concerns, caregiver files were incomplete, and there was a lack of consistency in communication with other team members. These unresolved issues contributed to an environment where both staff and caregivers were frustrated, and

potentially limited joint problem-solving opportunities that would have allowed the MFHs to remain in good standing.

Local policy states that VA-approved MFHs must meet all state and local licensure requirements and regulations as outlined in Ohio Administrative Code (OAC) Chapter 5122-33 Adult Care Facility (ACF) Regulations.[1] The OAC applies to facilities that provide accommodations and supervision to 3 or more (up to 16) unrelated adults, at least 3 of whom require personal care services. However, VA-approved MFHs housing only veterans are not required to have an actual state license. Because MFH-1 now has three unrelated adults requiring personal care but does not have official VA MFH designation, it is subject to OAC regulations, which prohibits ACF staff to hold a resident's POA.

VHA policy was silent on whether and how to report cases of MFH revocation to outside entities. Nonetheless, MFH staff had notified state authorities including the Ohio Department of Aging-Long Term Care Ombudsman, Ohio Mental Health and Addiction Services, and Adult Protective Services of the revocations. MFH staff further advised these agencies that veterans still resided in MFH-1. According to Ohio regulations, MFH-1 must now secure state licensure to operate legally as an MFH.

The OIG made one recommendation to the Under Secretary for Health (USH) to amend MFH policy to include processes for reporting MFH revocations to appropriate authorities.

Comments

The Executive in Charge, Office of the USH, and the VISN and Facility Directors concurred with our findings and recommendations. The Office of the USH provided acceptable improvement plans. (See Appendixes B, C, and D, pages 12–16, for the full text of the comments.) The OIG will follow up on the planned action until it is completed.

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

[1] On January 1, 2018, OAC 5122-33, Adult Care Facilities, was rescinded and combined under OAC 5122-30, Licensing of Residential Facilities. Citation references in this report are to authorities in force during our review.

Purpose

The VA Office of Inspector General (OIG) conducted a rapid response healthcare inspection to assess concerns about possible abuse, neglect, and/or financial exploitation of veterans residing in three medical foster homes (MFH) under the purview of the Chalmers P. Wylie VA Ambulatory Care Center (facility) in Columbus, OH. The purpose of this rapid response review was to determine whether current residents of the subject MFHs were at risk and whether MFH program managers assured compliance with VA policy and took appropriate actions when program deficits were identified.

Background

The facility provides outpatient medical and mental health care at its main ambulatory care center in Columbus and its four community based outpatient clinics in Grove City, Marion, Newark, and Zanesville, OH. From October 1, 2016, to June 30, 2017, nearly 39,000 veterans completed about 400,000 outpatient visits. The facility is part of Veterans Integrated Service Network (VISN) 10.

General MFH Program Description

The MFH Program provides primary and mental health care for medically complex and disabled veterans who meet nursing home level of care and prefer a non-institutional setting for long-term care. In general, MFHs are privately-owned residences staffed by caregivers who provide 24-hour supervision and assistance with activities of daily living (ADLs, or basic self-care tasks such as feeding, grooming, and toileting) and other care needs. The cost of residential care is financed by the veteran's own resources and includes room, meals, laundry, transportation, 24-hour supervision, and care and assistance with ADLs as defined by the veteran's care plan.

Veterans in the MFH Program are under the oversight of the MFH Program staff and must be enrolled in either the VA Home Based Primary Care (HBPC) Program or VA Mental Health Intensive Case Management (MHICM) Program. HBPC is comprehensive, longitudinal primary care provided by a physician-supervised interdisciplinary team of VA staff in veterans' homes, including MFHs. MHICM is an intensive case management program for veterans with complex chronic mental health disorders.

Facility's MFH Program Profile

The facility's MFH Program has been operational since 2015 and is staffed by two coordinators who determine eligibility, complete assessments, coordinate annual inspections, and admit veterans into the MFH Program. Per policy, MFH Coordinators are responsible for operational program oversight to include making monthly

unannounced visits to monitor for adherence to program guidelines.[2] HBPC staff visit MFH veterans on a scheduled basis, such as weekly or monthly, to assess their clinical and psychosocial conditions and care needs. HBPC staff are also responsible for educating MFH caregivers in specialized resident care needs as noted in the plan of care.

Local policy states that VA-approved MFHs must meet all state and local licensure requirements and regulations as outlined in Ohio Revised Code Chapter 5119.70 Adult Care Facility (ACF) [Definitions].[3] In 2013, the Ohio Revised Code was renumbered. The current code citation addressing residential facilities is ORC 5119.34, with governing regulations for Adult Care Facilities found in the Ohio Administrative Code (OAC) 5122-33. The OAC defines an ACF as an adult family home or group home that provides accommodations and supervision to 3 to16 unrelated adults, at least 3 of whom require personal care services. The OAC also requires that such facilities be licensed by the state. However, VA-approved MFHs housing only veterans are not required to have a state license.[4]

When the OIG was initially told of the MFH-related concerns, the facility had 9 approved homes serving 12 veterans. As of July 19, 2017, the facility had six approved MFHs serving eight veterans.[5]

Definitions of Abuse, Neglect, and Exploitation

The Centers for Disease Control and Prevention describes elder abuse as "an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult."[6]

- Physical abuse is the intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death.
- Emotional or psychological abuse is verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear, or distress.
- Neglect is failure by a caregiver or other responsible person to protect an elder from harm, or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and safety.

[2] VHA Handbook 1141.02, *Medical Foster Home Procedures*, November 10, 2009. This Handbook was in effect at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1141.02, *Medical Foster Home Procedures*, August 9, 2017.
[3] The local policy misidentified the statutory provision as "Ohio Revised Code Chapter 5119.70 Adult Care Facility *Regulation"* (emphasis added).
[4] VA-approved MFHs are subject to annual VA clinical and safety inspections and receive regular VA staff visits and oversight when veterans are in residence.
[5] One additional veteran had been placed in an MFH since the May 2017 report.
[6] The Centers for Disease Control and Prevention website: https://www.cdc.gov/violenceprevention/elderabuse/definitions.html. Accessed August 23, 2017.

- Financial abuse or exploitation is the illegal, unauthorized, or improper use of an older individual's resources by a caregiver or other person in a trusting relationship, for the benefit of someone other than the older individual.[7]

Veterans Health Administration (VHA) policy requires VA employees to report suspected abuse, neglect, or exploitation of community-based (non-hospitalized, non-nursing home) individuals in accordance with their respective state's guidelines.[8] In the state of Ohio, Adult Protective Services (APS) investigates and evaluates reports of suspected abuse, neglect, and exploitation of vulnerable adults age 60 and over.

Decision-Making Capacity

Autonomy is a basic principle of health care ethics and essentially requires health care providers to honor an individual's right to make his or her own decisions, except those for which they lack specific capacity. Responsibility for assessing decision-making capacity belongs with the clinician who is in charge of the patient's care and involves assessing the process the veteran uses to make a decision, not whether the final decision is correct or wise.

Prior Reports

A search did not identify relevant facility-specific or VHA reports involving MFH-related quality of care concerns. See Appendix A for other relevant OIG reports published in the past 5 years.

Reported Concerns and Sequence of Events

On May 23 and June 1, 2017, facility leaders notified the OIG's Office of Investigations of concerns about possible veteran abuse, neglect, and/or exploitation in MFHs owned or leased by Mr. and Mrs. X. Specifically, facility leaders reported:

- Veteran A, who resides in MFH-1, was seen at the facility's Urgent Care Center in mid-2017 for possible urosepsis, and during that visit, was found to also have a decubitus ulcer. Veteran A required hospital admission. The Urgent Care Center physician recommended an evaluation of veteran A's living arrangements.
- Upon further review, facility staff found that Mr. and Mrs. X were leasing two additional properties (MFHs 2 and 3) and then outsourcing care, which violated VA regulations.[9] Also, Mr. X was serving as financial power of attorney (POA) for two MFH veterans. VA regulations discourage MFH caregivers from attempting

[7] The Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/elderabuse/definitions.html. Accessed August 23, 2017.
[8] VHA policy also has internal requirements that must be met *before* reporting to APS.
[9] 38 C.F.R. § 17.73 and the VHA Handbook 1141.02 that was in effect during the period of review define an MFH as a private home in which an MFH caregiver provides care to a veteran resident and where the MFH caregiver lives in the MFH. On August 9, 2017, VHA Handbook 1141.02 was reissued using the same definition of an MFH.

to manage a resident's personal finances due to the high risk of conflict of interest; this arrangement is also prohibited under the Ohio Administrative Code.[10,11]

- In mid-2017, veteran E, who resided in MFH-2, was injured as a result of caregiver Y's "hurried and aggressive" actions during a shopping trip. The incident was reported to APS, and facility staff coordinated veteran E's transfer to another residential setting.

Soon after the alleged incidents were reported, the facility suspended the MFH designations and placement of veterans into MFHs 1–3 due to concerns about quality of care and compliance with administrative requirements. The three veterans remaining in MFH-1 (veterans A, B, and C) and the only veteran in MFH-2 (veteran D) were offered, but declined, transfer to alternate settings pending completion of an internal investigation.

At the time of the OIG's initial visit, investigations had not been completed and the subject MFHs had not yet been deemed appropriate and safe. Therefore, the veterans still residing in those homes were potentially at risk.

Scope and Methodology

The OIG initiated the review on July 11, 2017, and conducted site visits the weeks of July 17 and July 24. During the second site visit, the OIG team toured MFH-1 and another (non-subject) MFH about 45 minutes away.

The OIG interviewed the facility Director, MFH Coordinators, Chief of Social Work, Chief of Geriatrics and Extended Care, HBPC staff, and patient safety and risk managers. The OIG also interviewed Mr. and Mrs. X: veterans A, C, and D and some of their family members/guardians; caregiver Z and a caregiver from a non-subject MFH in Zanesville, OH; and a Veterans Benefits Administration Examiner; county APS representative; Ohio Department of Mental Health & Addiction Services representative; and VHA's acting MFH Program manager.

The OIG reviewed relevant VHA and facility policies and procedures, incident reports, internal reviews, patient advocate reports, privacy officer reports, VISN 10 issue briefs related to MFHs, and MFH inspection reports for fiscal year (FY) 2016 and quarters (Qs) 1–3 FY 2017. The OIG reviewed the medical records of veterans currently residing in MFHs 1–3 and select records of past veteran residents.

VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 cited in this report was beyond its recertification due date, March 31, 2016.

[10] VHA Handbook 1141.02, para. 29 (November 10, 2009). The same guidance is replicated in the August 9, 2017, revision at para. 24.
[11] Ohio Administrative Code 5122-33-21, Laundry services; activities; resident property, para. (C)(5).

The OIG considered this policy to be in effect, as it had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(3),[12] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[13] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[14]

The OIG **substantiates** allegations when the facts and findings support that the alleged events or actions took place. The OIG **does not substantiate** allegations when the facts show the allegations are unfounded. The OIG **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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[12] VHA Directive 6330(3), *Controlled National Policy/Directives Management System,* June 24, 2016.
[13] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document,* June 29, 2016.
[14] Ibid.

Case Summaries

MFH-1 was owned and operated by Mr. and Mrs. X, who served as caregivers to veterans A, B, and C.

Veteran A had lived with Mr. and Mrs. X and received HBPC services in their home for several years. In early 2015, Mr. and Mrs. X applied to become VA-approved MFH caregivers, and in April 2015, this designation was granted. Veteran A had a history of stroke and left hemiparesis (weakness), neurogenic bladder with suprapubic catheter, recurrent urinary tract infections, and methicillin-resistant *Staphylococcus aureus* (MRSA) positive status.[15] He was alert and oriented and appeared to have decision-making capacity.[16] Veteran A was bed-ridden and reliant on his caregivers for transportation to and from medical appointments. Veteran A cancelled a primary care appointment in summer 2017 and was evaluated in a private-sector Emergency Department (ED) later that month after a home health nurse found his catheter was not flushing. Veteran A attended primary care, dermatology, and urology appointments at the facility approximately one month after the ED visit.

Veteran A had no family members able to assist him, and Mr. X was his POA for finances and health care[17] before April 2015 when MFH-1 was granted official VA approval to care for veterans. Therefore, Mr. X was "grandfathered" in as veteran A's POA for finances and healthcare at the time of MFH approval. As recently as mid-2017, veteran A expressed satisfaction with his financial POA arrangements.

Veteran B was admitted to MFH-1 and the HBPC program in early 2017. He was wheelchair bound and required assistance with transfers and ADLs, and 24-hour supervision as a result of his progressive cognitive decline. After the facility suspended MFH-1's designation, HBPC services were discontinued in mid-2017. Veteran B continued to receive primary care services at the facility. Veteran B's sons had POA for their father's financial and health care decision-making. When the facility revoked MFH-1's designation, veteran B and his sons declined transfer to another MFH.

Veteran C was transferred to MFH-1 in mid-2017 from MFH-3 where he had resided for approximated 4 months. Veteran C's medical history included diabetes, depression, and chronic pulmonary disease. He was alert and oriented and appeared to have decision-making capacity. Veteran C was largely bedridden but able to transfer with assistance to a recliner using a Hoyer lift. Veteran C canceled several medical appointments in the summer of 2017, and while he had been receiving community-based (non-VA) hospice, he discontinued the hospice services in late July, reportedly to pursue curative treatment. HBPC staff received a letter from veteran C

[15] The Centers for Disease Control and Prevention defines MRSA as "methicillin-resistant Staphylococcus aureus, a type of staph bacteria that is resistant to several antibiotics." https://www.cdc.gov/mrsa/community/index.html, accessed August 21, 2017.
[16] The OIG found veterans A and C to be lucid and aware of their situations at the time of our interviews with them.
[17] A Durable POA for Health Care, also known as a Health Care Agent, is a specific person that can make health care decisions when a person can no long make their own decisions.

documenting his desire to discontinue HBPC services. A visiting physician completed an in-home intake assessment a month later. The OIG could not determine why veteran C missed his next scheduled VA primary care appointment and as of August 24, had no additional VA appointments scheduled.

Veteran C's cousin served as his financial and health care POAs until mid-2017 when veteran C appointed Mr. X to function as his POA. The cousin was reportedly concerned about this new arrangement, but acknowledged that it was logistically more feasible. Veteran C was reportedly engaged to caregiver Z, his previous caregiver in MFH-3.

MFH-2 was leased by Mr. and Mrs. X, but caregiver Y was the live-in caregiver. Veterans D and E were residents of MFH-2 but transferred to alternate living arrangements. No veterans currently reside in MFH-2.

MFH-3 was leased by Mr. and Mrs. X, but caregiver Z was the live-in caregiver. Veteran C used to live in MFH-3, but as of August 1, 2017, no veterans resided in MFH-3.

Inspection Results

The OIG applied the question of imminent risk to the three veterans still residing in MFH-1 at the time of our last visit. The OIG found the risk to veteran B to be minimal, primarily because his sons were actively involved in his care and served as his healthcare and financial POAs, and because veteran B was routinely seen by facility-based healthcare providers. Veteran A's and veteran C's compromised physical statuses and extensive reliance on Mr. and Mrs. X (non-family caregivers) left them potentially more vulnerable to abuse, neglect, and exploitation.

Issue 1: Risk to Veterans Currently Residing in the Subject MFHs

Abuse and/or Neglect

The OIG did not substantiate that veterans in MFH-1 were at imminent risk for abuse or neglect.

Since the facility suspended MFH-1's designation, VA employees, including the OIG, have no official authority to enter the dwelling. However, Mr. and Mrs. X permitted us to tour MFH-1 at a specified time and interview the veteran residents; Mr. and Mrs. X were present for all of the interviews. The OIG found the veterans to be clean and well-groomed and the home environment to be pleasant and well-maintained. Veterans A, B, and C and their family members all reported, without apparent duress, that they were satisfied with the care being delivered. All three veterans declined transfer to an alternative MFH placement after the facility suspended MFH-1's designation.

However, while veterans A and B continued to receive facility-based medical care and oversight, veteran C had chosen not to receive VA medical care at the time of OIG's

review. To promote optimal health outcomes, veteran C, with the assistance of his caregivers, should pursue alternate health care services.

Financial Exploitation

The OIG could not substantiate that veterans in MFH-1 were at imminent risk for financial exploitation. Veteran B's sons managed his finances, and for the purpose of this review, the OIG did not consider him to be at risk for financial exploitation.

Veterans A and C, however, did not designate family members to be their financial POAs. Veterans A and C, who both appeared to possess decision-making capacity, exercised their discretion to designate Mr. X as financial POA. VHA policy governing MFHs discourages this type of agreement due to the high risk of conflicts of interest. In this case, however, VHA policy does not apply because:

- Veteran A made Mr. X his financial POA *before* MFH-1 became an official VA-approved care setting, and
- Veteran C made Mr. X his financial POA *after* MFH-1's designation was revoked.

As noted above, OAC 5122-33[18] defines any establishment with three or more unrelated adults to be an ACF, regardless of how it holds itself out to the public. The same section of the OAC also prohibits ACF staff from holding a resident's POA. As of July 31, 2017, the OIG confirmed that MFH-1 had more than three unrelated adult residents requiring personal care and it no longer held VA MFH designation. Therefore, the MFH is subject to OAC requirements, including POA prohibitions.

Issue 2: MFH Program Compliance and Oversight

The OIG evaluated whether MFH program managers assured compliance with selected VHA policy requirements and took appropriate actions when concerns arose related to MFHs 1–3.

Policy Compliance

The facility's MFH program generally complied with selected elements of VHA policy including HBPC enrollment, quality monitoring for abuse and neglect, and live-in caregiver requirements.[19,20] However, an MFH coordinator[21] did not meet performance expectations related to communication and coordination in support of patient care and program activities. As outlined in VHA policy, MFH coordinators are responsible for identifying resident and care team members' concerns, and coordinating discussions with caregivers.

[18] On January 1, 2018, OAC 5122-33, Adult Care Facilities, was rescinded and combined under OAC 5122-30, Licensing of Residential Facilities. Citation references in this report are to authorities in force during our review.
[19] VHA Handbook 1140.01, *Community Residential Care Program*, February 10, 2014.
[20] VHA Handbook 1141.02.
[21] The facility had two MFH coordinators. One in particular did not meet performance expectations.

The OIG learned that an HBPC staff member had voiced concerns to the MFH coordinator about two of the veterans. The Chief of Social Work told OIG team members that the subject coordinator's documentation did not always reflect actions taken in response to concerns. Facility leaders conducted a review of the subject MFH coordinator's documentation, which revealed lack of appropriate medical record documentation, incomplete provider (caregiver) files, and lack of consistency in communication with other team members. The subject MFH coordinator was detailed to another position in the facility.

The subject MFH coordinator did not effectively facilitate appropriate communication, collaboration, and follow-up of concerns. These unresolved issues contributed to an environment where both staff and caregivers were angry and frustrated, and potentially limited joint problem-solving opportunities. Better communication and early intervention may have allowed the facility to retain MFHs 1–3 in good standing, thus allowing veterans to have broader access to this unique alternative to institutional care.

MFH Managers' Actions After Discovery of MFH Issues

MFH staff suspended new admissions to MFHs 1–3 based on concerns for the safety of the residents; provided verbal and written notification to the MFH caregivers regarding the suspension of new admissions; offered residents and/or their family members/guardians the option of transfer to alternate settings; proposed revocation of their VA-approved MFH status; and followed due process guidelines including notification of appeal rights.

The OIG further noted that VHA policy was silent on whether and how to report cases of MFH revocation to outside entities. Nonetheless, MFH staff had notified state authorities including Ohio Mental Health and Addiction Services and the Ohio Department of Health of the revocations. MFH staff further advised that veterans still resided in MFH-1. According to Ohio regulations, as MFH-1 now provides accommodations and supervision to three unrelated adults who required personal care services, it must secure state licensure to operate legally as an Adult Care Facility.[22]

Conclusions

During the site visits in July 2017, the OIG did not substantiate that the veterans remaining in MFH-1 were at imminent risk for abuse or neglect. The OIG found the three veterans still residing in MFH-1 to be clean and well-groomed and the home environment pleasant. None of the veterans or their family members voiced concerns about the care they received and all declined relocation to an alternate MFH.

The OIG could not substantiate that three veterans in MFH-1 were at imminent risk for financial exploitation. Although VHA policy discourages MFH owners/caregivers from managing the financial affairs of their residents, the two veterans who designated the

[22] Ohio Administrative Code 5122-33-02(A) & 03(A).

MFH owners/caregivers as their POA appeared to possess decision-making capacity and both declined to make changes. Because MFH-1 now has three unrelated adults requiring personal care but does not have official VA MFH designation, it is subject to OAC regulations, including POA prohibitions.

MFH program managers took appropriate action after determining that the subject MFHs were in violation of VHA policy. Specifically, managers suspended new admissions and provided appropriate notification to the MFH caregivers; offered to relocate residents to alternate settings; and followed due process guidelines.

While the facility generally met selected VHA requirements pertaining to MFH enrollment, monitoring for abuse and neglect, and caregiver selection, an MFH coordinator did not consistently facilitate appropriate communication, collaboration, and follow-up. These conditions may have contributed to an environment where both staff and caregivers were frustrated, and potentially limited joint problem-solving opportunities that would have allowed the MFHs to remain in good standing.

VHA policy did not require facilities to report cases of MFH revocation to outside entities; however, MFH managers did notify various state oversight authorities.

The OIG made one recommendation.

Recommendation

1. The Under Secretary for Health amends Medical Foster Home policy to include processes for reporting Medical Foster Home revocations to appropriate authorities to ensure current and future resident safety.

Appendix A

Prior OIG Reports September 1, 2014 through September 1, 2017

Facility Reports

Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio

1/14/2016 | 15-04694-80

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio

1/13/2016 | 15-05151-81

Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio

10/28/2013 | 13-02638-01

OIG reports are available at **www.va.gov/oig**.

Appendix B

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: DEC 22 2017

From: Executive In Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report: Healthcare Inspection, Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH (VAIQ 7862396)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Healthcare Inspection, Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH.

2. The Veterans Health Administration (VHA) concurs with recommendation 1 and provides the attached action plan.

3. The Office of Geriatrics and Extended Care believes that maintaining updated information concerning the Medical Foster Home (MFH) Program is essential to ensuring field staff are current in program processes.

4. VHA Handbook 1141.02, MFH Procedures, was recently revised and is currently pending final review and concurrence per the VHA policy review process.

5. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

Carolyn M. Clancy, M.D.

Attachment

Appendix B

Under Secretary for Health Comments

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH

Date of Draft Report: November 29, 2017

Recommendation Status Actions	**Completion Date**

<u>OIG Recommendation</u>

Recommendation 1. We recommended that the Executive in Charge, Under Secretary for Health office, amend MFH policy to include processes for reporting MFH revocations to appropriate authorities to ensure current and future resident safety.

<u>VHA Comments</u>: Concur

The Office of Geriatrics and Extended Care believes that maintaining updated information concerning the Medical Foster Home (MFH) Program is essential to ensuring field staff are current in program processes. Consequently, VHA Handbook 1141.02, MFH Procedures, was recently revised and is currently pending final review and concurrence per the VHA policy review process. The updated policy includes but is not limited to, guidance for reporting MFH revocations to the appropriate authorities. In the interim, the VHA Office of Regulatory and Administrative Affairs will issue a VHA Notice via email to all VHA staff providing guidance reporting requirements for revocation or approval for MFHs.

Status:	Target Completion Date:
In Process	February 2018

Appendix C

VISN Directors Comments

Department of Veterans Affairs **Memorandum**

Date: November 28, 2017

From: Network Director, VISN 10 (10N10)

Subj: Healthcare Inspection—Medical Care Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio

To: Director, (Regional Office) Office of Healthcare Inspections (54RR)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Please find the attached response to the OIG recommendation for the Healthcare Inspection – Medical Care Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio.

2. I concur with the Medical Center Director's response.

for Robert P. McDivitt, FACHE

Appendix D

Facility Directors Comments

Department of Veterans Affairs

Memorandum

Date: November 20, 2017

From: Director, Chalmers P. Wylie Ambulatory Health Care Center, Columbus, Ohio (757/00)

Subj: Healthcare Inspection—Medical Foster Home Program Concerns, Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio

To: Director, VA Healthcare System of Ohio (10N10)

1. Thank you for the opportunity to review the draft report on Medical Foster Home program concerns. I concur with the recommendation of Office of Inspector General (OIG).

2. On behalf of our health care organization and the Veterans we serve, I would like to thank the OIG review team for their hard work and dedication in reviewing our concerns regarding the medical Foster Home program.

3. Our facility has implemented new processes to strengthen our program management of the Medical Foster Home and role of the Coordinators to ensure oversight of the program remains in compliance with VHA Directive 1141.02 Medical Foster Home Program Procedures, dated August 9, 2017.

Wendy J. Hepker, FACHE
Director
Chalmers P. Wylie VA Ambulatory Care Center

Appendix D

Facility Directors Comments

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

OIG Recommendation

Recommendation 1. We recommended that the Under Secretary for Health amend MFH policy to include processes for reporting MFH revocations to appropriate authorities to ensure current and future resident safety.

Concur

Target date for completion: 11/22/2017

Facility response:

We strongly agree with the recommendation to the Under Secretary for Health to amend the MFH policy to include processes for reporting MFH revocations to appropriate authorities. In support of this recommendation, we reported to the Ohio Department of Health on 8/18/2017 our actions to revoke the MFH and advised the home was unlicensed with residents paying a caregiver.

We will report to the Ohio Department of Health the revocation of this MFH is now permanent.

Appendix E

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Toni Woodard, BS, Team Leader Victoria Coates, LICSW, MBA Roy Fredrikson, JD Eileen Keenan, RN, MSN Vanessa Masullo, MD Monika Spinks, RN, BSN, CPASRM Todd Springer, Special Agent
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Appendix F

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