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Healthcare Inspection

Patient Safety and Quality of Care Concerns in the Community Living Center

James A. Haley Veterans' Hospital Tampa, Florida

March 1, 2018

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding patient safety and poor quality of care in the Haley's Cove Community Living Center (CLC) at the James A. Haley Veterans Hospital (facility) in Tampa, FL.

On January 18, 2017, the OIG received information from a confidential complainant alleging that staff failed to implement appropriate safety measures for a resident[1] (Resident A) in the CLC, and as a result, he fell and sustained serious injuries, which have negatively affected his quality of life. In addition, we further heard speculation that Resident A's family thought the severity of his injuries could have been the result of abuse. Resident A's family also reported that CLC staff:

- Used the wrong urinary catheter size on Resident A in late 2016.
- Administered a new medication for agitation to Resident A without the family's consent.
- Increased the dose of an existing medication to Resident A without the family's consent.
- Failed to order a urinalysis after Resident A experienced mental status changes.
- Failed to make a reasonable effort to notify them when Resident A fell.
- Left Resident A lying [on a gurney] in the hallway unattended for a long period of time.

During the course of our inspection, we reviewed CLC-wide fall prevention practices and learned of a patient safety and quality of care issue regarding another resident (Resident B). In addition, we learned about allegations of three CLC residents (residents C, D, and E) and family members with concerns about possible abuse and/or neglect, and reluctance to speak out for fear of retaliation against their loved ones.

We also reviewed facility CLC nurse staffing and the environment of care.

Patient Safety and Quality of Care

We substantiated that on the night of Resident A's fall in late 2016, CLC staff had not implemented all fall precautions outlined in his individual care plan (ICP). Further, the Emergency Department (ED) physician did not adequately evaluate Resident A's injuries after the fall. The severity of Resident A's injuries, combined with a slow recovery often experienced by the elderly, had a negative impact on his quality of life, at least for a period of time.

[1] In this context, "resident" refers to people who live in the CLC.

On the night of Resident A's fall, CLC staff did not consistently implement fall precautions as outlined in his ICP. Specifically, we could not confirm via electronic health record (EHR) documentation or nursing staff interviews that Resident A's bed was in a low position (close to the floor) with wheels locked or that his call bell was within reach. Also, CLC staff told us that Resident A's bed alarm was off at the time of the fall, and while a floor mat was present on one side of the bed (where he fell), we could not confirm the presence of a floor mat on the other side of the bed as required.

The ED physician did not conduct an adequate evaluation of Resident A's condition. In the absence of a good history, the physician should have performed a thorough physical examination, considered ordering additional diagnostic imaging, or contacted CLC staff for additional information. Elderly patients who fall should have a thorough trauma evaluation because these patients may suffer multiple injuries in different organs, which could be missed if the physician only focuses on one body system. In addition, we found that inadequate communication between CLC and ED staff contributed to the incomplete evaluation and treatment of Resident A in the ED.

Although we heard speculation that Resident A's injuries were too severe to have been the result of a fall, we found his fractures, which all occurred on his left side from shoulder to thigh, were consistent with injuries seen in a fall with impact on the left side of the body. The resident's age, dementia, and bone loss made him more susceptible to falls and increased the likelihood of severe injuries.

We substantiated Resident A's family members' concerns that CLC staff used the wrong urinary catheter size on Resident A in late 2016, administered a new medication for agitation to Resident A without the family's consent, and increased the dose of an existing medication to Resident A without their consent. We found no evidence that the short-term use of a smaller catheter negatively impacted Resident A. Although we substantiated that Resident A's providers administered a new medication and an increased dose of an existing medication without the family's consent, we found this to be a reasonable action given Resident A's condition and behavior that day. While medication changes like those described would not have required consent, discussion with the resident or family is often a preferred practice. We found no evidence that the above actions negatively impacted Resident A.

Although we confirmed that Resident A's primary care providers failed to order a urinalysis after Resident A experienced a mental status change, we did not substantiate the implied inappropriateness of this action. Resident A's nurse practitioner examined Resident A and based on his/her knowledge of and experience with Resident A, did not order a urinalysis. The urinalysis completed the next day, after Resident A's fall, was within expected limits.

We did not substantiate that staff failed to make a reasonable effort to contact the family at the time of the fall or communicate the extent of Resident A's injuries. The nurse left a message on a family member's cell phone, a documented emergency contact number, within hours of the early morning incident.

Although we confirmed that Resident A was lying on a gurney in the hallway for 5.5 hours, we did not substantiate the implied inappropriateness of this condition. Due to Resident A's injuries, probable pain, and the need for additional x-rays and testing, it may have been less disruptive and less painful to have Resident A remain on a gurney rather than transferring him in and out of bed. In addition, all CLC staff could assist in monitoring Resident A while in the hallway outside the nurses' station.

We also reviewed the circumstances surrounding Resident B's fall in early 2017 and found that despite his being assessed as "high-risk" for falls, CLC staff did not implement fall precautions as outlined in his ICP. Resident B fell and was diagnosed with a left hip fracture. Resident B had hip surgery followed by a complicated post-operative period and died 9 days after the fall.

CLC-Wide Fall Prevention Practices

Overall, we found a pattern of fall prevention measure failures that placed CLC residents at risk for falls. While the CLC's fall rates and falls with major injury rates were lower than the VHA-wide aggregate rate for fiscal year (FY) 2016, in quarters 1–2 FY 2017, the CLC exceeded VHA-wide rates for falls with major injuries (due to residents A and B, and a third resident who broke an arm). The common theme was the CLC staff's failure to consistently implement and document fall precautions. A similar example of non-compliance dated back to at least 2014, and although facility leaders identified corrective actions and reportedly implemented them at that time, improvements were not sustained.

During our unannounced site visit on March 8, 2017, we visually inspected CLC residents' rooms and compared all of the 46 CLC residents' ICPs and EHR documentation and implementation of fall prevention strategies. We found CLC staff did not consistently implement fall precautions as outlined in residents' ICPs including ensuring that residents used hip protectors (or documenting the refusal or contraindication) and/or chair alarms. We also found inconsistencies between CLC staff and CLC leaders' understanding of the availability of the fall precaution resources like hip protectors and chair alarms.

Facility Response to Alleged Abuse, Neglect, and Retaliation

Due to alleged events of abuse, neglect, and retaliation occurring greater than a year prior to our site visit, we could not reliably reconstruct the events. Therefore, we focused on whether the facility sufficiently reviewed and responded to the allegations involving the residents discussed in Issue 3 of this report.

We found the facility did not adequately review and follow-up with Resident C's three allegations of abuse in 2015. We found that CLC leaders did not conduct appropriate internal reviews of alleged patient abuse and other unexplained injuries relative to Resident C. In one instance, we found no evidence that CLC leaders conducted a fact-finding review of the alleged event or reported the incident to the VA police. In the second instance, the CLC nurse manager conducted a fact-finding review; however, the

fact-finding review was inadequate as it did not include documented interviews with relevant staff, results of an EHR review, or the rationale of how CLC leaders determined that the allegations were "not substantiated." In the third instance, we found no evidence that CLC leaders conducted a fact-finding review of the alleged event.

We found that the facility adequately reviewed and followed-up with Resident D's allegations of neglect in 2016. Facility leaders conducted appropriate internal reviews of the allegations given by the family, including an administrative investigative board (AIB).

We found that the facility adequately reviewed and followed up with Resident E's allegations that a CLC nursing assistant was "too rough" when providing patient care in 2016. Facility leaders conducted appropriate internal reviews of the allegations, including an AIB that substantiated the allegation.

We did not substantiate family members' concerns about possible retaliation from staff if they complained about care. We found no evidence to support their perceptions.

CLC Nurse Staffing

We randomly selected the February 21–22, 2017 CLC nurse staffing schedules for review. We found that each unit[2] met the minimum staffing levels; however, they did not meet the staffing mix recommendation of two registered nurses per shift per unit. CLC nursing leaders confirmed that staffing was not ideal and noted that staffing issues arise when nursing staff "call out" for their shifts or if residents need 1:1 observation. In those instances, CLC leaders either borrowed staff from another unit or offered overtime to staff to ensure coverage.

Environment of Care

During our unannounced visit, we evaluated the environment of care on CLC units B and D. Overall, we found the CLC units to be clean, odor free, and well-maintained, and resident rooms to be free of clutter.

We recommended that the Facility Director ensure:

- CLC and ED staff understand and comply with policies for communication about residents requiring evaluation and treatment.
- CLC leaders develop a system to ensure fall precautions identified in the Falls Assessment are consistently reflected in the ICP and implemented accordingly, and that staff are held accountable.

[2] Haley's Cove CLC consists of 64 beds divided into three units. Unit B, formerly unit C, contains 35 beds; unit D contains 19 beds; and the hospice and palliative care unit contains 10 beds. In January 2017, Unit C relocated to Unit B due to renovations. We limited the focus of this inspection to units B and D.

- The availability and functionality of fall prevention and safety devices such as hip protectors and chair alarms.
- CLC leaders follow through on efforts to determine staff knowledge deficits related to fall prevention and institute training and process improvements.
- CLC leaders conduct appropriate reviews and implement required actions in cases of suspected abuse or neglect.
- An adequate nurse staffing mix to meet the acuity levels and needs of the CLC's residents.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes B and C, pages 23–27 for the full text of the comments.) Based on information provided by the Veterans Integrated Service Network and Facility, we consider Recommendations 3, 5, and 6 closed. For the remaining open recommendations, 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) conducted a healthcare inspection to assess allegations regarding patient safety and poor quality of care in the Haley's Cove Community Living Center (CLC) at the James A. Haley Veterans' Hospital (facility) in Tampa, FL. During the course of our review, we learned of allegations involving suspected patient abuse and neglect and family members' fears of retaliation for reporting their concerns. The purpose of our review was to determine whether the allegations had merit.

Background

The facility provides a broad range of inpatient and outpatient medical, surgical, geriatric, and mental health services. It has 402 acute care beds and 64 CLC beds located on the main hospital campus and a 33-bed domiciliary located off site. The facility is part of Veterans Integrated Service Network (VISN) 8 and serves a veteran population of about 218,000 throughout four counties in central and western Florida. The facility has four community-based outpatient clinics located in Brooksville, Lakeland, New Port Richey, and Zephyrhills, FL, and a primary care annex located in Tampa, FL.

CLC

CLCs, formerly called nursing homes, provide a homelike environment and activities for veterans (referred to as residents[3] in the remainder of this report). According to the Veterans Health Administration (VHA), the mission of a CLC is to restore each resident "to his or her highest level of well-being. It is also to prevent declines in health and to provide comfort at the end of life."[4] The residents' needs determine their length of stay. Within the CLC, a resident can receive assistance with activities of daily living (for example, bathing or dressing), skilled nursing care (for example, wound care or administration of medications), and medical care. The Haley's Cove CLC is located on two floors in a building adjacent to the main hospital. Each floor consists of two wings, forming an "L" shape, with a nursing station located centrally. Most residents have private rooms.[5]

[3] In this context, "resident" refers to people who live in the CLC.
[4] https://www.va.gov/geriatrics/guide/longtermcare/VA_Community_Living_Centers.asp. Accessed January 25, 2017.
[5] Haley's Cove CLC consists of 64 beds divided into three units. Unit B, formerly unit C, contains 35 beds; unit D contains 19 beds; and the hospice and palliative care unit contains 10 beds. In January 2017, Unit C relocated to Unit B due to renovations. We limited the focus of this inspection to units B and D.

Fall Statistics and Reduction Strategies

Falls are the leading cause of fatal injury and the most common cause of nonfatal trauma-related hospital admissions among older adults. Falls result in more than 2.8 million injuries treated in Emergency Departments (ED) annually, including over 800,000 hospitalizations and more than 27,000 deaths.[6]

Facility CLC policy states that residents are considered to be at risk for falls, and that registered nurses (RN) are responsible for assessing all CLC residents for fall risk and risk for fall injury on admission, quarterly, annually, after a fall, and upon a significant change.[7] VHA strongly advocates for a restraint-free environment,[8] and in such an environment, patient falls happen. As such, interventions are typically designed to minimize falls and to prevent serious injuries when falls occur. Per facility policy, a Falls Care Plan should be initiated and include the implementation of fall precautions.[9] Fall precautions may include ensuring that:

- Hip protectors and floor mats are in place.
- The bed is low with wheels locked.
- A call bell, light cord, and personal items are within reach.
- The room is free of known environmental hazards.
- The level of observation is increased when the resident is out of bed.
- Comfort and toileting needs are checked every 2 hours.
- Residents and families receive appropriate falls-related education.

The VHA National Patient Safety Improvement Handbook requires that facilities perform an aggregate review for falls, which allows analysis of a group of similar incidents or event types to determine common causes, thereby facilitating coordinated actions to prevent recurrences.[10]

Prior Reports

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

[6] National Council on Aging, *Falls Prevention Facts*, https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/. Accessed June 5, 2017.
[7] Significant changes could include brief hospital stay, surgery, procedure, or significant change in medication.
[8] A restraint-free environment would include no restraints (wrist, ankle, chair, bed, or chemical) and anything that could impede movement of the resident.
[9] Medical Center Memorandum 118-05, *Fall Prevention and Management*, May 2015.
[10] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This VHA Handbook was scheduled for recertification on March 31, 2016 but has not been recertified.

Allegations

On January 18, 2017, OIG's Office of Investigations received information from a confidential complainant alleging that staff failed to implement appropriate safety measures for a resident (Resident A) in the CLC, and as a result, he fell and sustained serious injuries, which have negatively affected his quality of life. In addition, we heard speculation that Resident A's family thought the severity of Resident A's injuries could have been the result of abuse. Resident A's family also reported that CLC staff:

- Used the wrong urinary catheter size on Resident A in late 2016.
- Administered a new medication for agitation to Resident A without the family's consent.
- Increased the dose of an existing medication to Resident A without the family's consent.
- Failed to order a urinalysis after Resident A experienced mental status changes.
- Did not make a reasonable effort to notify them when Resident A fell.
- Left Resident A lying [on a gurney] in the hallway unattended for a long period of time.

During the course of our review, we reviewed CLC-wide fall prevention practices and learned of patient safety quality of care concerns for another resident (Resident B). We also learned about allegations of three additional CLC residents (residents C, D, and E) and family members with concerns about possible abuse and/or neglect, and reluctance to speak out for fear of retaliation against their loved ones.

We also reviewed nurse staffing and the environment of care (EOC).

Scope and Methodology

We initiated our review on January 24, 2017 and conducted three site visits:

- A rapid response visit January 26–27 to assess whether Resident A or other CLC residents were at risk due to poor care or deficient patient safety practices.
- A follow-up visit February 15–17 to collect further information and interview additional staff, residents, and family members.
- An unannounced visit March 8 at 6:00 a.m. to observe general EOC conditions and whether specialized care and/or fall safety precautions were evident for CLC residents as outlined in their interdisciplinary care plans (ICP).[11]

[11] ICPs are developed collectively by members of the treatment team based on their comprehensive assessments of the residents' needs, goals, and treatment/care approaches.

We interviewed the complainant, Resident A and/or family members, the four additional CLC residents and/or their family members, staff members on duty during our unannounced visit, and residents who were able to converse with us. We also interviewed facility leaders, the Patient Advocate, the Patient Safety Manager, the Chief of Biomedical Engineering, and relevant staff and leaders within the CLC.

We reviewed relevant facility policies and procedures, incident reports, internal reviews, patient advocate reports, and aggregate CLC fall data for fiscal year (FY) 2016 and quarters (Qs) 1–2 FY 2017. We completed case reviews for Resident A and the four other residents with concerns covering the entirety of their CLC admissions. We evaluated nurse staffing data for selected time frames and dates. We also reviewed the ICPs for all of the residents in the CLC as of March 8.

VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 cited in this report was scheduled for recertification on March 31, 2016. We 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]

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

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.

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

Case Summary—Resident A

Resident A is a male in his 90s with a history of dementia, high blood pressure, heart disease, low thyroid hormone, vitamin D deficiency, osteopenia or bone loss, peripheral neuropathy (abnormal sensation in the extremities), and frequent falls. He had been living in the CLC since mid-2014 for short-term rehabilitation after hernia repair surgery, but later transitioned to long-term care status due to his functional decline. From 2014 to 2016, Resident A had multiple hospital admissions, mainly for urinary tract infections. From the summer to fall of 2016, Resident A had several assessments for fall risk. For each assessment completed, Resident A scored as high risk and the electronic health record (EHR) reflected multiple fall precaution strategies in place.

On a day in late 2016 (day 1), Resident A received his usual medications; however, his mood later became argumentative. The staff documented that Resident A was aggressive, agitated, and refusing care, made "delusional" statements, and attempted to hit a nurse who tried to redirect him. In the evening, the nurse gave him a PRN (as needed) dose of quetiapine[15] 25 milligrams (mg) for agitation, but Resident A refused to take it. Resident A's agitation continued and the nurse called the on-call physician who ordered an injection of haloperidol.[16] In the early morning on day 2, the nurse administered an injection of haloperidol .5 mg to help sedate him.[17] Resident A slept for several hours. On day 3 when he was less agitated, nursing staff gave him ramelteon 8 mg[18] and helped him to bed; however, the medication did not induce sleep and Resident A requested to get back up an hour later. Resident A was placed in his wheelchair outside of the nurses' station and the remainder of the night was uneventful.

During the day on day 4, staff did not document any behavioral concerns related to Resident A. In the evening, staff attempted to administer an increased dose of quetiapine 75 mg, although it is not clear whether Resident A swallowed any of the medication. Staff also administered ramelteon 8 mg approximately 2 hours later.

During this time, the CLC psychiatrist evaluated Resident A and recommended that the assigned CLC nurse practitioner (NP) evaluate for medical causes of confusion,[19] but left further evaluation and treatment to the NP's discretion. By co-signing the CLC psychiatrist's note, the NP acknowledged the recommendation made by the psychiatrist. The NP examined Resident A and did not order the recommended tests.

[15] Quetiapine is an anti-psychotic medication used to treat symptoms of schizophrenia, mania, or depression.
[16] Haloperidol is an anti-psychotic medication used to treat severe behavioral problems (for example, aggressive, impulsive behavior) in patients who have already received other medicines that did not work well.
[17] Haloperidol was a new medication for Resident A. We did not find documentation of a discussion with either Resident A or his family prior to use.
[18] Ramelteon is a medication that helps patients who have sleep-onset insomnia (difficulty falling asleep) fall asleep more quickly.
[19] The psychiatrist suggested "we assess for any covert medical problem (UTI [urinary tract infection], PNA [pneumonia], etc.)." Infections such as urinary tract infection and pneumonia can present as confusion.

Shortly after midnight on day 5, a staff member making routine bed checks on the unit found Resident A lying face up on the floor mat. When asked about the events leading up to the incident, Resident A responded, "I felled."

Approximately one hour after the fall, the nurse documented a call to the CLC on-call physician explaining the incident involving Resident A. About 15 minutes later, the CLC nurse received orders from the CLC on-call physician to send Resident A to the ED. The CLC nurse documented that he/she contacted the ED charge nurse to discuss Resident A, and the CLC nurse transfer note documented that Resident A had a "…hematoma to forehead and left elbow. Resident c/o [complained of] left arm pain." Approximately 30 minutes later, the nurse noted in the Post Fall Note that upon arriving in Resident A's room he/she found the bed in the low position, the call light on the bed, the floor mat in place, the room lights on, and the room free of clutter.

The ED physician documented that the "patient [was] brought here from [CLC] with [a complaint of] falling out of bed and hitting his head." He/she wrote that Resident A denied joint pains or swelling and Resident A's extremities showed no signs of swelling. The physician ordered a head computed tomography (CT) scan, which was negative for bleeding or abnormalities, and discharged Resident A about 2 ½ hours after the fall. At the time of pick-up, the ED nurse informed the CLC nurse that the ED physician did not order any imaging tests for Resident A's arm. After arriving back to the CLC, Resident A continued to complain of left arm pain.

In the morning on day 5, the CLC nurse informed the NP of the night's events and the swelling in Resident A's left shoulder. The NP examined Resident A and ordered x-rays of Resident A's shoulders, elbows, and hips. Later that morning, the CLC physician transferred Resident A to the inpatient medicine service for left humerus,[20] 7th and 8th rib, pelvic, and femoral neck fractures.[21] The following day, Resident A underwent surgery for a hip replacement. The orthopedist also attempted to place pins to stabilize the fracture in the humerus without success. The rest of the fractures were non-operative.

Resident A stayed in the intensive care unit for observation after the surgery and received blood transfusions. Eight days later, Resident A was transferred to the progressive care unit (PCU - a less intensive treatment environment). Resident A's post-operative course included antibiotic-induced diarrhea and urinary tract infection; however, these infections resolved with treatment. Resident A also had a decline in his nutritional status and required a gastrostomy tube for nutritional feeding.[22] By early 2017, Resident A had recovered sufficiently to return to the CLC; however, the family did not consent for Resident A to return to the CLC or transfer to another nursing home facility. Approximately 2 months later, Resident A no longer needed a peripheral

[20] The humerus is the long bone in the upper arm.
[21] The femur is the long bone in the leg. The head of the femur forms the hip joint. The femoral neck connects the head of the femur to the shaft.
[22] Gastrostomy tube is a tube inserted through the abdomen that delivers nutrition directly to the stomach.

intravenous (IV) catheter or weekly blood draws. About a month later, Resident A transferred from the PCU to an inpatient medicine unit.[23]

Inspection Results

Issue 1: Patient Safety and Quality of Care

A. Resident A Fall in Late 2016

We substantiated that on the night of the resident's fall, CLC staff had not implemented all fall precautions outlined in Resident A's ICP. Further, the ED physician did not adequately evaluate Resident A's injuries after the fall. The severity of Resident A's injuries, combined with a slow recovery often experienced by the elderly, had a negative impact on his quality life, at least for a period of time.

Fall Precautions

On the night of Resident A's fall, CLC staff did not consistently implement fall precautions as outlined in his ICP. Specifically, we could not confirm via EHR documentation or nursing staff interviews[24] that Resident A's bed was in a low position (close to the floor) with wheels locked or that his call bell was within reach on the night of his fall. Also, CLC staff told us that Resident A's bed alarm was off at the time of the fall, and while a floor mat was present on one side of the bed (where he fell), we could not confirm the presence of a floor mat on the other side of the bed as required.

Resident A's ICP called for staff to check on him every hour when he was in bed. Staff reported conducting hourly bed checks throughout the night of the fall, but they are only required to document these bed checks "by exception," meaning when they find problems or changes. Therefore, we could not determine in the EHR review whether staff conducted appropriate bed checks.

Further, Resident A's ICP called for him to wear hip protectors when out of bed; however, staff stated, and our review of his EHR confirmed, that this was not consistently done. Some staff members told us that Resident A's family declined the hip protectors, although we did not find documented evidence of this. The EHR did reflect that Resident A refused to wear hip protectors on at least three occasions during his stay in the CLC.

During our review, we heard speculation that Resident A's injuries were too severe to have been the result of a fall. We found, however, that Resident A's fractures, all occurring on the left side from shoulder to thigh, were consistent with injuries seen in a fall with impact on the left side of the body. In the days leading up to the fall, nursing

[23] Often, patients who are improving from intensive care may be moved to the PCU. Once improved (i.e. weaned off medication drips, less frequent nursing monitoring), a patient may be downgraded to the general medical ward.
[24] Facility documentation and interviewees' testimony were inconsistent on this point.

staff documented several nights when Resident A was out of bed. On the night of the fall, nursing staff told us that they found Resident A sitting in his wheelchair. Staff could not determine how Resident A got into his wheelchair, but assisted him in returning to bed. A staff member reportedly stayed with Resident A until he fell asleep. Within the next hour, Resident A reportedly fell out of bed and sustained the reported injuries. Resident A reported to both the CLC nursing staff and the ED nurse that he fell. Resident A's age, dementia, and bone loss made him more susceptible to falls and increased the likelihood of severe injuries in comparison to other residents.[25]

ED Evaluation

The ED physician did not conduct an adequate evaluation of Resident A's condition. While the ED physician ordered the proper evaluation for Resident A's head trauma, he did not gather history regarding the mechanism of Resident A's injuries and only performed a limited examination of his extremities. It is unclear if the ED physician reviewed the nursing transfer note (which referenced left elbow and arm pain) or if the ED physician tried to move Resident A's elbow. We found no evidence that the ED physician attempted to contact CLC staff for additional information surrounding the cause or extent of Resident A's injuries.

Low-velocity falls in the elderly are a frequent cause of hospital admission and are associated with severe injuries and poor outcomes. Elderly patients who fall should have a thorough trauma evaluation because these patients may suffer multiple injuries in different body systems, which could be missed if the physician only focuses on one body system. In the absence of a good history, the ED physician should have contacted CLC staff for additional information, performed a thorough physical examination, or considered ordering more diagnostic imaging. Facility leaders conducted an institutional disclosure[26] advising Resident A's family members of the inadequate ED evaluation and their right to pursue a tort claim.

Communication

Inadequate communication contributed to the incomplete evaluation and treatment of Resident A in the ED. Specifically:

- Although CLC policy[27] requires the CLC on-call physician to notify the ED physician of resident transfers, we found no documented evidence of this communication, nor could either provider recall if they spoke prior to the transfer.

[25] Resident A had osteopenia or decreased bone density on his x-ray.
[26] According to VHA Handbook 1104.08, *Disclosure of Adverse Events to Patients*, October 2, 2012, an institutional disclosure is a formal process by which facility leader(s), together with clinicians and others, inform the patient or patient's representative that an adverse event has occurred during the patient's care and provide specific information about the patient's rights and recourse.
[27] Nursing Standard Operating Procedure 201-10, *Transferring Residents from Haley's Cove Community Living Center to Emergency Department*, January 2015.

- CLC staff monitoring Resident A after his return from the ED noted that he was guarding his arm; however, staff made no further contact with the ED staff.

Family's Related Concerns

The CLC staff used the wrong urinary catheter size on Resident A [in late 2016.]

We substantiated that in late 2016, the CLC nursing staff used the wrong urinary catheter size. We found documentation that a 22 French (Fr) suprapubic catheter[28] was consistently used from late 2014 through 2016. However, in late 2016, we found that the staff used an 18Fr suprapubic catheter. We found no documentation to explain the change in size. Three days later, at the family's request, staff replaced the 18Fr suprapubic catheter with a 22Fr suprapubic catheter. We found no evidence that the short-term use of a smaller catheter negatively impacted Resident A.

The CLC staff administered a new medication for agitation to Resident A without the family's consent.

We substantiated that Resident A's providers administered a new medication for agitation to Resident A without the family's consent. However, we found this to be a reasonable action given Resident A's condition and behavior that day.[29] While consent was not required to administer the medication, discussion with the resident or family is generally a preferred practice.

On a day in late 2016, nursing staff noted that Resident A was agitated and aggressive and that his usual medication, at the prescribed doses, was ineffective. Nursing staff attempted to administer a small oral PRN dose of quetiapine, but Resident A refused to take it. The nursing staff documented concern for Resident A's safety as well as the safety of other residents. The on-call physician ordered an intramuscular injection of haloperidol, which the nurse administered shortly after midnight and permitted Resident A to sleep for several hours. The following day Resident A appeared lethargic. A family member expressed concern with the use of haloperidol and the potential risks associated with this medication. At that time, the CLC clinical providers provided education and support to the family member on the use of haloperidol. We found no evidence that this one-time injection of haloperidol negatively impacted Resident A or otherwise contributed to his fall 2 days later.

CLC staff increased the dose of one of Resident A's existing medications without the family's consent.

We substantiated that Resident A's providers increased an existing medication without his family's consent. Resident A had a history of increased confusion, anxiety, and

[28] A suprapubic catheter is a tube that drains urine from a bladder.
[29] It is medically appropriate to administer a small dose of an anti-psychotic medication to control agitation for the safety of the residents and staff within the CLC.

agitation in the evenings. We found multiple documented discussions between the CLC psychiatrist and Resident A's family member (the next of kin) about the change or potential change to his psychotropic medications to manage these symptoms. Resident A's routine medication regimen included 8 mg of ramelteon, 50 mg of quetiapine, and 25 mg of quetiapine PRN. On a day in late 2016, Resident A's primary care provider placed a new order for 75 mg of quetiapine. Given Resident A's increased agitation during this time, the increased quetiapine dose was appropriate. While the psychiatrist routinely discussed medication adjustments with Resident A's family, we found no documentation that the primary care provider did so. While medication adjustments would not have required consent, discussion with the resident or family is generally a preferred practice. We found no evidence that this medication adjustment negatively impacted Resident A or otherwise contributed to his fall 2 days later.

CLC staff failed to order a urinalysis.

Although we confirmed that Resident A's primary care provider failed to order a urinalysis after Resident A experienced a mental status change, we did not substantiate the implied inappropriateness of this action. Although Resident A's psychiatrist suggested obtaining a urinalysis, he deferred to the CLC NP for decision-making. We found the NP's decision was reasonable not to proceed with the suggested urinalysis based on the patient's examination, and his/her experience and knowledge of Resident A. The results from the urinalysis done the next day following Resident A's fall were within expected limits.

CLC staff did not make a reasonable effort to notify the family when Resident A fell or communicate the severity of his injuries.

We did not substantiate that staff failed to make a reasonable effort to contact a member of Resident A's family at the time of the fall. Further, we did not substantiate that the nurse failed to communicate the extent of Resident A's injuries when he/she left the message for the family member.

On the night of the fall, the charge nurse documented approximately 2 hours after the fall that he/she was unable to reach the family member and that he/she left a message. The nurse specifically left a non-urgent message to call the CLC. The charge nurse documented that the family member returned his/her call the next morning. The charge nurse provided information on Resident A's condition and answered the family member's questions. During this telephone call, the family member advised that the other phone number on file was for his/her home; it was not a work number. The charge nurse took appropriate steps to update contact information in the EHR.

We found that the nurse made a reasonable effort to notify the family member with a documented emergency contact number. Further, if the initial message conveyed the fall as non-emergent, then this would have been consistent with the information the nurse knew at the time.

CLC staff left Resident A lying [on a gurney] in the hallway unattended for a long period of time.

Although we confirmed that Resident A was lying on a gurney in a hallway outside the nursing station for several hours, we did not substantiate the implied inappropriateness of this condition. We found that on the night of the fall, Resident A returned to the CLC from the ED, and was placed back in bed, and staff continued to monitor him throughout the night. In the morning, the charge nurse determined that Resident A would probably need to return to the ED to have his arm examined. Staff returned Resident A to a gurney and positioned him in the hallway to await the arrival of the NP for further evaluation and so staff could continue to monitor him. The NP examined Resident A and ordered additional x-rays of his shoulders, elbows, and hips. Following the x-rays, Resident A went to the laboratory for additional tests. Approximately an hour later, the NP met with Resident A's family member to discuss Resident A's fall and subsequent care. Resident A transferred to an inpatient unit about 2 hours later. While 5.5 hours is a long time to be on a gurney, we determined that because staff positioned Resident A in the hallway, all staff could assist in monitoring him.

B. Resident B Fall in Early 2017

Resident B was a male in his 80s with a history of hypertension, dementia, and hearing impairment. He had a history of falls both prior to and during his stay at the CLC. Upon admission to the CLC in mid-2016, nursing staff completed an evaluation including a fall assessment. Resident B's fall precautions included hip protectors, chair and bed alarms, floor mats, and bed in the low position. Further, he was not to be left unattended in his wheelchair.

In early 2017, the charge nurse observed Resident B sitting in his wheelchair in his room unattended in the late afternoon. Approximately 2 hours later, staff heard a "crash" from Resident B's room and the resident yelling for help. Resident B was evaluated in the ED where an x-ray revealed a left hip fracture. The following day Resident B had hip surgery. Resident B had a complicated post-operative period and died 9 days after the fall.

We reviewed Resident B's EHR and found that staff observed him in his wheelchair unattended and did not take action, but also:

- Staff documented the use of hip protectors once throughout Resident B's stay in the CLC.
- Staff did not document the use of chair or bed alarms throughout Resident B's stay in the CLC even though Resident B was at a high risk for falls and had fallen several times in the months prior to his death. Each time, the post-fall plan made specific recommendations about using these alarms:
    - After a fall in late 2016, EHR documentation stated, "…continue bed alarm," and "…order chair alarm."

- During an interdisciplinary case conference in late 2016, documentation reflected, "…provide chair and/or bed alarm."
- Following a fall in early 2017, documentation reflected, "…ensure bed alarm functions."

We found consistent documentation that staff implemented floor mats and low bed precautions.

The facility conducted an internal review of the fall as required and completed an institutional disclosure to the family.

Issue 2: CLC-Wide Fall Prevention Practices

We found a pattern of fall prevention failures that placed CLC residents at risk for falls. In general, the CLC's fall rates and falls with major injury rates were lower than the VHA-wide aggregate rate for FY 2016. However, in Qs 1–2, FY 2017, the CLC exceeded VHA-wide rates for falls with major injuries (due to residents A and B, and a third resident who broke an arm). The common theme was the CLC staff's failure to consistently implement and document fall precautions. A similar example of non-compliance occurred in 2014, and although the facility identified corrective actions and reportedly implemented them at that time, improvements were not sustained. We provided the facility a detailed list of our findings and removed the information from the report because it contained protected information.

Snapshot of Non-Compliance on March 8

During our unannounced site visit on March 8, 2017, we visually inspected CLC residents' rooms and compared all of the 46 CLC residents' ICPs and their most recent Falls Assessment. We specifically reviewed the level of the residents' fall risk, the documentation and implementation of fall prevention strategies, and staff members' knowledge of individual residents' fall precautions/orders.

CLC staff did not consistently implement fall precautions as outlined in patients' ICPs. Further, not all staff we interviewed were able to state what fall precautions should be in place for individual CLC residents or how to locate the information. Table 1, below, reflects inconsistencies between what staff documented in the ICP, the Falls Assessment, and what we observed.

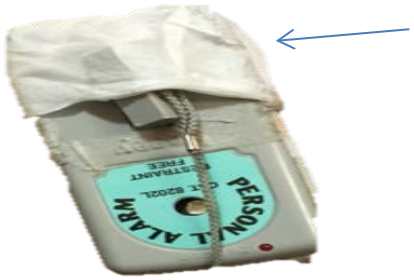
Table 1. Comparison of Documented Fall Precautions and Practices

Fall Prevention Strategies	Documented in ICP	Documented in Falls Assessment	OIG Observed
Hip Protectors	38	9	13[30]
Bed Alarms	14	5	17
Floor Mats[31]	21	8	17
Bed in Low Position	29	26	37
Chair Alarm	13	3	4
Chair Belt	27	0	22

Data based on OHI's review of the CLC residents' ICP, most recent Falls Assessment, and OIG unannounced site visit on March 8, 2017.

We also found inconsistencies between CLC staff and CLC leaders' understanding of the availability of fall precaution resources (hip protectors and chair alarms). During our unannounced site visit, staff on units B and D showed us newly appointed spaces in their supply rooms for the storage of hip protectors, which allows for easier access. Another staff member explained that they do not have enough chair alarms and the ones they do have are often held together using tape in order for them to work (see photograph 1). The Chief of Biomedical Engineering told us that the facility does not have a "good" inventory of chair alarms and that biomedical engineering rarely received a work order to repair chair alarms. CLC leaders confirmed that chair alarms are not repaired when broken, but rather thrown out and replaced with new ones.

Photograph 1: Chair alarm[32]



According to facility policy, universal fall precautions include posting a sign in a visible location that states "Don't Fall – Call!", having the resident's call bell within reach, and the bed wheels locked.[33]

[30] OIG decided against disturbing any sleeping residents during our unannounced visit occurring at 6:00 a.m.
[31] The CLC received the delivery of two new floor mats for each resident on the afternoon of March 8, 2017.
[32] Photograph of taped together chair alarm taken by OIG staff during our unannounced visit.
[33] Medical Center Memorandum 118-05, *Fall Prevention and Management*, May 2015.

During our unannounced visit, we found that:

- 45 of the 46 (98 percent) resident rooms inspected had the "Don't Fall – Call!" sign posted.
- 40 of the 46 (87 percent) resident rooms inspected had locked bed wheels.
- 32 of the 42 (76 percent) resident rooms inspected had the resident's call bell within reach.[34]

CLC leaders acknowledged deficiencies with documentation and the need for improved communication. Further, CLC leaders and the acting Patient Safety Manager reported having quarterly meetings with CLC staff to review policies and practices, and are planning to distribute a staff questionnaire to identify knowledge deficits and institute appropriate training and process improvements.

Issue 3: Facility Response to Alleged Abuse, Neglect, and Retaliation

Due to alleged abuse, neglect, and retaliation occurring greater than a year prior to our site visit, we could not reliably reconstruct the events. Therefore, we focused on whether the facility sufficiently reviewed and responded to the allegations involving residents C, D, and E as discussed below.

Facility policy on patient abuse and neglect defines the procedures for reporting, evaluating, and following up on allegations of patient abuse. Employees who witness or have knowledge of suspected abuse must report the incident to their immediate supervisor and complete a written report of contact. The Service Chief or designee will conduct a preliminary fact-finding review to determine if there is any suspicion of abuse, and the employee alleged to have committed the abuse will be detailed to a non-patient care assignment until the conclusion of the fact-finding review.

Once the designee completes the fact-finding review, the CLC Chief Nurse and the Associate Director of Patient Care Services (ADPCS) reviews the findings. If the fact-finding review does not substantiate the allegation, the case is closed. If the fact-finding review does substantiate the allegation or requires further investigation, the Risk Manager may provide his/her assessment and evaluation of the incident, or the ADPCS recommends convening an administrative investigative board (AIB) to the Facility Director. The AIB conducts a formal investigation of the alleged incident, and based on the AIB findings, disciplinary action may occur.

Resident C

We found the facility did not adequately review and follow-up with Resident C's allegations of abuse in 2015. We found that facility managers did not conduct

[34] We did not include in our count the four residents who were either out of bed or in the community dayroom.

appropriate internal reviews of the alleged patient abuse and other unexplained injuries relative to Resident C in 2015.

Resident C is a male in his 90s with a history of advanced dementia and combativeness. In 2014, the family admitted him to the CLC for medical reasons as well as being unable to care for him at home. In late 2015, a member of Resident C's family made allegations of patient abuse that were subsequently reported to VA police. While the family member was specifically alleging abuse occurring 2 days in late 2015, he/she referenced incidents of alleged abuse occurring earlier in calendar year 2015 as well, including:

- In early 2015 (Event 1), CLC employee X allegedly abused Resident C, resulting in bruising on his temple, fingers, and arm. The family member reported his/her concerns to CLC staff, employee X was removed from caring for Resident C, and the bruising stopped. The case was not reported to VA police at the time of the event, nor was a fact-finding review initiated.
- In mid-2015 (Event 2), CLC employee Y allegedly abused Resident C multiple times, resulting in a shoulder injury. Although a housekeeping aide reportedly witnessed the abuse, neither the family member nor the witness reported the case to the CLC nurse manager (NM) or VA police at the time of the event.
- In late 2015 (Event 3), a member of Resident C's family was concerned about bruising to the resident's face and chest. A CLC physician evaluated Resident C and explained to the family that Resident C was at high risk for self-injury due to the diagnosis of dementia with behavioral features.

Event 1. We found no evidence that CLC leaders conducted a fact-finding review of the alleged event. Our EHR review found that in early 2015, staff documented several incidents of Resident C being combative and aggressive towards staff with one incident resulting in the resident having a red and swollen thumb. Managers documented the injury and discussion of the occurrence with the involved staff. Also in early 2015, Resident C developed red spots or bumps on his back and leg. The red spots or bumps appear to have been an allergic reaction and Resident C received treatment. We found no documentation in the EHR about bruising on Resident C's temple, finger, or arm in early 2015.

Event 2. The CLC NM conducted a fact-finding review and reassigned employee Y after learning of the allegations 2 months later. CLC leaders determined the allegations were not substantiated. However, we determined the fact-finding review was inadequate, as it did not include:

- documented interviews with the housekeeping aide or employee Y
- documented results of an EHR review
- a rationale of how CLC leaders determined that the allegations were "not substantiated"

Further, while the CLC NM forwarded the fact-finding review summary to the CLC Chief Nurse, it did not appear that the CLC Chief Nurse reviewed and discussed the summary results with the ADPCS.

Event 3. We found no evidence that CLC leaders conducted a fact-finding review of the alleged event. In addition, we found that despite advising Resident C's family member that he/she [the VA police officer who took the report] would "be referring this case to the VA Police Detective for further investigation," VA Police took no apparent action to follow up on the allegations.

Resident D

We found that the facility adequately reviewed and followed up with Resident D's allegations of neglect in 2016. Without specific dates, witnesses, and obvious and/or documented evidence, we acknowledge that it was difficult to determine with certainty what did or did not happen in the past. Facility leaders conducted a fact-finding review in accordance with policy.

In late 2016, Resident D's family reported to Florida congressional leaders four incidents in which Resident D felt neglected. The complaints centered around nursing staff not responding to his calls for assistance, and specifically noted an instance when nursing staff reportedly left Resident D in soiled clothing for hours without intervention.

Facility policy defines neglect as the refusal or failure to fulfill any part of an employee's obligations or duties to a patient. Neglect can be repeated conduct or a single incident of carelessness. The Assistant Chief for Quality Management conducted the fact-finding review and forwarded the summary of findings to the Facility Director through the ADPCS. The Facility Director and the ADPCS initialed the provided copy and the Facility Director gave comments and feedback to the involved staff. Given the available information about the alleged incidents, we found the fact-finding review to be reasonable and credible.

During an early 2017 ICP family meeting, a staff member was assigned to serve as a companion to Resident D for about 4 hours per day.

About a week later, Resident D's family alleged abusive acts by a CLC staff member including kicking Resident D's bed, being "rough" with him, talking "nasty," and allowing him to go without food on a day in early 2017. Per policy, CLC leaders reassigned the subject employee to a non-patient care area while the AIB conducted its investigation.

The AIB did not substantiate the allegations of patient abuse. Given the available information about the alleged incidents, we found the AIB to be thorough, reasonable, and credible.

Resident E

We found that the facility adequately reviewed and followed-up with Resident E's allegations that a CLC nursing assistant was "too rough" when providing patient care in 2016. CLC leaders promptly removed the nursing assistant from direct patient care responsibilities and conducted a fact-finding review into the allegation.

The fact-finding review, which found reasonable evidence of patient abuse and the need for an AIB, was forwarded to the ADPCS, the CLC Chief Nurse, and Human Resource Service. The non-CLC NM who chaired the AIB recommended that the nursing assistant complete training and review the Code of Conduct Policy. Although detailed to a non-patient care assignment in late 2016, the nursing assistant took an extended leave from the facility. In early 2017, the nursing assistant returned to his/her detailed assignment, completed the recommended training, and reviewed the Code of Conduct Policy.

Retaliation

We did not substantiate family members' concerns about possible retaliation from staff if they complained about care. We found no evidence to support their perceptions.

We spoke with residents and family members about their concerns of possible retaliation. Although the residents and family members expressed concern about retaliation and some hesitancy to speak with us, they could not provide examples of retaliation during our interviews. We provided the residents and family members with our contact information and encouraged them to call if they experienced any retaliation from staff. We did not hear anything further on the subject from the residents or family members.

Issue 4: CLC Nurse Staffing

The CLC Nurse Staffing Methodology completed for FY 2017 recommended an increase in nursing staff and mix per shift to accommodate the higher patient acuity levels and ensure two RNs would be available per shift.[35] The recommended staffing mix was to be comprised of 30 percent RNs, 33 percent licensed practical nurses (LPNs), and 37 percent nursing assistants. As of February 6, 2017, the facility reported vacancies of 1.2 full time employee equivalent RNs and 4.6 LPNs.

Although the staffing methodology recommended two RNs per shift per unit, CLC leaders told us it was not possible due to the limited number of RNs and the

[35] Nurse Staffing Methodology provides a standardized method of determining appropriate direct care staffing for nursing personnel. The methodology assists with long-term planning and budget projections. VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This directive was in effect during the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017 and contains the same or similar language regarding nurse staffing methodology.

reconfiguration of the CLC units in February 2016. Specifically, the CLC was previously located on one unit, so the staffing was adequate to meet the need. However, the CLC separated into two units to allow more residents to have private rooms.[36] With this reconfiguration, staffing resources became even more limited. Staff and residents' family members reported that the current staffing levels were inadequate to meet the acuity levels and needs of the CLC residents, and CLC nursing leaders confirmed that staffing was not ideal.

We randomly selected the February 21–22, 2017 CLC nurse staffing schedules for review. We found that each unit met the minimum staffing levels; however, they did not meet the staffing mix recommendation of two RNs per shift per unit. CLC nursing leaders noted that staffing issues arise when CLC staff "call out" for their shifts or if residents need 1:1 observation.[37] In those instances, CLC leaders either borrowed staff from another unit or offered overtime to staff to ensure coverage.

Issue 5: Environment of Care

VHA requires facilities to maintain a clean and safe health care environment in accordance with applicable requirements.[38] We reviewed relevant EOC and Infection Prevention (IP) policies and committee meeting minutes for calendar year 2016. We found the EOC and IP committee meeting minutes were thorough in their discussion and follow-through of corrective actions.

We also conducted EOC rounds on units B and D in the CLC. Overall, we found the units clean, odor free, and well-maintained, and resident rooms to be free of clutter.[39]

Conclusions

We substantiated that on the night of Resident A's fall in late 2016, CLC staff had not implemented all fall precautions outlined in his ICP. Further, the ED physician did not adequately evaluate Resident A's injuries after the fall. The severity of Resident A's injuries, combined with a slow recovery often experienced by the elderly, had a negative impact on his quality of life, at least for a period of time.

On the night of Resident A's fall, CLC staff did not consistently implement fall precautions as outlined in his ICP. Specifically, we could not confirm via EHR documentation or nursing staff interviews that Resident A's bed was in a low position (close to the floor) with wheels locked or that his call bell was within reach on the night

[36] In 2012, the CLC decreased bed capacity from 120 to 54 and opened a 10-bed Hospice Unit. The CLC unit was located in one unit. In February 2016, the CLC expanded the number of private rooms to 30 and expanded to two units (C and D). Bed capacity remained at 54.
[37] Staff use 1:1 observation, or one-to-one observation, when a resident is unable to be left alone due to concerns of self-harm.
[38] VHA Directive 1608, *Comprehensive Environment of Care Program*, February 1, 2016.
[39] For the purpose of this inspection, we considered clutter only on the floor if it could possibly cause a trip or fall. Residents are encouraged to have and display limited personal items to promote a "homelike" environment.

of the fall. Also, CLC staff told us that Resident A's bed alarm was off at the time of the fall, and while a floor mat was present on one side of the bed (where he fell), we could not confirm the presence of a floor mat on the other side of the bed as required.

The ED physician did not conduct an adequate evaluation of Resident A's condition. In the absence of a good history, the physician should have performed a thorough physical examination, considered ordering additional diagnostic imaging, or contacted CLC staff for additional information. Elderly patients who fall should have a thorough trauma evaluation because these patients may suffer multiple injuries in different organs, which could be missed if the physician only focuses on one body system. In addition, we found that inadequate communication between CLC and ED staff contributed to the incomplete evaluation and treatment of Resident A in the ED.

Although we heard speculation that Resident A's injuries were too severe to have been the result of a fall, we found his fractures, which all occurred on his left side from shoulder to thigh, were consistent with injuries seen in a fall with impact on the left side of the body. The resident's age, dementia, and bone loss made him more susceptible to falls and increased the likelihood of severe injuries.

We substantiated Resident A's family's concerns that CLC staff used the wrong urinary catheter size on Resident A in late 2016, administered a new medication for agitation to Resident A without the family's consent, and increased the dose of an existing medication to Resident A without their consent. We found no evidence that the short-term use of a smaller catheter negatively impacted Resident A. Although we substantiated that Resident A's providers administered a new medication and an increased dose of an existing medication without the family's consent, we found this to be a reasonable action given Resident A's condition and behavior that day. While medication changes like those described would not have required consent, discussion with the resident or family is often a preferred practice. We found no evidence that the above actions negatively impacted Resident A.

Although we confirmed that Resident A's primary care providers failed to order a urinalysis after Resident A experienced a mental status change, we did not substantiate the implied inappropriateness of this action. Resident A's NP examined Resident A and based on his/her knowledge of and experience with Resident A, did not order a urinalysis. The urinalysis completed the next day, after Resident A's fall, was within expected limits.

We did not substantiate that staff failed to make a reasonable effort to contact the family at the time of incident or communicate the extent of Resident A's injuries. The nurse left a message on a family member's cell phone, a documented emergency contact number, within hours of the early morning incident.

Although we confirmed that Resident A was lying on a gurney in the hallway unattended for a long period of time, we did not substantiate the implied inappropriateness of this condition. Due to Resident A's injuries, probable pain, and the need for additional x-rays and testing, it may have been less disruptive and less painful to have Resident A

remain on a gurney rather than transferring him in and out of bed. In addition, all CLC staff could assist in monitoring Resident A while in the hallway outside the nurses' station.

We also reviewed the circumstances surrounding Resident B's fall in early 2017 and found that despite his being assessed as "high-risk" for falls, CLC staff did not implement fall precautions as outlined in his ICP. Resident B died 9 days after the fall.

Overall, we found a pattern of fall prevention measure failures that placed CLC residents at risk for falls. While the CLC's fall rates and falls with major injury rates were lower than the VHA-wide aggregate rate for FY 2016, in Qs 1–2, FY 2017, the CLC exceeded VHA-wide rates for falls with major injuries (due to residents A and B, and a third resident who broke an arm). The common theme was the CLC staff's failure to consistently implement and document fall precautions. A similar example of non-compliance occurred in 2014, and although the facility leaders identified corrective actions and reportedly implemented them at that time, improvements were not sustained.

During our unannounced site visit on March 8, 2017, we visually inspected CLC residents' rooms and compared all of the 46 CLC residents' ICPs and EHR documentation and implementation of fall prevention strategies. We found CLC staff did not consistently implement fall precautions as outlined in residents' ICPs including ensuring that residents used hip protectors (or documenting the refusal or contraindication) and/or chair alarms. We also found inconsistencies between CLC staff and CLC leaders' understanding of the availability of the fall precaution resources like hip protectors and chair alarms.

We found the facility did not adequately review and follow up with Resident C's allegations of abuse in 2015. We found that CLC managers did not conduct appropriate internal reviews of alleged patient abuse and other unexplained injuries relative to Resident C. In one instance, we found no evidence that CLC leaders conducted a fact-finding review of the alleged event or reported the incident to the VA police. In the second instance, the CLC NM conducted a fact-finding review; however, the fact-finding review was inadequate as it did not include documented interviews with relevant staff, results of a medical record review, or the rationale of how the CLC leaders determined that the allegations were "not substantiated." In the third instance, we found no evidence that CLC leaders conducted a fact-finding review of the alleged event.

We found that the facility adequately reviewed and followed-up with Resident D's allegations of neglect in 2016. Facility leaders conducted appropriate internal reviews of the allegations given by the family, including an AIB. Given the available information about the alleged incidents, we found the AIB to be thorough, reasonable, and credible.

We found that the facility adequately reviewed and followed-up with Resident E's allegations that a CLC nursing assistant was "too rough" when providing patient care in 2016. Facility leaders conducted appropriate internal reviews of the allegations,

including an AIB that substantiated the allegation. CLC and facility leaders took prompt and appropriate actions to address the concerns.

We did not substantiate family members' concerns about possible retaliation from staff if they complained about care. We found no evidence to support their perceptions.

We randomly selected the February 21–22, 2017 CLC nurse staffing schedules for review. We found that each unit met the minimum staffing levels; however, they did not meet the staffing mix recommendation of two RNs per shift per unit. CLC nursing leaders confirmed that staffing was not ideal and noted that staffing issues arise when nursing staff "call out" for their shifts or if residents need 1:1 observation. In those instances, CLC leaders either borrowed staff from another unit or offered overtime to staff to ensure coverage.

During our unannounced visit, we evaluated the EOC on CLC units B and D. Overall, we found the CLC units to be clean, odor free, and well-maintained, and resident rooms to be free of clutter.

We made six recommendations.

Recommendations

1. We recommended that the Facility Director ensure that Community Living Center and Emergency Department staff understand and comply with policies for communication about residents requiring evaluation and treatment.

2. We recommended that the Facility Director ensure that Community Living Center leaders develop a system to ensure fall precautions identified in the Falls Assessment are consistently reflected in the Individual Care Plan and implemented accordingly, and that staff are held accountable.

3. We recommended that the Facility Director ensure the availability and functionality of fall prevention and safety devices such as hip protectors and chair alarms.

4. We recommended that the Facility Director ensure that Community Living Center leaders follow through on efforts to determine staff knowledge deficits related to fall prevention and institute training and process improvements.

5. We recommended that the Facility Director ensure that Community Living Center leaders conduct appropriate reviews and implement required actions in cases of suspected abuse or neglect.

6. We recommended that the Facility Director ensure an adequate nurse staffing mix to meet the acuity levels and needs of the Community Living Center's residents.

Appendix A

Prior OIG Reports

Facility Reports

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of James A. Haley Veterans' Hospital, Tampa, Florida
3/23/2016 | 16-00007-206

Combined Assessment Program Review of the James A. Haley Veterans' Hospital, Tampa, Florida
3/23/2016 | 15-04709-208

Review of Alleged Patient Scheduling Issues at the VA Medical Center, Tampa, Florida
2/5/2016 | 15-03026-101

Topic Related Reports

Patient Abuse and Neglect

Healthcare Inspection – Alleged Resident Abuse and Abuse Reporting Irregularities at the Pueblo Community Living Center, VA Eastern Colorado Healthcare System, Denver, Colorado
11/29/2012 | 12-03858-46

CLC

Healthcare Inspection – Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon
10/12/2016 | 15-00506-420

Healthcare Inspection – Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida
6/7/2016 | 14-03183-317

Healthcare Inspection – Staffing and Quality of Care Issues in the Community Living Center, Charlie Norwood VA Medical Center, Augusta, Georgia
3/19/2015 | 14-02437-117

Healthcare Inspection – Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi
5/28/2014 | 14-01119-168

OIG reports are available on our website at www.va.gov/oig

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 15, 2017

From: Acting Network Director, VISN 8 (10N8)

Subj: Healthcare Inspection—Patient Safety and Quality of Care Concerns in the Community Living Center, James A. Haley Veterans' Hospital, Tampa, Florida

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

1. Thank you for the opportunity to review the draft report and the facility's response.

2. I have reviewed the response and concur. VISN 8 will actively support the facility in the completion of all recommendations and will assist in monitoring for compliance.

3. If you have any questions or need additional information, please contact the VISN 8 Quality Management Officer at 727-575-8005.

Timothy W. Liezert

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 8, 2017

From: Director, James A. Haley Veterans' Hospital (673/00)

Subj: Healthcare Inspection - Patient Safety and Quality of Care Concerns in the Community Living Center, James A. Haley Veterans' Hospital, Tampa, Florida

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

1. Thank you for the opportunity to review the draft report.

2. Prior to the OIG's inspection of the CLC, James A. Haley Veterans' Hospital had already called for an internal investigation after a fall in December 2016, and began taking corrective actions based on our own internal investigation and performance improvement efforts. JAHVH concurs with the OIG's recommendations, has completed corrective actions and has sustainment plans in place.

3. If you have any questions or need additional information, please contact Chief, Quality Management, at 813-972-2000, ext. 6604.

Joe D. Battle
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 Facility Director ensure that Community Living Center and Emergency Department staff understand and comply with policies for communication about residents requiring evaluation and treatment.

Concur

Facility response: CLC Nursing implemented use of the Long-Term Care Nursing Transfer note to document the nursing assessment of the resident's condition prior to sending to the Emergency Department (ED). A visual guide on how to complete patient transfer notes was provided to CLC RNs. The ED Medical Director reinforced education with ED physicians of the importance of a comprehensive evaluation of elderly patients after a ground level fall. An audit tool of the completion of the transfer note has been developed and a threshold of 90% compliance for three consecutive months has been set.

Target date for completion: March 15, 2018.

Recommendation 2. We recommended that the Facility Director ensure that Community Living Center leaders develop a system to ensure fall precautions identified in the Falls Assessment are consistently reflected in the Individual Care Plan and implemented accordingly, and that staff are held accountable.

Concur

Facility response: CLC leaders will conduct a 100% audit of individualized care plans to ensure the interventions identified in the fall assessment are implemented (including documentation of resident or family refusals) with target of 90% compliance for three consecutive months.

Target date for completion: March 15, 2018.

Recommendation 3. We recommended that the Facility Director ensure the availability and functionality of fall prevention and safety devices such as hip protectors and chair alarms.

Concur

Facility response: Logistics Service increased inventory par levels of hip protectors based on identified CLC needs. Existing floor mats were upgraded and replaced with

128 new high-density beveled floor mats; which were placed on each side of the CLC beds. All chair and bed alarms in the CLC were assessed by Biomedical Engineering staff for their functionality and volume to ensure alarms were sufficiently audible. Additionally, new chair alarms were purchased and delivered to CLC. CLC leadership conducted a physical review of all patient rooms and verified the new mats were in place. Biomedical Engineering staff completed their review; all alarms are functioning as designed with volume set. New chair alarms arrived and were implemented.

Target date for completion: October 11, 2017.

We respectfully request closure of this recommendation.

OIG Update December 2017: We accepted this action as complete.

Recommendation 4. We recommended that the Facility Director ensure that Community Living Center leaders follow through on efforts to determine staff knowledge deficits related to fall prevention and institute training and process improvements.

Concur

Facility response: CLC RNs were educated on expected post fall documentation. A visual guide on how to complete the Post Falls Note at 24, 48, and 72 hours after a fall was posted on all units. The charge nurse hand off process was modified to ensure post falls notes are completed at the 24, 48 & 72 hour intervals. CLC Nursing leadership will conduct an audit of post-fall notes with a threshold of 90% compliance for three consecutive months.

Target date for completion: March 15, 2018.

Recommendation 5. We recommended that the Facility Director ensure that Community Living Center leaders conduct appropriate reviews and implement required actions in cases of suspected abuse or neglect.

Concur

Facility response: We identified that the staff member who conducted the review of the allegations did not follow policy regarding reporting and assurance of a robust review.

Administrative and Clinical Service Chiefs were sent a copy of the policy to review on January 26, 2017. The Nursing CLC front-line and supervisory staff were educated on the reporting and review requirements of alleged patient abuse/neglect during a meeting on June 23, 2017. The policy includes reporting requirements to senior leadership.

Follow-up education for front-line CLC staff regarding reporting requirements will occur annually. Education to supervisory CLC staff will be repeated annually. New hires to the CLC receive education of the policy during their orientation to the unit(s) and annually thereafter.

Target date for completion: June 23, 2017.

We respectfully request closure of this recommendation.

OIG Update December 2017: We accepted this action as complete.

Recommendation 6. We recommended that the Facility Director ensure an adequate nurse staffing mix to meet the acuity levels and needs of the Community Living Center's residents.

Concur

Facility response: Daily huddles are held to review shift staffing levels, assignments, and resident acuity with charge nurses. The impact of CLC nursing staff unplanned absences have been minimized through the new availability of the Nursing Assistant and Intermittent RN Pool.

Target date for completion: August 11, 2017.

We respectfully request closure of this recommendation.

OIG Update December 2017: We accepted this action as complete.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Joanne Wasko, LCSW, Team Leader Victoria Coates, LICSW, MBA LaFonda Henry, MSN, RN-BC Miquita Hill-McCree, MSN, RN Martha Kearns, MSN, FNP April Terenzi, BA, BS Carol Torczon, MSN, ACNP Toni Woodard, BS
Other Contributors	Patrick Crockett, Resident Agent in Charge, Bay Pines Office of Investigations Jennifer Christensen, DPM Anita Pendleton, AAS Evonna Price, MD Larry Ross, Jr., MS Barbara Wright, JD Amy Zheng, MD

Appendix E

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