DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess specific aspects of the care provided to a patient who died following elopement from a community living center (CLC) at the Chillicothe VA Medical Center (facility) in Ohio.[1]

In early 2020, the OIG received notification from VA that, days prior, a motor vehicle struck and killed a patient in their early 60s near facility grounds.[2] The patient had eloped from the CLC hours earlier. The OIG had concerns regarding the appropriateness of the admission given the patient suffered from paranoid schizophrenia and was involuntarily civilly committed to the CLC.[3] The OIG also had concerns about the patient's elopement-prevention care while admitted to the CLC. Additionally reported in the notification was that facility staff had not noticed the patient was missing for nearly three hours prior to death.

Given these concerns, the OIG opened a healthcare inspection to determine whether (1) the patient's admission to the CLC was appropriate, (2) the patient's care was adequate to mitigate the patient's risk for elopement, and (3) facility staff followed missing patient procedures following the patient's elopement.

The OIG determined that the patient was not appropriate for admission to the CLC. In early 2019, the patient was transferred to the facility's CLC long-stay mental health recovery unit (the unit). VA CLCs are skilled nursing homes, and Veterans Health Administration's (VHA) admission criteria requires that patients be psychiatrically stable and have service needs that align with those offered by the CLC.[4] The patient was not psychiatrically stable at the time of admission and the patient's needs did not align with the services offered by the CLC. Further, although the CLC screening process identified that the patient did not meet admission criteria, CLC staff admitted the patient because facility leaders encouraged the admission due to a lack of alternative placement options.

The OIG determined that, once admitted, interventions implemented by staff were inadequate to mitigate the patient's risk for elopement. The patient eloped multiple times from the CLC during

[1] Merriam-Webster, *Definition of Elopement*. To elope (elopement) is to escape or leave a healthcare facility without permission or authorization, https://www.merriam-webster.com/dictionary/elopement. (The website was accessed on July 6, 2020.) For purposes of this report, OIG uses patient and resident synonymously.

[2] The OIG uses the singular form of they (their) in this instance for patient privacy.

[3] Substance Abuse and Mental Health Services Administration, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, 2019. Involuntary civil commitment is a legal intervention used to require a person with symptoms of a serious mental health condition to be confined in a psychiatric hospital, or otherwise engage in treatment in an outpatient setting for a specific time period.

[4] VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers, September 2, 2012.

a one-year stay. Facility staff failed to address the need to change interventions that had proven ineffective in the past to prevent the patient from eloping. Additionally, facility staff did not attempt to change, or request changes to the security or structure of the unit. The OIG determined that the care plan lacked unique, individualized, and progressive approaches specific to the patient and the patient's level of functioning and history of successful elopements from the unit. As a result, the patient continued to elope from a safe environment (the unit) to an unsafe environment.

The OIG found that the nurse practitioner who managed the patient's CLC care and served as the mental health consultant to the CLC did not have a background or training in the delivery of mental health care and was privileged in family practice. Further, the unit nursing staff who provided the day-to-day care and elopement prevention for the patient reportedly received limited training in behavioral health interventions.

The OIG is concerned with the lack of behavioral and psychiatric care provided to the patient given the primary reason for admission to the unit was treatment of schizophrenia. The patient continually displayed undesirable behaviors during this stay, including frequent wandering or successful elopement from the unit, verbal and physical aggression, urinating in undesirable locations such as group rooms or in public, introduction of contraband into the facility, and receiving police citations for smoking on the unit. Although the patient was seen multiple times by a psychiatric provider in the first six weeks of admission and five times during a one month period in the summer, the patient received little other psychiatric care. Additionally, the elopement interventions recommended by psychology were not incorporated into the patient's care plan. The nurse practitioner and unit staff with minimal formal training in mental health care were presented the responsibility of providing most of the patient's care. The OIG determined that the patient's behavioral health care was inadequate to mitigate the risk for elopement.

Unit nursing staff failed to report all of the patient's elopements to patient safety as required by policy. In addition to the eight reported events, the OIG found another seven actual missing patient events and 10 close calls documented in the patient's electronic health record that were not reported.[5] The OIG also determined that the Patient Safety Manager missed opportunities to intervene to mitigate elopement risk. The Patient Safety Manager was aware of the patient's pattern of elopements, by means of the unit elevator, and failed to fully explore the systemic or physical structural deficits that may have contributed to this pattern. Within a month of the patient's death, safety changes were made to the unit, including adding a structural or security barrier to the unit elevators. Earlier patient safety reviews could have provided an opportunity to

[5] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. VHA defines close calls as "an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention."

identify risk mitigation options, including resolving structural weaknesses, to prevent future elopements.

On the date of the patient's death, facility staff failed to detect the patient was missing for nearly three hours. Facility video evidence revealed that the patient entered the unit elevator at 6:13 p.m. and did not return to the unit. The video shows the patient walking slowly throughout the facility property at various times until 9:03 p.m., when the patient is viewed for the last time exiting the property on foot. Facility staff first noticed that the patient was not on the unit at 9:00 p.m. when attempting to locate the patient for medication administration. Facility staff reported that, prior to the patient's death, unit nurses used an unofficial procedure to document each patient's location on the unit every hour.[6] Using this procedure, nursing staff erroneously documented the patient as being in the unit at 7:00 p.m. and 8:00 p.m. on the day the patient eloped and died. Although the specific staff member and supervisor were unaware that this error occurred, both acknowledged the patient could have been misidentified because of distractions from other patients on the unit at the time.

In general, facility staff reported receiving minimal training on how to perform hourly patient counts. The facility did not have adequate policies and procedures to routinely verify the locations of at-risk patients or prevent them from eloping. Facility leaders reported being aware of the documentation error on the night of the patient's death and responding with documentation training for all unit nursing staff a few weeks after the incident. Since the patient's death, facility leaders reported they have also drafted a new written standard operating procedure to guide staff in conducting hourly patient counts.

The OIG determined facility staff did not adequately respond to the missing patient event. Facility staff failed to immediately report the missing patient to VA police, which added an additional 30 minutes to the three-hour delay in detecting the missing patient. OIG interviews revealed that unit staff lacked knowledge of the requirement to immediately contact VA police when a patient is suspected to be missing. Once notified that the patient was missing, the facility reported that the two police officers on duty both started to search the more than 300-acre facility grounds. The OIG learned that the VA police did not generate a facility missing patient alert or notify local law enforcement agencies. Facility staff explained that in the 45 minutes VA police searched for the patient they did not have sufficient time to generate the mandatory alerts. Use of a facility missing patient alert would have broadcast a message to all available staff on campus to assist with search efforts. An alert to local law enforcement would have allowed passing law enforcement vehicles to be on the lookout for the patient. As the VA police failed to issue these notifications, search efforts were restricted to CLC staff and the two responding officers.

[6] Facility staff used an unofficial one-page paper that listed all patients on the unit and provided boxes for each hour of the day for staff to document a code for where each patient was seen that hour.

The OIG determined that facility leaders did not ensure that facility staff received required initial or annual missing patient training. This lack of training likely contributed to the inadequate response to this missing patient event.

Long-stay mental health recovery units are intended to assist patients who are psychiatrically stable and suffer from chronic mental illnesses "coupled with geriatric or other syndromes."[7] During the inspection, multiple facility staff described the unit to OIG as long-term care for patients with only mental health treatment needs, or as long-term psychiatric hospitalization. Another description offered by facility staff defined the unit as a locked long-term care unit, for patients under 65 years of age, who suffer from only chronic psychiatric disorders. Facility staff reported that, at times, nearly 25 percent of the unit's 41 beds were occupied by patients who were involuntarily committed by court order due to mental illness. Veterans Integrated Service Network (VISN) 10 staff described the unit as providing treatment, "for complex patients with psychotic disorders, who may have risk factors for self-harm or harming others." Although, they added that the unit is not intended "to treat acutely suicidal or homicidal individuals."

CLCs follow the Centers for Medicare and Medicaid Services long-term care standards, which specifically exclude facilities who provide care primarily for mental illness.[8] VHA policy provides general CLC environment of care standards, which suggest patients have access to safe outdoor areas, offer a home-like environment, include patient's personal belongings, and have furnishings that "consider the unique needs of the populations served."[9] VHA policy makes little mention of mental health standards of care in CLCs.[10] In contrast, all inpatient mental health programs are designated as acute care beds and are subject to VHA's inpatient mental health environment of care standards.[11] Using CLCs for long-term psychiatric hospitalization without clear mental health standards of care could result in adverse patient outcomes.

The OIG made two recommendations to the VISN Director. The first recommended that the VISN Director consult with the VA Office of Mental Health and Suicide Prevention and review

[7] VHA Handbook 1142.02.

[8] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008, states that the provision of services in CLCs are consistent with the long-term care standards set forth by The Joint Commission, and for legal purposes, CLCs are subject to laws and policies governing nursing home care in VA nursing homes as set forth in Title 38 United States Code (U.S.C.) §§ 101(28), 1710, 1710A and 1710B. VHA subsequently provided guidance indicating that CLCs would no longer be inspected using The Joint Commission standards, but would instead be inspected using Centers for Medicare and Medicaid Services standards starting in 2016. As a result of this change, CLC staff received training on the Centers for Medicare and Medicaid Services survey process and regulations. In light of this, the OIG used the Centers for Medicare and Medicaid Services standards for purposes of determining whether the provision of care was adequate. 42 Code of Federal Regulations (C.F.R.) §§ 483.5 (2017); 42 C.F.R. §§ 435.1010 (2006).

[9] VHA Handbook 1142.01.

[10] VHA Handbook 1142.02; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[11] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013; VHA Handbook 1142.02.

the facility's long-stay mental health recovery unit practices related to classification and commitment of patients, and the second recommendation related to a review of the patient's mental health care during the 2019 stay in the facility's CLC.

The OIG made 10 recommendations to the Facility Director regarding accurate policies, procedures, and staff training on the appropriate care for CLC patients and missing patients.

Comments

The VISN Director and Facility Director concurred with the recommendations and provided acceptable action plans (see appendixes A and B for the Directors' comments). The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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Contents

Abbreviations

CLC	community living center
CMS	Centers for Medicare and Medicaid Services
EHR	electronic health record
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess specific aspects of the care of a patient who died following elopement from a community living center (CLC) at the Chillicothe VA Medical Center (facility) in Ohio.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 10, provides primary care, specialty care, nursing home care, and acute and chronic mental health services. The Veterans Health Administration (VHA) classifies the facility as level 1c.[2] From October 1, 2018, through September 30, 2019, the facility served 22,449 patients and had a total of 295 operating beds, including 55 inpatient beds, 78 domiciliary beds, and 162 CLC beds.

OIG Concerns

In early 2020, the OIG received notification from the VA Office of Security and Law Enforcement that days prior, a motor vehicle struck and killed a patient in their 60s near facility grounds.[3] The patient had eloped from the CLC hours earlier.[4]

The OIG Hotline Division reviewed the notification and the patient's electronic health record (EHR) and had concerns regarding the appropriateness of the admission, as the patient suffered from paranoid schizophrenia and was involuntarily civilly committed (involuntarily committed) to the CLC.[5] The OIG also had concerns about the patient's elopement-prevention care while admitted to the CLC. Additionally reported in the notification was that facility staff did not notice the patient was missing for nearly three hours prior to death. Given these concerns, the OIG opened a healthcare inspection to determine whether

[1] Merriam-Webster, *Definition of Elopement*. To elope (elopement) is to escape or leave a healthcare facility without permission or authorization, https://www.merriam-webster.com/dictionary/elopement. (The website was accessed on July 6, 2020.) For purposes of this report, the OIG uses patient and resident synonymously.

[2] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and complexity. Complexity levels include 1a, 1b, 1c, 2, or 3, with level 1a facilities being the most complex and level 3 facilities being the least complex.

[3] The OIG uses the singular form of they (their) in this instance for patient privacy.

[4] The VA Office of Security and Law Enforcement has oversight of police services charged with law enforcement on VA campuses.

[5] Substance Abuse and Mental Health Services Administration, *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, 2019. Involuntary civil commitment is a legal intervention used to require a person with symptoms of a serious mental health condition to be confined in a psychiatric hospital, or otherwise engage in treatment in an outpatient setting for a specific time period.

- The patient's admission to the CLC was appropriate,
- Patient care was adequate to mitigate the patient's risk for elopement, and
- Facility staff followed missing patient procedures following the patient's elopement.

During the inspection, the OIG noted a concern that the facility's long-stay mental health recovery unit (unit) in the CLC may not have been utilized as VHA intended (see section 4 discussion).

Scope and Methodology

The OIG initiated the inspection on January 23, 2020, and conducted interviews the week of March 30, 2020.

The OIG interviewed the Facility Director, Associate Director for Patient Care Services, Quality Management staff, VA police staff, CLC staff, and other staff who had relevant knowledge about the patient and processes under review. The OIG reviewed applicable VHA directives and handbooks, facility policies, Centers for Medicare and Medicaid Services (CMS) standards, issue briefs, external inspections and surveys, relevant legal documents, facility logs, safety incident reports, VA police reports, missing patient response training documents, and the patient's EHR.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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.

Patient Case Summary

The patient had a long history of psychiatric hospitalizations due to paranoid schizophrenia and antisocial personality disorder, with multiple admissions to the facility since the late 90s.[6] In 2018, the patient, who also suffered from diabetes mellitus, was brought from a group home to the facility because of unorganized, unpredictable behavior. Group home staff reported that the patient attempted to set the group home's barn on fire, stole all of the knives, threatened to stab another resident, and attempted to kick the windshield out of the group home vehicle during transport. Group home staff believed the patient had not been swallowing medications and was later spitting them out. At the facility, the patient received an injection of haloperidol decanoate and was discharged back to the group home.[7]

Approximately two months later, group home staff brought the patient back to the facility. The patient was admitted to the inpatient mental health program due to eloping from the group home, being non-adherent with medications, increased agitation, violent behavior, and an exacerbation of schizophrenia. The patient was unable to return to the group home and required alternative placement. Referral was made to the facility's CLC, but based on the input of a facility psychiatrist the patient was not accepted for admission. A psychiatrist noted the patient was "inappropriate" and "poorly suited" for admission to the CLC. The patient was discharged to a community nursing home.

In late 2018, the patient exited a locked area of the community nursing home and became aggressive with staff while attempting to leave the building. The patient was subsequently taken by local police to a community hospital and involuntarily committed. The patient had reportedly refused medications at the community nursing home for several days and had become more aggressive before attempting to leave. The patient was transferred from the community hospital to the facility's inpatient mental health unit where the antipsychotic drug regimen was adjusted and the patient received injectable haloperidol decanoate as needed, becoming less agitated with a decrease in psychoses.

In early 2019, the patient was transferred from the facility's inpatient mental health program to the unit. Upon admission to the unit, facility staff requested, and the local county probate court approved, that the patient be involuntarily committed to the unit and forcibly given medications deemed necessary. At the time of the patient's CLC admission, a psychiatrist described the patient as "[representing] a substantial risk to the rights and safety of others and [the patient] due

[6] Schizophrenia is a mental disorder where reality is not interpreted in a normal way. Patients may have hallucinations, delusions, and disordered thinking. Routine daily functioning is often impaired. Antisocial personality disorder is a mental disorder characterized by persistent manipulative, callously indifferent, irresponsible, sometimes criminal behavior, with disregard for the feelings of others.

[7] Haloperidol decanoate is a long-acting injectable (intramuscular) drug for the treatment of acute agitation in patients with schizophrenia.

to the chronic and well-documented propensity for unsafe behaviors (arson, theft, carrying/hiding weapons, elopement, intimidation, assault and non-compliance, with/disregard for rules/laws/social mores)." The patient was considered a wandering risk "as evidenced by elopement from previous placement."[8] Within a week of admission, the patient eloped for the first time and placement of an elopement alarm was ordered.[9] Ultimately, the patient was uncooperative and refused to wear the alarm. The patient remained in the CLC for the next 12 months and repeatedly demonstrated behavioral disturbances, eloped multiple times, and frequently refused medications, which was believed to contribute to psychotic exacerbations.

In late 2019, a psychiatry resident noted that the patient was frequently uncooperative with medication administration, had a history of not swallowing medications and later spitting them out, and may not have been receiving full doses of the prescribed antipsychotic regimen. As the patient's disruptive behaviors had been escalating, including physical aggression toward staff, the antipsychotic regimen was changed from a daily oral tablet of risperidone to a monthly intramuscular injection of paliperidone to ensure the patient would effectively receive the antipsychotic medication.[10] Following this change by psychiatry, the patient's nurse practitioner documented that the patient's "behavior/mood has improved some with [the] change" in antipsychotic drug regimen. A staff nurse expressed a similar observation to the OIG.

Video records indicate that on the evening of the patient's death, the patient eloped from the CLC at 6:13 p.m. The Ohio State Highway Patrol reported that, at approximately 10:15 p.m., the patient wandered onto a state road where a motor vehicle struck and fatally injured the patient. At 10:40 p.m., paramedics pronounced the patient dead at the scene.

[8] CMS, *Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual*, October 2019. CMS defines wandering as patient movement that could be, directionless, aimless, driven by confusion or delusions, and the patient may not be aware of risks the movement possess to personal safety.

[9] CMS, *Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual*. An elopement alarm is a tool used to reduce the risk of missing patient events and is worn as a bracelet, pin or button, or shoe sensor that triggers an alarm when the wearer nears an exit point or moves outside a defined area.

[10] Risperidone is a second-generation antipsychotic medication (also known as an atypical antipsychotic) taken orally and used to treat schizophrenia; Paliperidone, used to treat schizophrenia, is a second-generation antipsychotic medication (also known as an atypical antipsychotic) available in a long acting injectable formulation which, following an initial titration period, requires an injection every 28 days.

Inspection Results

1. Inappropriate CLC Admission

The OIG determined that the patient's admission to the CLC was inappropriate because the patient's mental health needs could not be addressed safely in the CLC setting. In early 2019, the patient was transferred to the facility's CLC long-stay mental health recovery unit from the facility's inpatient mental health program.[11]

VA CLCs are skilled nursing homes and follow CMS regulations and standards for long-term care facilities.[12] Long-stay mental health recovery units, a type of CLC unit, are intended to assist patients who "have chronic stable mental illness coupled with geriatric or other syndromes, that render them less able to function in non-institutional settings."[13] For admission to a CLC unit, VHA requires that patients are psychiatrically stable and have service needs that align with those offered by the CLC.[14] The patient was not psychiatrically stable at the time of admission, and the patient's needs did not align with the services offered by the CLC.

In fall 2018, two months prior to admission, the unit's attending psychiatrist screened the patient and determined the patient was inappropriate for admission due to "the lack of needed behavioral controls within" the unit. The attending psychiatrist noted the lack of controls "would only encourage and aggravate" the patient's undesirable behaviors. Additionally, the attending psychiatrist documented that the patient's "actions" represented a "substantial risk" to other patients in the unit. The patient's condition did not improve between this screening and admission to the unit. The OIG learned that facility leaders encouraged staff to admit the patient to the unit because they believed there were no other appropriate options.

Facility staff described the patient, at the time of admission and during the patient's stay, as psychiatrically unstable.[15] On the day of admission, the patient's EHR indicated the patient was refusing medication, too acutely mentally ill to be screened for depression, uncooperative with

[11] The scope of this inspection did not include a review of the patient's stay and discharge from the inpatient mental health program.

[12] VHA Handbook 1142.01 states that the provision of services in CLCs are consistent with the long-term care standards set forth by The Joint Commission, and for legal purposes, CLCs are subject to laws and policies governing nursing home care in VA nursing homes as set forth in Title 38 United States Code (U.S.C.) §§101(28), 1710, 1710A and 1710B. VHA subsequently provided guidance indicating that CLCs would no longer be inspected using The Joint Commission standards, but would instead be inspected using CMS standards starting in 2016. As a result of this change, CLC staff received training on the CMS survey process and CMS regulations. In light of this, the OIG used the CMS standards for purposes of determining whether the provision of care was adequate. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

[13] VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers, September 2, 2012.

[14] VHA Handbook 1142.02.

[15] The patient's stay, as referenced in this report, was the patient's stay in the unit from early 2019 to early 2020.

basic commands, and a risk for elopement. The attending psychiatrist documented the patient was a "substantial risk to the rights and safety of others and [the patient]," and submitted a request for involuntary commitment to the court.[16] The admission assessment did not delineate the patient's needs, or identify how the unit could meet these needs. Other EHR documentation indicated that the patient's CLC care needs related only to the patient's mental health conditions. While admitted, the patient eloped multiple times, and was verbally and physically aggressive with staff and other patients. Facility staff reportedly did not explore a referral to a higher level of care, citing that the unit was the highest level of long-term care available within VA and the community.[17] Facility staff communicated with the court about difficulties they experienced in caring for the patient, including attempted or successful elopements, refusal to wear an elopement alarm, and forcible elopement alarm removal.[18] The court was aware the patient continued to receive medications forcibly, and was verbally aggressive and threatening with staff. Although facility staff communicated these challenges, they offered the court an inaccurate description of the unit as a locked long-term psychiatric unit with 24-hour supervision.[19]

The OIG determined that the patient was not appropriate for admission to the CLC. The OIG found that, although the CLC screening process identified that the patient was not appropriate, CLC staff admitted the patient because facility leaders encouraged the admission due to a lack of alternative placement options.

2. Inadequate Care to Mitigate Risk of Elopement

The OIG determined that interventions implemented by staff were inadequate to mitigate the patient's risk for elopement. The patient eloped multiple times from the CLC during a one-year stay. The OIG found that facility staff failed to provide individualized, progressive, mental health-driven interventions to prevent the patient from eloping. The OIG found that facility staff assigned to care for the patient were inadequately trained in mental health care, and the Patient Safety Manager missed opportunities to intervene to mitigate the patient's risk for elopement. The OIG also determined that unit nursing staff failed to report all of the patient's elopements to the Patient Safety Manager as required by policy.

[16] The EHR reflects that the involuntary commitment was requested to facilitate an easier return of the patient if the patient eloped from the unit, and to allow for involuntary medication administration. The legal justification documented for the commitment was because the patient represented a substantial risk of physical harm to others and needed mental health treatment.

[17] When questioned specifically about the option of admitting the patient to the facility's inpatient mental health program, the Chief, Psychiatry Service reported that this was not an appropriate placement option and would have resulted in the patient remaining in the inpatient program for the duration of the CLC stay and exacerbated the patient's antisocial personality disorder.

[18] Ohio Revised Code § 5122 requires that mental health care be provided in the least-restrictive setting possible; nothing specifically prohibits placement in a CLC.

[19] The OIG attributed the reason for this erroneous description to a common misperception shared by facility staff and is discussed further in inspection results, section 4.

Care Plan Interventions to Prevent Elopement

VHA acknowledges that patients with physical, mental, or cognitive impairments require additional monitoring and protection to prevent injury or death.[20] VHA requires CLC care planning to be individualized, patient centered, and reflective of patient's preferences and needs.[21] When patients lack decision-making capacity, VHA necessitates that guardians be involved in the formulation of care plans.[22] VHA adopts the CMS guidelines using the Resident Assessment Instrument, Minimum Data Set for patient assessment and care planning in CLCs.[23] These guidelines require that the triggers and reasons for wandering behavior are assessed and methods to minimize the behavior are incorporated into the care plan.[24] CMS also places a focus on determining "the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety if wandering places the resident at risk."[25] Both CMS and VHA note the need for staff to prevent and minimize risks to patients whose wandering behaviors could place them in unsafe situations.[26] Staff must assess patients for the potential to wander or elope at the time of CLC admission.[27] Care plans must be reviewed and revised periodically, to include changes to interventions in response to fluctuations in the patient's needs.[28]

Facility CLC staff assessed the patient to be an elopement risk at the time of admission to the unit and incorporated elopement prevention into the care plan. Initially, the only intervention listed to prevent the patient from eloping was for nursing staff to "round every hour to ensure safety and needs." One week following admission, the patient successfully eloped for the first time, and as a result an elopement alarm was ordered. The elopement alarm order remained in place until early spring 2019 and was renewed for a five-week period later in spring 2019. Records indicated the patient repeatedly refused to wear, forcibly removed, or destroyed the device. Concerned that the patient would self-injure attempting to remove the device, facility staff discontinued its use.

Within 14 days of admission, the following interventions were added to the patient's elopement-prevention care plan:

[20] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
[21] VHA Handbook 1142.01.
[22] VHA Handbook 1142.01.
[23] VHA Handbook 1142.01.
[24] CMS, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.
[25] CMS, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.
[26] VHA Directive 2010-052, CMS, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.
[27] VHA Directive 2010-052.
[28] CMS, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.

- Staff would remind the patient not to stand by the elevator.
- If elopement occurred, staff would follow elopement protocol.
- No unsupervised time outside would be granted due to safety concerns.

After these interventions were documented, the only change to this area of the care plan was to periodically remove or add unsupervised time outside. From early summer 2019 to fall 2019, the patient was intermittently granted 15 minute increments per day outside, either alone or with the supervision of another patient from the unit.

Although the patient successfully eloped at least seven times during this stay, changes were not made to the interventions used to prevent elopement. In addition, facility staff did not attempt to change, or request changes to, the security or structure of the unit.

Facility staff attempted to incorporate the patient's and guardian's preferences into the care plan. The care plan was reviewed and revised periodically and included basic elements for mitigating the patient's elopement behavior. However, the care plan was not individualized, patient centered, or reflective of the patient's needs. It did not include a description of the triggers and reasons for the patient's wandering behavior, or provide a specific plan to prevent or minimize risks to the patient. Additionally, facility staff failed to address the need to change interventions that had proven ineffective in the past to prevent the patient from eloping.

The OIG determined that the care plan lacked unique, individualized, and progressive approaches specific to the patient, and the patient's level of functioning, and history of successful elopements from the unit. As a result, the patient continued to elope from a safe environment (the unit) to an unsafe environment.

Mental Health Care to Prevent Elopement

VHA necessitates that CLCs integrate "geriatric psychopharmacology treatment" into the available services.[29] Geriatric and mental health care providers must collaborate when CLC patients display behaviors such as aggression and wandering.[30] CLCs are also required to have a psychologist to provide psychological assessment and treatment, including behavior management.[31] According to facility policy, "only trained and qualified staff" may facilitate behavior management therapies.[32] Consultation with the facility integrated ethics consult service

[29] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This handbook was amended on November 16, 2015.

[30] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[31] VHA Handbook 1160.01. "Behavior management therapies are therapeutic strategies that use reinforcement and conditioning principles to change specific behaviors. The techniques are derived from psychological learning theories." Facility Policy 11-01, *Patient Behavior Management*, March 2, 2018.

[32] Facility Policy 11-01.

is required prior to the use of restrictive behavior management interventions, such as behavior modification or restriction of free time.[33]

The OIG found that the nurse practitioner, who managed the patient's CLC care and served as the mental health consultant to the CLC, did not have a background or training in the delivery of mental health care, and was privileged in family practice. The CLC psychologist believed the nurse practitioner was a psychiatric nurse practitioner. In addition to the care provided by the nurse practitioner, the patient received the following individual mental health care during the year-long stay:

- Six visits with a psychologist
- Multiple visits with psychiatric providers in early 2019 and summer 2019
- One visit per month with four different psychiatric providers in four nonconsecutive months

The patient received no individual mental health care for 4 of 12 months of the stay in 2019.[34]

In early 2019, a consult request was entered in the EHR for the patient to receive a psychological assessment to address "ongoing behavioral problems associated with preoccupation with elopement." The patient was seen by psychology staff approximately one month later, and the results and recommendations were documented in the EHR one month after the visit. The assessment noted that the patient's attempts to elope from the unit would likely continue, and provided recommendations to the patient's care team including encouraging the patient to participate in the unit's programming, as well as pleasant activities such as art, writing, drawing, games, gardening, animal interaction, and one-to-one conversations. Psychology notes reflected the patient did not require additional psychology follow-up.

The OIG found that, despite several care plan reviews, the recommendations were not added to the patient's care plan. Over six months after the psychological assessment, the approaches of using drawing and games were incorporated into the patient's care plan but for the purpose of preventing the patient from smoking on the unit. Care plans serve as a tool for the care team to communicate and organize the patient's care.[35] All staff delivering direct care to CLC patients are required to have access to the care plan to ensure each element is applied appropriately.[36] The

[33] Facility Policy 11-01. Restrictive behavior management interventions are designed to restrict the individual rights of a patient. The facility uses the term "free time" to describe a privilege provided to unit patients allowing them to spend daily unsupervised time outside of the unit.

[34] In spring 2019, the patient was seen by psychiatry during a short stay in the hospital due to ingesting an unknown substance.

[35] VHA Handbook 1142.01.

[36] VHA Handbook 1142.01.

OIG determined that the omission of this information limited the effective communication of the psychologist's recommendations.

The unit nursing staff, who provided the day-to-day care and elopement prevention for the patient, reportedly received limited training in behavioral health interventions. Members of the patient's treatment team were aware of this lack of training and acknowledged that, as a result, behavioral health interventions on the unit were often misapplied. When interviewed, multiple unit nursing staff reported only two options to prevent patients from eloping, the use of an elopement alarm and hourly nursing rounds. CMS guidance advises "the use of an alarm as part of the resident's plan of care, does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning."[37]

At various times during the CLC stay, the patient's free time was restricted for safety reasons. Facility staff reportedly did not request an integrated ethics consult and were unaware of the requirement to request an ethics consultation when applying restrictive behavior management therapies.

The OIG is concerned with the lack of behavioral and psychiatric care provided, given the primary reason for the patient's admission to the unit was for the treatment of schizophrenia. The patient continually displayed undesirable behaviors during the year-long stay including frequent wandering or successful elopement from the unit, verbal and physical aggression, urinating in undesirable locations such as group rooms or in public, introduction of contraband into the facility, and receiving police citations for smoking on the unit. Although the patient was seen multiple times by a psychiatric provider in the first six weeks of this admission and five times during a one month period in the summer, the patient received little other psychiatric care. Additionally, the elopement interventions recommended by the psychology team were not incorporated into the patient's care plan. The nurse practitioner and unit staff with minimal formal training in mental health care were presented the responsibility of providing most of the patient's care. The OIG determined that the patient's behavioral health care was inadequate to mitigate the risk for elopement.

Reporting and Reviewing Missing Patient Events

VHA requires that all missing patient events are reported to the patient safety manager.[38] Once reported, the patient safety manager determines the type of patient safety review that must be completed.[39] Patient safety reviews look for causal factors, which drive system change to prevent reoccurrence.[40]

[37] CMS, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.
[38] VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011.
[39] VHA Handbook 1050.01.
[40] VHA Handbook 1050.01.

During the patient's stay the facility Patient Safety Manager was made aware of five missing patient events, prior to the event that resulted in the patient's death, that involved the patient leaving the unit undetected by unit staff and later being located on campus. The Patient Safety Manager informed the OIG that the events, which occurred as early as the first month of admission, would be reviewed using an "aggregate root cause analysis" and that the review was not due until July 15, 2020. When asked about a responsibility to intervene, the Patient Safety Manager told the OIG that CLC staff were aware of the patient's risk for elopement.

Facility leaders reported that the Patient Safety Manager escalated the first event to their attention. However, the OIG found that the Patient Safety Manager did not notify facility leaders of subsequent elopement events. Within a month of the patient's death, safety changes were made to the unit, including adding a structural or security barrier to the unit elevators. Earlier patient safety reviews could have provided an opportunity to identify risk mitigation options, including resolving structural weaknesses, to prevent future elopements.

The OIG determined that the Patient Safety Manager missed opportunities to intervene to mitigate elopement risk. The Patient Safety Manager was aware of the patient's pattern of elopements, by means of the unit elevator, and failed to fully explore the systemic or physical structural deficits that may have contributed to this pattern.

The Patient Safety Manager did not have a full understanding of the number of the patient's elopements. In addition to the reported events, the OIG found another seven actual missing patient events and 10 close calls documented in the EHR that were not reported.[41]

Facility staff told the OIG that nursing staff on duty at the time the incidents occurred would have been responsible for reporting the incidents to the Patient Safety Manager. The unit had one nurse manager and 31 subordinate nursing staff. The nurse manager told the OIG that all events were reported. However, the OIG determined that unit nursing staff failed to report all of the patient's elopements to patient safety as required by policy.

3. Failure to Detect and Respond to a Missing Patient Event

Facility staff did not follow missing patient procedures after the patient eloped on the day of the patient's death. The OIG found that facility staff failed to detect the patient was missing for nearly three hours. When the patient was noted to be missing, facility staff failed to follow policy to locate the patient. In addition, facility leaders did not ensure the facility had a missing patient prevention policy or that staff completed annual missing patient training.

[41] VHA Handbook 1050.01. VHA defines close calls as "an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention."

Delayed Detection of the Missing Patient

Facility video evidence revealed that, on the day the patient died, the patient entered the unit elevator at 6:13 p.m. and did not return to the unit. The video shows the patient walking slowly throughout the facility property at various times until 9:03 p.m., when the patient is viewed for the last time exiting the property on foot. Facility staff first noticed that the patient was not on the unit at 9:00 p.m. when attempting to locate the patient for medication administration.

Facility staff must know the whereabouts of at-risk patients and determine the potential risk for all patients to elope, wander, or become missing.[42] VHA uses the term "at-risk patient" to determine the degree of elopement prevention required, and the response if a patient is missing.[43] Facilities are required to have written policies and procedures for the prevention and management of wandering patients.[44] To ensure early identification of missing at-risk patients, these policies and procedures must include patient supervision, surveillance, and search procedures.[45] VHA also requires that staff complete routine systematic verification of at-risk patients' locations.[46] Throughout the admission and at the time of death the patient was considered to be an "at-risk patient" for elopement, and the patient's care plan listed hourly location verification as a method of elopement prevention.

Facility staff reported that, prior to the patient's death, unit nurses used an unofficial procedure to document each patient's location in the unit every hour.[47] Using this procedure, nursing staff erroneously documented the patient as being in the unit at 7:00 p.m. and 8:00 p.m. on the day the patient eloped and died. The specific staff member and supervisor were unaware that this error occurred. The specific staff member acknowledged the patient could have been misidentified because of distractions from other patients on the unit at the time. In general, facility staff reported receiving minimal training on how to perform hourly patient counts. Staff reported frequent distractions and the possibility of misidentifying patients during hourly counts. Facility leaders reported being aware of the documentation error on the night of the patient's death and responded with documentation training for all unit nursing staff a few weeks after the incident.

While facility policies outlined the procedure to search for a missing patient and to use and maintain elopement alarms, they did not detail a procedure for the supervision and monitoring of

[42] VHA Directive 2010-052. Patients who are a danger to themselves or others are considered at-risk patients. At-risk patients who tend to stray outside of their care area are considered wandering patients. At-risk patients who disappear from patient care areas are considered missing patients.

[43] VHA Directive 2010-052.

[44] VHA Directive 2010-052.

[45] VHA Directive 2010-052.

[46] VHA Directive 2010-052.

[47] Facility staff used an unofficial one-page paper that listed all patients on the unit and provided boxes for each hour of the day for staff to document a code for where each patient was seen that hour.

at-risk patients.[48] The facility policy regarding search procedures mentioned the requirement for staff to be trained on "patient count procedures;" however, the policy provided no further information or a definition of this term.[49] Since the patient's death, facility leaders reported they have drafted a new written standard operating procedure to guide staff in conducting hourly patient counts.

The OIG determined that facility staff failed to detect the patient was missing for nearly three hours. Had facility staff noted the patient was missing at 7:00 p.m., staff would have had two additional hours to locate the patient. The facility did not have adequate policies and procedures to routinely verify the locations of at-risk patients or to prevent them from eloping.

Failure to Follow Policy in Response to the Missing Patient Event

When facility staff first noted the patient was not on the unit at 9:00 p.m., they did not follow facility policy to search for and locate the patient. Facility policy required that when a patient was suspected to be missing, staff immediately take the following actions:[50]

- Notify VA police that the patient is missing.
- Conduct a preliminary search of the unit, nearby offices, and common areas.
- Document the search results in the patient's EHR.
- Notify VA police and the nurse supervisor of the search results.

Facility policy required that staff take specific actions if the patient was still missing after 30 minutes: [51]

- Notify the responsible medical provider, patient's guardian, administrative officer of the day, and the Facility Director.
- VA police search the facility grounds and buildings; issue a missing patient alert to all facility staff; and immediately notify city, county, and state law enforcement agencies.

At 9:00 p.m., facility staff conducted a preliminary search of the area and documented the search in the patient's EHR. However, facility staff did not contact the VA police until 9:30 p.m., after they were unsuccessful in locating the patient. OIG interviews revealed that unit staff lacked knowledge of the requirement to immediately contact VA police when a patient is suspected to be missing.

[48] Facility Policy 07-22, *Management of Wandering and Missing Patient Events* (Search Procedure), October 20, 2017; Facility Policy, 11-164, *ResidentGuard™ Monitoring System*, March 2, 2018.

[49] Facility Policy 07-22.

[50] Facility Policy 07-22.

[51] Facility Policy 07-22; Responsible medical providers are defined in the facility policy as the attending physician, the medical officer of the day or the psychiatric officer of the day.

Facility staff indicated that following the preliminary search, notification was attempted for all required parties. The VA police were advised that the patient was court-committed to the CLC and was considered a danger to [the patient] and others. However, due to facility staff erroneously documenting that the patient was still in the unit at 7:00 p.m. and 8:00 p.m., police were unaware that the patient had been missing from the unit for over three hours.

Once notified that the patient was missing, the facility reported that the two police officers on duty started to search the more than 300-acre facility grounds. Based on interviews and evidence, the OIG learned that the VA police did not generate a facility missing patient alert and did not notify local law enforcement agencies. Facility staff explained that in the 45 minutes VA police searched for the patient, they did not have sufficient time to generate the mandatory alerts. Use of a facility missing patient alert would have broadcast a message to all available staff on campus to assist with search efforts. An alert to local law enforcement would have allowed passing law enforcement vehicles to be on the lookout for the patient. As the VA police failed to issue these notifications, search efforts were restricted to the CLC staff and the two responding officers.

The OIG determined facility staff did not adequately respond to the missing patient event. Facility staff failed to immediately report the missing patient to VA police, which added an additional 30 minutes to the three-hour delay in detecting the missing patient. Had the notification occurred sooner, and the search expanded, facility staff would have had more opportunity to find the patient.

Failure to Train Staff to Respond to Missing Patient Events

VHA requires that all new staff receive initial orientation on policies and procedures to identify, assess, and find missing patients.[52] Additionally, missing patient drills must be "conducted at least once a year for all shifts at the facility."[53] Training drills should include information from close calls or actual missing patient events and be frequent enough to "evaluate known areas of vulnerability."[54]

Facility staff explained that education on missing patient procedures was not part of a standardized process at the facility. The OIG found that, prior to the patient's death, the last missing patient drill for unit staff was conducted in late 2018 (14 months prior) and failed to include all shifts in the training. After the patient's death, the facility conducted a missing patient drill in early 2020, but failed to include a simulated missing patient event and critical staff.[55] According to recent drill records, facility staff who worked in the unit were unable to describe

[52] VHA Directive 2010-052.

[53] VHA Directive 2010-052.

[54] VHA Directive 2010-052.

[55] Only limited clinical staff were involved in the drill; the administrative officer of the day, medical officer of the day, psychiatric officer of the day, and the nursing officer of the day were not included.

the missing patient response procedure, locate the current missing patient policy, or provide the location of the missing patient checklist. After the patient's death, facility leaders were made aware by an internal review that initial training and annual drills had not occurred in accordance with policy.[56] Facility leaders believed that the policy and response to the event were adequate and did not disclose any policy changes as a result of this post-event knowledge.

The OIG determined that facility leaders did not ensure that facility staff received required initial or annual missing patient training. This lack of training likely contributed to the inadequate response to this missing patient event.

4. Other Concern: Use of the Unit for Long-Term Psychiatric Hospitalization

Long-stay mental health recovery units are intended to assist patients who are psychiatrically stable and suffer from chronic mental illnesses "coupled with geriatric or other syndromes."[57] During the inspection, multiple facility staff described the unit to the OIG as long-term care for patients with only mental health treatment needs, or as long-term psychiatric hospitalization. Another description offered by facility staff defined the unit as a locked long-term care unit for patients under 65 years of age who suffer from only chronic psychiatric disorders. Additionally, facility staff reported that, at times, nearly 25 percent of the unit's 41 beds were occupied by patients who were involuntarily committed by the court due to mental illness. VISN 10 staff described the unit as providing treatment, "for complex patients with psychotic disorders, who may have risk factors for self-harm or harming others." Although, they added that the unit is not intended "to treat acutely suicidal or homicidal individuals."

CLCs follow the CMS long-term care standards, which specifically exclude facilities who provide care primarily for mental illness.[58] VHA policy provides general CLC environment of care standards, which suggest patients have access to safe outdoor areas, offer a home-like environment, include patient's personal belongings, and have furnishings that "consider the unique needs of the populations served."[59] VHA policy makes little mention of mental health standards of care in CLCs, with the exception of requiring one full-time psychologist for every 100 CLC beds to provide psychological assessment and treatment.[60] VHA also requires the integration of "geriatric psychopharmacology treatment."[61]

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[56] VHA Directive 2010-052.

[57] VHA Handbook 1142.02. VHA differentiates CLC long-stay mental health recovery units from long-stay dementia care units. The facility's CLC had both types of units. The OIG did not review the facility's dementia care unit as a part of this inspection.

[58] 42 Code of Federal Regulations (C.F.R.) §§ 483.5 (2017); 42 C.F.R. §§ 435.1010 (2006).

[59] VHA Handbook 1142.01.

[60] VHA Handbook 1160.01; VHA Handbook 1142.02.

[61] VHA Handbook 1160.01.

In contrast, all inpatient mental health programs are designated as acute care beds and are subject to VHA's inpatient mental health environment of care standards.[62] As an example, if applied, these standards would have required the unit to have[63]

- A secure outdoor area that met multiple safety standards,
- Furnishings and fixtures that could not be used as weapons, and
- An entrance with two interlocking doors to prevent patient elopement.

As the unit was considered a CLC and not an inpatient mental health unit, the mental health environment of care standards did not apply. Because the unit lacked a secure outdoor area, secure furnishings, and a two-door entry system, the following occurred:

- The patient was not taken outside for weeks at a time. Staff reported that all windows on the unit were locked, and those who required supervision were only able to go outside when staffing demands allowed for staff accompaniment. The unit did not have a screened courtyard or other safe area for patients to go outside.
- The patient acted out on several occasions, including assaulting staff with a metal Thanksgiving display, tipping over furniture, and hiding lighters and homemade weapons.
- The patient eloped multiple times and no effort was made to implement a secure two-locked-door vestibule system. Facility staff described that access to the unit was via an elevator that required key access to move. However, patients could also get on the elevator and wait for it to be called to another floor by a third party and then exit.

The impact of VISN and facility staff describing the unit as primarily for the long-term treatment of patients with only serious mental illnesses could be far-reaching. The facility website states that the facility "serves as a chronic mental health referral center for VA Medical Centers in southern Ohio and parts of West Virginia and Kentucky." The OIG is concerned that this CLC unit may not have been used as VHA intended. Using CLCs for long-term psychiatric hospitalization without clear mental health standards of care could result in adverse patient outcomes.

[62] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013; VHA Handbook 1142.02.
[63] VHA Mental Health Environment of Care Checklist, November 15, 2018.

Conclusion

The patient's admission to the CLC was inappropriate as determined by the CLC's own screening process. The patient's overall care needs did not align with the services and capabilities available in the CLC. Although the CLC screening process identified that the patient was not appropriate, CLC staff admitted the patient because facility leaders encouraged the admission.

During the patient's stay, interventions implemented by staff were inadequate to mitigate the patient's risk for elopement. The patient eloped multiple times and facility staff failed to provide individualized, progressive, mental health-driven interventions to prevent elopement. Facility staff assigned to care for the patient were inadequately trained in mental health care. In addition, the Patient Safety Manager missed opportunities to intervene to mitigate elopement risk.

Facility staff did not follow missing patient procedures when the patient eloped in early 2020. Facility staff failed to detect that the patient was missing for nearly three hours. When the patient was found to be missing, facility staff failed to follow policy to locate the patient. In addition, facility leaders did not ensure the facility had a missing patient prevention policy or completed annual missing patient training. The lack of training and policy likely contributed to the inadequate response to this missing patient event. Given the lack of mental health standards applicable to the unit as a CLC and considering the complex mental health needs of this patient, the OIG is concerned that the unit may not have been used as intended.

Recommendations 1–12

1. The Veterans Integrated Service Network Director consults with the VA Office of Mental Health and Suicide Prevention to review the classification and commitment of patients to the long-stay mental health recovery unit in the facility's community living center, and makes recommendations to ensure the provision of safe mental health care to patients at the Chillicothe VA Medical Center.

2. The Veterans Integrated Service Network Director conducts a comprehensive review of the patient's calendar year 2019 mental health care, including psychiatric care and medication management, and makes recommendations to the facility, if indicated.

3. The Chillicothe VA Medical Center Director establishes a review process to ensure that community living center assessments clearly align the service offerings of the community living center with the individual needs of patients.

4. The Chillicothe VA Medical Center Director ensures development of a process to address the care needs of patients who are determined inappropriate for community living center admission.

5. The Chillicothe VA Medical Center Director establishes a review process to ensure that community living center care plans are consistent with applicable Veterans Health

Administration policy and communicated to the community living center staff caring for patients.

6. The Chillicothe VA Medical Center Director ensures all community living center long-stay mental health recovery unit staff receive mental health training and pass competency evaluations to provide care specific to the needs of the population served.

7. The Chillicothe VA Medical Center Director ensures that all facility staff are trained on, and comply with, the facility policy concerning patient behavior management.

8. The Chillicothe VA Medical Center Director ensures that all facility community living center staff report near-miss and actual missing patient events to patient safety staff and monitors for compliance.

9. The Chillicothe VA Medical Center Director ensures that patient safety staff review reported events for patterns or trends indicating risks to patients with a need for mitigation and confirms that effective mitigation strategies are initiated.

10. The Chillicothe VA Medical Center Director ensures all facility community living center staff receive initial orientation on how to prevent and respond to missing patient events, activating all alerts and involving all relevant staff, as required.

11. The Chillicothe VA Medical Center Director reviews the facility's policy on missing patients, ensures that it clearly outlines actions staff should take to prevent missing patient events, and verifies that relevant staff are trained and knowledgeable about such actions.

12. The Chillicothe VA Medical Center Director ensures that VA police officers receive training and resources to provide missing patient alerts to all facility staff and appropriate law enforcement agencies.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 22, 2021

From: Network Director, VISN 10 (10N10)

Subj: Healthcare Inspection—Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio

To: Director, Office of Healthcare Inspections, (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I appreciate the opportunity to review the revised Office of the Inspector General (OIG) draft report, Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio.

2. As a High Reliability Organization, we are committed to ongoing improvement and a review of processes, to ensure we are delivering the highest quality of care in the safest manner to our Veterans. These recommendations give us an opportunity to do that.

3. I concur with Recommendations 1 and 2, as well as the recommendations detailed in the Facility Director's memorandum. I am committed to supporting the actions needed to resolve these recommendations.

4. The attachment contains the comments and actions that have already been completed, addressing the recommendations in the report.

(Original signed by:)

RimaAnn O. Nelson
Network Director

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network Director consults with the VA Office of Mental Health and Suicide Prevention to review the classification and commitment of patients to the long-stay mental health recovery unit in the facility's community living center, and makes recommendations to ensure the provision of safe mental health care to patients at the Chillicothe VA Medical Center.

Concur.

Completed: October 15, 2020

VISN Director Comments

VISN 10 immediately responded by raising initial awareness of the concerns outlined in this report to the VA Office of Mental Health and Suicide Prevention. VISN 10 immediately responded by raising initial awareness of the concerns outlined in this report to the VA Office of Mental Health and Suicide Prevention. Consultation on this matter was obtained from the Office of General Counsel (OGC). In addition, representatives from the Chillicothe VA Medical Center, VISN 10 network office, Office of Mental Health and Suicide Prevention and the Office of Geriatrics and Extended Care participated in a collaborative discussion on September 25, 2020 to determine recommendations to be made to the facility to ensure provision of safe mental health care to patients at the Chillicothe VA Medical Center. Recommendations from this discussion and from OGC were summarized and issued to the facility via a memorandum from the VISN 10 Network Director on October 15, 2020.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Veterans Integrated Service Network Director conducts a comprehensive review of the patient's calendar year 2019 mental health care, including psychiatric care and medication management, and makes recommendations to the facility, if indicated.

Concur.

Completed: November 25, 2020

VISN Director Comments

An interdisciplinary team of subject matter experts external to the facility was appointed by the VISN 10 Network Director to conduct a comprehensive review of the patient's calendar year 2019 mental health care, including psychiatric care and medication management. The review is complete, and the team is compiling a written summary to include recommendations, if indicated. The summary will be reviewed by VISN leadership and provided to facility leadership upon completion.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 22, 2021

From: Director, Chillicothe VA Medical Center (538)

Subj: Healthcare Inspection—Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio

To: Director, VA Healthcare—VISN 10, Cincinnati, Ohio (10N10)

1. I have reviewed the report titled Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio. The leadership team at the Chillicothe VA Medical Center is committed to implementing corrective actions for the recommendations made by OIG and pursuing all measures to ensure safe, high-quality care for the Veterans we serve.

2 I concur with all the recommendations outlined in this report.

3. The leadership team at the Chillicothe VA Medical Center is committed to implementing corrective actions for the recommendations made by OIG and will diligently pursue all measures to ensure safe, high-quality care for the Veterans we serve.

(*Original signed by*:)

Dr. Kathy W. Berger
Medical Center Director

Facility Director Response

Recommendation 3

The Chillicothe VA Medical Center Director establishes a review process to ensure that community living center assessments clearly align the service offerings of the community living center with the individual needs of patients.

Concur

Target date for completion: October 1, 2021

Facility Director Comments

The established process for Community Living Center (CLC) referrals includes a review by an Interdisciplinary Team (IDT) of clinical providers, nursing, rehabilitation therapy and social work of Veterans referred to the CLC for admission. An assessment of each Veteran's individualized needs is based on known medical conditions, physical condition, and any requirement for long-term care, dementia care, mental health or hospice services.

Standard Operating Procedure (SOP) CLC 110-143, Reasons for Omission/Denial of Admission to Community Living Center, was developed and implemented by February 12, 2021. Criteria outlined in the SOP improved the admission review process and helps ensure Veterans being admitted into the CLCs have been assessed and that their identified needs can be met.

The Clinical Database is a nursing assessment completed within eight hours of admission to the CLC. This assessment involves the systematic collection of data concerning the Resident's needs and is used to develop the initial interdisciplinary Care Plan. Care Plans are updated after the monthly reassessment period and/or as needed according to changes in a resident's physical or mental status. This process further ensures that CLC services align with individual resident needs.

Care Plan education was provided to 100% of CLC staff by October 28, 2020. Care Plans are being audited monthly for completeness and accuracy with a focused action plan developed for specific Care Plan elements not meeting 90% compliance. Audits will be continued, with oversight by the CLC Chief Nurse and the Rehabilitation and Extended Care Chief, until 6 consecutive months of 90% compliance is met.

Recommendation 4

The Chillicothe VA Medical Center Director ensures development of a process to address the care needs of patients who are determined inappropriate for community living center admission.

Concur.

Target date for completion: October 1, 2021

Facility Director Comments

According to VHA Handbook 1142.02, Section 8.a., all Veterans admitted into the CLC must be medically and psychiatrically stable. The Rehabilitation and Extended Care Clinical Liaison and interdisciplinary CLC Referral Review Group reviews all referral documents prior to acceptance of a Veteran, including clinical history, physical function, and any specialized care needs. A determination is made as to whether the Chillicothe VA CLC can meet their care needs.

SOP CLC 110-143, Reasons for Omission/Denial of Admission to Community Living Center, was developed and implemented by February 12, 2021. Should the CLC Referral Review Group determine that the appropriate level of care and/or required services cannot be provided in the CLC environment, the social work team engages with the referral source to help identify appropriate placement options.

To further enhance the availability of services for Veterans with serious mental illness, the Chillicothe VA Medical Center and VISN 10 will engage in efforts to develop a residential mental health service model. Development of this model will require a comprehensive review of staffing, training and education needs, and an evaluation of physical space. The target date for an initial proposal for of this model is October 1, 2021.

Recommendation 5

The Chillicothe VA Medical Center Director establishes a review process to ensure that community living center care plans are consistent with applicable Veterans Health Administration policy and communicated to the community living center staff caring for patients.

Concur.

Target date for completion: March 31, 2021

Facility Director Comments

To ensure Community Living Center (CLC) care plans are consistent with applicable VHA policy, CLC Interdisciplinary Team members were assigned education through TMS, "CLC Care Plan Education" (VA 4559872). Standard Operating Procedure GECL 110-105, Geriatrics and Extended Care Treatment Plan of Care, is included in the module. As of October 28, 2020, all assigned staff had completed the module.

In addition, six consecutive months of care plan audits is in progress to ensure the completeness and accuracy of care plans. The Care Plan Audit includes questions concerning the presence of an Interdisciplinary Care Plan; resident-centered goals; personalization of the care plan; objectives specific to physical, spiritual, and psychological needs; involvement of the resident or surrogate decision maker; identifying interventions; modification of goals as needed; care reflected in the plan being implemented; and appropriateness of goals for the diagnosis given. Any item not meeting 90% is put into an action plan. The audits include a monthly random chart review of 20 charts. October's Care Plan audit has been completed. Compliance with this recommendation is reported monthly to the Quality Council and weekly in the Director's Morning Meeting.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The Chillicothe VA Medical Center Director ensures all community living center long-stay mental health recovery unit staff receive mental health training and pass competency evaluations to provide care specific to the needs of the population served.

Concur.

Completed November 3, 2020

Facility Director Comments

To ensure all Community Living Center (CLC) long-stay mental health recovery unit staff are educated on and pass competency evaluations concerning the care specific to the needs of the population served, the Chief, Mental Health Care Line (MHCL) developed a TMS training, "Patient Behavior Management" (VA 4559683) and recommended another, "Mental Health Recovery: How to Transform Principles Into Practice" (VA 33942). The TMS modules were assigned to all Community Living Center (CLC) staff in early October 2020.

The "Patient Behavior Management" module reviews Policy Memo No. 11-01, Patient Behavior Management. The module includes a review of behavior management techniques, reinforcement techniques, restrictive behavior management techniques, and what is considered punishment. "Patient Behavior Management" was completed by all assigned staff as of October 30, 2020.

The "Mental Health Recovery: How to Transform Principles Into Practice" module instructs staff how to approach care in a holistic manner considering the whole person, environment, and medical factors impacting recovery to ensure individualized patient-centered care. "Mental

Health Recovery: How to Transform Principles Into Practice" training was completed by all assigned staff as of November 3, 2020.

A post-test was developed and served to evaluate staff competency for each module. Compliance with this recommendation was reported monthly to the Quality Council and weekly in the Director's Morning Meeting through completion.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 7

The Chillicothe VA Medical Center Director ensures that all facility staff are trained on, and comply with, the facility policy concerning patient behavior management.

Concur.

Completed November 11, 2020

Facility Director Comments

To ensure all facility staff are trained on and comply with Medical Center Policy 11-01, Patient Behavior Management, the Chief, Mental Health Care Line (MHCL) developed the TMS training, "Patient Behavior Management" (VA 4559683).Assignments were made to all facility clinical staff on October 13, 2020.

The "Patient Behavior Management" module reviews Medical Center Policy 11-01, Patient Behavior Management. The module includes a review of behavior management techniques, reinforcement techniques, restrictive behavior management techniques, and what is considered punishment.

As of November 11, 2020, all assigned clinical staff have completed the training module. Compliance with this recommendation was reported monthly to the Quality Council and weekly in the Director's Morning Meeting through completion.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 8

The Chillicothe VA Medical Center Director ensures, that all facility community living center staff report near-miss and actual missing patient events to patient safety staff, and monitors for compliance.

Concur.

Target date for completion: March 31, 2021

Facility Director Comments

The Chillicothe VA Medical Center Executive Leadership Team (ELT) is committed to improving safety and reliability within the organization, which requires a Just Culture of transparency and trust where errors and near misses are regarded as opportunities to improve processes that could cause harm. Greater reliability requires a work environment where employees are empowered to speak up for safety. HRO Baseline Training, which includes an overview of HRO, Just Culture and Joint Patient Safety Reporting (JPSR) reporting, was provided to Chillicothe VA Medical Center staff February 25-28, 2020. To date 54.9% of staff have been trained, and training will continue until all staff have received HRO Baseline Training. In addition, staff are also completing HRO 101 and 201 in TMS. Through the facility's Great Catch Program, We Care Rounding, Employee Town Meetings, weekly and monthly newsletters, the ELT is reinforcing our culture of safety, so staff feel safe in reporting negative events, and our commitment to zero harm.

Retraining of Community Living Center (CLC) nursing leadership on the reporting process of near-miss and actual missing patient events through the JPSR system was conducted in Nursing Daily Leadership Huddles to reinforce the process. As of October 13, 2020, all CLC nursing leadership had received the retraining.

To ensure all CLC staff report near-miss and actual missing patient events to patient safety staff, all CLC staff were re-educated on the proper procedure for reporting near-miss and actual missing patient events within the Joint Patient Safety Reporting (JPSR) system. Re-education was conducted by CLC leadership in CLC Staff Huddles and one-to-one for evening and night shift staff. The JPSR Reporter Training PowerPoint was used utilized in the trainings.

In addition, the Patient Safety presentation for New Employee Education (NEO) was modified to include a segment on the missing patient process and Medical Center Policy 07-22, Management of Missing and Absent Patient Events, and has been implemented.

Finally, Behavior Incident Note (BIN) notes are being reviewed and cross-referenced with daily report sheets to ensure that reports were entered into JPSR for all near-miss and actual missing patient events. The October Near Miss/JPSR Audit report is complete with 100% events

reported. Monitoring will continue until 95% compliance has been reached for six consecutive months. Compliance with this recommendation is reported monthly to the Quality Council and weekly in the Director's Morning Meeting.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 9

The Chillicothe VA Medical Center Director ensures that patient safety staff review reported events for patterns or trends indicating risks to patients with a need for mitigation, and confirms that effective mitigation strategies are initiated.

Concur.

Target date for completion: July 15, 2021

Facility Director Comments

Reports of all absent and missing patient events are reviewed daily at the Director's Morning Meeting. Any patterns or trends noted are addressed. Furthermore, the annual review of wandering and missing (AWM) patient events utilizing the Patient Safety Assessment Tool (PSAT) is conducted annually for the period May 1 to April 30 and is due to the National Center for Patient Safety on or before July 15, 2021. The review is conducted by an interdisciplinary team to identify patterns and trends and take corrective action to mitigate any identified risks.

Recommendation 10

The Chillicothe VA Medical Center Director ensures all facility community living center staff receive initial orientation on how to prevent and respond to missing patient events, activating all alerts and involving all relevant staff, as required.

Concur.

Target date for completion: December 04, 2020

Facility Director Comments

Initial orientation is being standardized across the CLCs. Additionally, to ensure all Community Living Center (CLC) staff receive training on Medical Center Policy 07-22, Management of Wandering and Missing Patient Events, including how to prevent and respond to missing patient events, activate alerts, and involve relevant staff, the TMS course, "Management of Missing and Absent Patients" (VA 4561828) was assigned to all CLC staff. Nursing leadership on the CLC

neighborhoods will monitor compliance with the TMS education with a target completion date of November 30, 2020.

Once all CLC staff complete the TMS course, the VA Police Department will begin Missing Patient drills on the CLC neighborhoods to reinforce the training. Compliance with this recommendation is reported monthly to the Quality Council and weekly in the Director's Morning Meeting.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 11

The Chillicothe VA Medical Center Director reviews the facility's policy on missing patients, ensures that it clearly outlines actions staff should take to prevent missing patient events, and verifies that relevant staff are trained and knowledgeable about such actions.

Concur.

Target date for completion: December 4, 2020

Facility Director Comments

The Chillicothe VA Medical Center Director and the VA Police Department reviewed Medical Center Policy 07-22, Management of Wandering and Missing Patient Events. Revisions were made to the policy to ensure actions staff should take to prevent missing patient events are clearly outlined. The new policy was published on October 28, 2020.

To ensure staff are knowledgeable concerning the actions to take to prevent missing patient events, the TMS course, "Management of Missing and Absent Patients" (VA 4561828) was assigned to all facility staff. Compliance with this recommendation is reported monthly to the Quality Council and weekly in the Director's Morning Meeting.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 12

The Chillicothe VA Medical Center Director ensures that VA police officers receive training and resources to provide missing patient alerts to all facility staff and appropriate law enforcement agencies.

Concur.

Completed October 30, 2020

Facility Director Comments

The Chief, VA Police Department, provided education for VA Police officers in multiple modalities to ensure all officers are knowledgeable of missing patient alerts, necessary actions to take during a missing patient event, and the available resources to utilize during such events.

Included in the education was face-to-face instruction of VHA Directive 2010-052, Management of Wandering and Missing Patients, and Medical Center Policy 07-22, Management of Wandering and Missing Patient Events. VA Police officers were also assigned the TMS module, "Management of Missing and Absent Patients" (VA 4561828). All VA Police officers have completed the module.

The VA Police Department also conducted "Rapid Response Drills" will all VA Police officers to reinforce the education and training provided on missing patient alerts, necessary actions to take during a missing patient event, and the available resources to utilize during such events. As of October 30, 2020, all VA Police officers had completed all education, training, and drills. Compliance with this recommendation was reported monthly to the Quality Council and weekly in the Director's Morning Meeting.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

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