DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison

HEALTHCARE INSPECTION | REPORT #22-01341-43 | JANUARY 26, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Montana Healthcare System to review an allegation of abuse of a patient in their late 70s at the Miles City VA Community Living Center (CLC) and to assess quality of care for the patient at the CLC and Fort Harrison VA Medical Center (facility).[1]

In late fall 2021, facility staff reported an allegation of patient abuse at the CLC to the facility's VA Police and OIG criminal investigators, stating that a patient was forced to participate in physical therapy in the CLC on two occasions by a physical therapist and nursing staff.[2] The VA Police conducted a preliminary investigation. The OIG criminal investigators, after completing an independent investigation of the allegation, advised the facility to submit a report to the OIG Office of Healthcare Inspections.

The OIG Office of Healthcare Inspections initiated an inspection to evaluate the patient's alleged mistreatment incidents and quality of care at the CLC.[3] In addition, the OIG reviewed the patient's quality of care during hospitalizations at the facility immediately before and after the CLC admission. The OIG also reviewed facility leaders' oversight and actions related to the allegation.

The OIG determined that this was not the first time that there were alleged issues of patient abuse at the CLC; three previous investigations confirmed findings of mistreatment or abuse in the CLC.

- In 2018, a factfinding substantiated allegations of mistreatment of a patient by CLC nursing staff.[4]

[1] The OIG uses the singular form of *they* to protect a patient's privacy.

[2] The physical therapist and one registered nurse were identified in the complaint. The physical therapist resigned in early 2022. The OIG contacted the identified physical therapist for an interview and the invitation was declined. At the time, the OIG did not have testimonial subpoena authority to compel an interview.

[3] National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*, eds. Richard Bonnie and Robert Wallace. Washington (DC): The National Academies Press; 2003. The OIG uses the term 'mistreatment' in this report "to encompass the conduct and harmful consequences." Mistreatment is "(a) intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm."

[4] Specific findings were related to the care of the patient in which nurses disregarded provider orders and a food safety issue. The OIG categorized these behaviors as "mistreatment."

- In August 2020, an administrative investigation substantiated that two CLC nurses were witnessed or observed "to be exhibiting behaviors consistent with Patient Abuse and Neglect."[5]
- At the end of November 2020, an administrative investigation was conducted and substantiated that the behavior of a CLC nurse met criteria for "serious offenses" of patient mistreatment.[6]

Two nurses involved in the mistreatment with this patient were also involved in the other incidents, one in the 2018 incident and both in the August 2020 incident.

After an OIG interview in this review, the Rocky Mountain Veterans Integrated Service Network (VISN) 19 Director initiated an inspection of the CLC by VISN and Veterans Health Administration (VHA) national staff, approximately eight weeks after the OIG inspection was initiated and one week after the OIG was onsite. Following the inspection, the VISN Director documented quality of care concerns resulting in a temporary closure of the CLC.

In late 2021, the patient was admitted to the facility for shortness of breath and an inability to perform self-care. After a 34-day stay and treatment for coronavirus disease 2019 (COVID-19) pneumonia, the patient was admitted to the CLC for short-term rehabilitation.[7] On CLC day 9, the patient was re-admitted to the facility for 11 days for "discontent" at the CLC, until the patient was stabilized and discharged to a state veterans home. The hospitalist told the OIG of receiving a call from the CLC physician (the physician) who documented the patient was "not cooperating with rehabilitation." Eighteen days after the facility discharged the patient to a state veterans home, the patient was admitted to the intensive care unit of a community hospital. A computerized tomography (CT) scan of the chest revealed a mass in the lung that appeared to be metastatic cancer. Nine days later the patient died.

[5] Specific findings were related to two nurses leaving a patient on the floor after a fall. The review also found a nurse manager had improper communication regarding the investigation.

[6] Specific findings were related to a nurse hurting a patient during wound care and speaking "harshly and rudely" to multiple patients.

[7] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

Figure 1. *Timeline of the Patient's Care.*
Source: The OIG's review of the patient's electronic health record.

The OIG substantiated the allegation that the patient was forced to participate in physical therapy in the CLC by a physical therapist and nursing staff. Specifically, on two occasions, the physical therapist obtained assistance from nursing staff to force the patient to participate in physical therapy sessions after the patient refused. According to the VHA Handbook, patients "have the

right to accept or refuse any medical treatment or procedure recommended to them."[8] Providers are not permitted to "unduly pressure or coerce the patient into consenting to a particular treatment or procedure."[9]

The OIG learned that the physical therapist and nurses forced the patient to walk after the patient verbally refused and physically lowered the patient to the floor. Staff reported the physical therapist and a nurse lifted the patient to stand and then pulled the patient's walker forward compelling the patient to walk. After the incident, the patient reported to staff that a thumb was inserted in the patient's armpit to lift the patient to a standing position after the patient refused to participate. During a CLC physical therapy session on CLC day 5, a physical therapist documented the patient was not cooperative and requested assistance from the CLC nurse manager to continue the session. According to the electronic health record (EHR), the patient was manually assisted to a standing position. The physical therapist documented assisting the patient with ambulation on the next day, which was met "with high levels of resistance" and that the patient attempted to throw a front-wheeled walker. A VA police report documented bruises to the patient's arms and staff told the OIG that the patient sustained skin tear(s) during this session. The OIG concluded that the physical therapist and nurses violated VHA policy by failing to respect the patient's right to refuse treatment and subjecting the patient to mistreatment during two physical therapy sessions.

The OIG determined that the CLC nurse manager and CLC assistant nurse manager (nurse managers), who witnessed the mistreatment incidents that gave rise to the allegation of abuse, did not make a report or discuss the incidents with facility leaders as required. During interviews, the nurse managers told the OIG of not reporting the incident because they did not feel the patient was mistreated or they were not directly involved in the incident. VHA policy requires all employees to report any kind of patient mistreatment to their supervisor.[10] Facility policy further describes that "health care practitioners are responsible as 'mandatory reporters,' for documenting pertinent information about the abuse," in the EHR.[11] The OIG found that the physician, who was the only physician assigned to the CLC, was made aware of the mistreatment incidents by a staff member on CLC day 7 and did not make a report of the allegation to their supervisor.[12] The physician told the OIG of being informed of the event and of not being "in a role to get involved…of things that I didn't witness." Although the allegations of abuse were

[8] VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021.

[9] VHA Handbook 1004.01(5).

[10] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

[11] Facility MCM 11-22-207, *Suspected Abuse and Neglect: Identification, Evaluation, Treatment, Referral, and Reporting of Possible Victims*, January 29, 2019.

[12] The physician had clinical privileges for primary care and geriatric medicine. The physician told the OIG of working 60 percent of the time in primary care at a facility outpatient clinic and 40 percent at the CLC.

reported to a facility leader days after the incident, the nurse managers and the physician were obligated to ensure reporting of the incidents to their supervisors. The nurse managers' and physicians' failure to report and document the mistreatment incidents delayed investigation and intervention and placed patients at additional risk.

Additionally, the OIG determined that the nurse managers and the physician failed to follow patient safety reporting requirements. Facility staff "[h]ave a duty to report patient safety incidents" and are required to utilize the JPSR [Joint Patient Safety Report] system for reporting.[13] Facility policy requires that staff "must report any instances or allegations of workplace violence, sexual assault incidents, patient abuse, and any other public safety incidents to supervisors."[14] "The Disruptive Behavior Reporting System (DBRS) is a VA-approved secure web-based reporting mechanism providing means for all VA employees to alert the DBC [Disruptive Behavior Committee]…about behaviors that cause a safety concern."[15] The mistreatment incidents, including the incident that resulted in the patient's injuries, required reporting.[16] The nurse managers and physician reported not initiating a JPSR or a disruptive behavior report regarding the safety-related incidents because either they felt nothing was done in error or they were not directly involved in the incident. As a result, the patient safety manager and the Disruptive Behavior Committee chair did not receive timely information that may have led to safety reviews and efforts to prevent the recurrence of mistreatment incidents and disruptive behavior.

The OIG did find, however, that one JPSR report was submitted that detailed the events when the patient attempted to hit the physical therapist and subsequently suffered skin tears.[17] This report was submitted three days after the second mistreatment incident. The nurse manager explained during an interview with the OIG that a disruptive behavior report should have been submitted because the patient attempted to hit staff. When questioned by the OIG as to why the patient's injury and objection to the forced physical therapy were not reported, the physician stated that the rapid progression of events "short-circuited my ability to discuss it with anyone."

The OIG further determined that nursing staff, including the nurse manager and a registered nurse, who cared for the patient, failed to provide quality care by not following the patient's plan

[13] Facility SOP Number 1, *Guidance for Reporting Patient Safety Incidents at Montana VA Health Care System*, September 24, 2021.

[14] Facility MCP 11-25-513, *Workplace Violence Prevention Program (WVPP)*, October 31, 2020. Reports of patients who exhibit disruptive behaviors are assessed, tracked, and managed by the facility's Disruptive Behavior Committee.

[15] VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2022. VHA Directive 5019.01 has been renumbered to 1160.08(1) but the content has not changed.

[16] Facility MCP 11-25-513.

[17] While the reporter was not identified, the CLC physician, CLC nurse manager, and CLC assistant nurse manager told the OIG of not submitting a JPSR.

of care to report changes in the patient's condition to the physician or patient's family, and by not documenting the changes in the patient's status in the EHR.

VHA requires the patient's care team to adhere to a plan of care for each patient that maximizes the quality of life and focuses on improving clinical outcomes.[18] The CLC standard operating procedure for nursing documentation requires the use of nurse care notes in the EHR to communicate changes in patients' conditions with other providers who are involved in the interdisciplinary care of the patient.[19] According to the patient's plan of care, the nursing staff was required to notify the physician of changes in the patient's condition and to notify the patient's family of changes in the patient's behavioral status. Further, the nursing staff was required to document changes in the patient's condition.[20]

During the first session of physical therapy on CLC day 2 with the patient, the physical therapist performed a gait test with and without oxygen. During the test, the patient's oxygen saturation significantly decreased without oxygen with minimal walking and increased to low normal with supplemental oxygen. The physical therapist noted a rapid, irregular heart rate, associated with dizziness. There was no documentation in the EHR that the physical therapist notified the physician of low oxygen saturations or rapid, irregular heart rate during the session.

The nurse manager participated in the patient's physical therapy session on CLC day 5, and the nursing staff participated in the session the next day when the patient sustained several skin tears and bruises. While the nurse manager and other nursing staff documented their involvement in the session and that the patient's arm was "scratched," there was no documentation of the size and appearance of the skin tears in the patient's EHR, as required.

Based on EHR review and interviews with the physician, the OIG determined that the nursing staff failed to communicate changes in the patient's condition, verbally or through documentation, as required. Specifically, the nursing staff did not communicate the decrease in oxygenation during activity, the patient's refusal to participate in physical therapy, and the patient's new skin tears.

A registered nurse told the OIG of providing first aid for the patient's skin tears sustained during the incident on CLC day 6, but the OIG did not find wound care documentation as required. The OIG concluded that gaps in the nursing staff's communication and documentation impacted the quality of the patient's care as well as compromised the continuity of care by not providing key information required for clinical decision-making.

The OIG determined that the physician failed to document complete and accurate entries into the patient's EHR. The facility policy for providers' documentation standards states the provider is

[18] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
[19] CLC SOP, *Unit Nursing Documentation Template*, March 9, 2021.
[20] CLC SOP, Unit Nursing Documentation Template.

responsible for the completion of accurate and clinically relevant entries into the EHR.[21] The physician reported having a 45-minute talk with the patient regarding goals to enable the patient to return home; however, did not recall documenting the conversation. The OIG did not find evidence that the physician documented the encounter with the patient, entered orders, or changed the patient's interdisciplinary plan of care in the EHR. The physician's failure to document the mistreatment incidents led to missed opportunities to address these quality-of-care deficiencies and ensure patient safety.

Prior to admission to a CLC, VHA requires an evaluation of whether services available meets the care needs and requirements of the prospective patient.[22] The OIG determined that the CLC did not have a designated screening process for reviewing the suitability of patients for admission, potentially limiting the abilities of the CLC to determine acceptability for admission or the need for the correct level of care being considered for a patient. According to VHA, "[t]he need for placement into a VA CLC is based on an assessment of medical, nursing, and therapy needs; level of functional impairment, cognitive status; rehabilitation needs; and special emphasis care needs," such as end-of-life care.[23]

The OIG heard conflicting information regarding the CLC admissions process. The assistant nurse manager told the OIG that the facility had a screening process for admissions, but the physician described to the OIG a different process. The OIG found no documentation in the EHR of an evaluation of the patient's suitability for CLC admission or whether the facility had the capability to provide the necessary care and services for the patient. Failure to have a defined screening and admissions process may have impacted the recognition of the care the patient needed to achieve goals in the plan of care.

The OIG learned the patient's interdisciplinary team (IDT) note for a discussion on CLC day 7, which may have provided relevant information regarding the patient's medical status to facility staff, was entered five days after the patient was discharged to the facility. Facility procedure requires IDT notes to be completed within 24 hours of the IDT meeting.[24] During the onsite inspection, the OIG reviewed CLC operational and care delivery processes and identified that IDT notes were not documented timely. The minimum data set coordinator stated the delay in transferring the documentation to the EHR began in October 2021 and was currently inputting documentation from January 2022 due to a lack of nursing coverage for the coordinator.[25] As a

[21] MCP 11-25-232, *Documentation Standards for Licensed Independent Practitioners*, August 14, 2020.

[22] VHA Handbook 1142.01.

[23] VHA Handbook 1142.01.

[24] CLC SOP, Unit Nursing Documentation Template.

[25] The Minimum Data Set, used in VHA CLCs, is a "core set of screening, clinical, and functional status elements that forms the foundation of this comprehensive assessment," accessed June 3, 2022, http://vaww.vhadataportal.med.va.gov/DataSources/RAIMDS.aspx. (This is an internal website not publicly accessible.)

result, medical records were incomplete and prevented other providers from reviewing the medical information.

After the patient was discharged on CLC day 9 and admitted to the facility for continuing care, the patient had a chest x-ray that indicated a possible lung mass. After recovery from COVID-19, "CT is indicated in patients with functional impairment and/or hypoxemia."[26] A radiologist and Hospitalist 3 both documented a recommendation to follow up with a CT scan of the chest. A different hospitalist, who discharged the patient on hospital day 11, documented in the discharge summary the patient's limitations included "persistent weakness" and "increased oxygen needs in the CLC" but did not document a follow-up plan for the chest x-ray changes or the need for a CT scan to evaluate for a possible lung mass. The discharging hospitalist told the OIG of not noting the previous hospitalist's documentation regarding the lung mass concern. The OIG would expect a physician taking over care for the patient to review documentation of prior care and recommendations. While the OIG recognizes the identification of the patient's lung mass sooner would not have likely changed the outcome, the lack of care coordination did not afford the patient, or the patient's family member, the opportunity to determine the most appropriate care plan including hospice care.

During the review, the OIG discovered additional findings related to facility oversight processes for three previous investigations in the CLC in 2018 and 2020. The OIG determined that facility leaders failed to recognize a pattern of CLC patient mistreatment by nursing staff over a three-year period.[27] Although facility leaders completed, in March 2022, an administrative investigation of the allegations of the patient's abuse that gave rise to this healthcare inspection, and took action, the OIG was concerned the pattern of mistreatment had not been recognized earlier. The OIG would have expected facility leaders to track and trend substantiated allegations of mistreatment and to take corrective measures as indicated.

Additionally, facility leaders failed to comply with VHA's state licensing board reporting policy, despite the three previous mistreatment incidents. Reporting to state licensing boards is required by VHA when a licensed healthcare professional is found to have "significantly failed to meet

[26] Geoffrey D. Rubin et al., "The Role of Chest Imaging in Patient Management During the COVID-19 Pandemic: A Multinational Consensus Statement From the Fleischner Society," *Chest* 158, no. 1 (July 2020):106-116; Bedirhan Ustun and Cille Kennedy, "What is 'functional impairment'? Disentangling disability from clinical significance," *World Psychiatry*, June 2009. "Functional impairment refers to limitations due to the illness."

[27] The facility reported to the OIG that during this time frame "a contributing factor is the multiple changes in leadership. There had been four individuals that held the position for facility Director, five that held the position for Associate Director, eight that held the position for Chief of Staff, and three that held the position for Associate Director, Patient Care Services, in either an acting or permanent capacity."

generally accepted standards of clinical practice" and there is a concern for patient safety.[28] VHA established a five-stage process that includes facility reviews, a facility director decision, and, if appropriate, reporting to state licensing boards, which should be completed in less than 100 calendar days.[29]

For the 2018 and 2020 mistreatments, the facility could not provide documentation to the OIG indicating that state licensing board reporting had been considered.[30] For the 2021 mistreatment, the facility provided an email from the Associate Director for Patient Care Services that stated that the mistreatment did not meet the criteria for reporting to the state licensing board. The OIG found no reason for the incident not meeting criteria and no evidence that the Facility Director finalized the reporting decision.

During the inspection, the OIG received correspondence from the VISN indicating a report was initiated to the respective state licensing boards for two nurses and the physical therapist involved in the patient's mistreatment incidents. As of September 2022, the OIG received documentation that reporting of the actions of employees to state licensing boards was ongoing. The OIG concluded that the failures to respond to a pattern of mistreatment and to follow the required VHA process for reviewing and reporting licensed healthcare professionals to state licensing boards may have fostered a culture of mistreatment at the CLC and, ultimately, led to continued incidents of mistreatment.

Finally, the OIG found that facility leaders did not assess the physician's performance and competence for treating patients in the CLC as required. VHA and facility policy require that privileged providers have ongoing professional practice evaluations (OPPEs) to ensure the quality and safety of care provided to patients.[31] The Chief of Staff (COS) is responsible for

[28] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 12, 2005, rescinded January 28, 2021. "VA has broad authority to report to SLBs [State Licensing Boards] those currently appointed or separated licensed health care professionals whose behavior or clinical practice substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients." VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

[29] VHA Handbook 1100.18. VHA Directive 1100.18.

[30] VA OIG, *Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities*, report No. 20-00827-126, April 7, 2022. The OIG published a report that revealed concerns about facility directors' noncompliance with VHA's state licensing board and the National Practitioner Data Bank reporting policies, suggesting potential systemic failures.

[31] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012; the credentialing portion of the handbook was superseded by VHA Directive 1100.20, *Credentialing of Health Care Providers*, dated September 15, 2021. Facility MCM 11-22-02 *Credentialing and Privileging of Licensed Independent Providers*, June 20, 2019. Facility *Bylaws and Rules of the Medical Staff*, updated June 2019. An OPPE "is an evidence-based privilege renewal process and is part of a decision-making process used on a semi-annual basis to continue a provider's existing privilege(s) or scope of practice."

oversight of CLC medical functions, such as completing or designating staff to complete the physician's OPPEs.[32]

The OIG learned the only OPPEs completed on the physician during the last few years were for primary care provided at one of the facility's community-based outpatient clinics. During interviews, the OIG learned that staff had different understandings of who was responsible for the physician's CLC patient care oversight. The COS told the OIG during an interview that the OPPEs for the physician were done by primary care providers. The associate chief of staff for primary care and associate chief of primary care, who was the physician's supervisor, told the OIG that they had not performed OPPEs on the care that the physician provided to CLC patients because supervision for the physician's CLC care was under hospital medicine. However, the associate chief of staff for medicine told the OIG of never having done an OPPE for the physician and assumed the position fell directly under the COS. The OIG concluded that, without oversight of the care the physician provided in the CLC, leaders did not fully assess the physician's performance and competence.

The OIG made one recommendation to the Rocky Mountain Network Director related to the review of facility staff's actions taken in response to the allegations and concerns related to the identified patient. The OIG made six recommendations to the Facility Director related to the rights of CLC patients, the care provided to the patient by the CLC nursing staff and physician and, during the patient's acute care hospitalization, the screening and admissions process for CLC patients, and compliance with the state licensing board reporting policy compliance.

VHA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion. For this report, the Facility Director provided a memorandum with comments to the OIG during the draft phase. The OIG considered and reviewed the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to OIG findings and recommendations.

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[32] Facility MCM 11-19-228, *Medical Supervision of Extended Care Residents*, July 1, 2016.

Contents

Abbreviations

ADPCS	Associate Director for Patient Care Services
CLC	community living center
COS	Chief of Staff
COVID-19	coronavirus disease 2019
CT	computerized tomography
EHR	electronic health record
IDT	interdisciplinary team
JPSR	Joint Patient Safety Report
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Montana Healthcare System to review an allegation of mistreatment of a patient at the Miles City VA Community Living Center (CLC) and to assess quality of care for the patient at the CLC and Fort Harrison VA Medical Center (facility).[1]

Background

The Montana VA Health Care System is part of Veterans Integrated Service Network (VISN) 19 and includes the facility, 13 community-based outpatient clinics, and the CLC. The Veterans Health Administration (VHA) classifies the facility as a complexity level 3, low complexity.[2] The facility has 23 hospital beds, 6 intensive care unit beds, 24 domiciliary beds, and 17 CLC beds. From October 1, 2020, through September 30, 2021, the facility served 38,835 patients. The Miles City CLC is located in southeastern Montana, 349 miles from the facility.

Community Living Centers

VHA CLCs provide short- and long-stay care to patients with a variety of medical conditions. Patients can receive assistance with their activities of daily living (such as bathing or dressing), short-stay rehabilitation (such as physical therapy), short-stay skilled nursing care (such as wound care), and hospice and palliative care.[3] Short-stay programs are intended to help patients regain the ability to perform daily living tasks.[4]

Allegations and Related Concerns

In late fall 2021, facility staff reported an allegation of patient abuse at the CLC to the facility's VA Police and OIG criminal investigators, that a patient was forced to participate in physical

[1] National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*, eds. Richard Bonnie and Robert Wallace. Washington (DC): The National Academies Press; 2003. The OIG uses the term 'mistreatment' in this report "to encompass the conduct and harmful consequences." Mistreatment is "(a) intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm."

[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. A level 3 facility has "low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs."

[3] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008; VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012.

[4] VHA Handbook 1142.02.

therapy in the CLC by a physical therapist and nursing staff.[5] The VA Police conducted a preliminary investigation. The OIG criminal investigators, after completing an independent investigation of the allegation, advised the facility to submit a report to the OIG Office of Healthcare Inspections.

The OIG Office of Healthcare Inspections initiated an inspection to evaluate the patient's alleged mistreatment incidents and quality of care at the CLC. In addition, the OIG reviewed the patient's quality of care during hospitalizations at the facility immediately before and after the CLC admission. The OIG also reviewed facility leaders' oversight of the CLC and actions related to the allegation.

After an OIG interview, the VISN 19 Network Director initiated an inspection of the CLC by VISN and VHA national staff, approximately eight weeks after the OIG inspection was initiated and one week after the OIG was onsite. Following the inspection, the VISN Director documented quality of care concerns resulting in a temporary closure of the CLC. The OIG will continue to monitor the results of the VISN recommendations through completion.

Scope and Methodology

The OIG initiated the healthcare inspection on January 28, 2022. The OIG team conducted virtual and onsite interviews from February 24 through May 4, 2022. The OIG team interviewed the VISN 19 Network Director, Facility Director, facility Chief of Staff (COS), facility Associate Director for Patient Care Services (ADPCS), facility associate chiefs of staff for medicine and primary care, facility hospitalists, facility quality management staff, CLC nursing leaders, the CLC physician (the physician), and CLC nursing staff with relevant knowledge.[6] In addition, the OIG team reviewed electronic health record (EHR) entries for all CLC patients from August 2021—January 2022.

The OIG conducted an unannounced site visit at the CLC in mid-March 2022 to review patient safety and care delivery processes. The CLC site visit included in-person interviews with 15 patients and 4 nurses, observations of CLC operational and care delivery, and telephone interviews with the patient's family members.

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 documents on the same or similar issue(s).

[5] The physical therapist and one registered nurse were identified in the complaint. The physical therapist resigned in early 2022. The OIG contacted the identified physical therapist for an interview and the invitation was declined. At the time, the OIG did not have testimonial subpoena authority to compel an interview.

[6] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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. 1101, 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, was in their 70s with a history of atrial fibrillation, high blood pressure, chronic obstructive pulmonary disease, chronic thrombocytopenia, and follicular lymphoma.[7] The follicular lymphoma was diagnosed in 2009 and was in remission. The patient had a stroke in 2016, which resulted in left arm numbness, visual impairment, and dizziness. In late 2021, the patient was admitted to the facility from home after a wellness check revealed shortness of breath and an inability to perform self-care.

First Facility Hospitalization

The patient presented to the facility emergency department with a low-grade temperature and required supplemental oxygen by nasal cannula to maintain oxygen saturations at 91 percent.[8] A chest x-ray showed new abnormal findings in both lungs.

The patient tested positive for coronavirus disease 2019 (COVID-19) shortly after admission. The diagnosis was changed to COVID-19 with possible pneumonia and new hypoxemia. The other admission diagnoses were "difficulty with self-care," poor functioning of the kidneys, and malnutrition. The patient was isolated for 20 days and started on a combination of medications to treat the COVID-19 pneumonia. On hospital day 3, the patient had developed an increased

[7] The OIG uses the singular form of *they* to protect a patient's privacy.

[8] National Institutes of Health/National Library of Medicine, "*Pulse Oximetry*," accessed June 1, 2022, https://medlineplus.gov/lab-tests/pulse-oximetry/. "A normal oxygen saturation level ranges between 95 percent and 100 percent" although it may be "somewhat lower" for people with lung problems. The blood oxygen level is measured by pulse oximetry, a small electronic device clipped to the fingertip, or a blood test.

requirement for oxygen and a repeat chest x-ray was ordered, which the radiologist read as being consistent with pneumonia.

On hospital day 4, chest imaging was repeated and the radiologist documented worsening findings in the right lung from the previous chest x-ray.

On hospital day 5, the patient developed severe respiratory difficulties and a hospitalist (Hospitalist 1) transferred the patient to the intensive care unit for closer monitoring and treatment. Due to the patient's deterioration, an additional medication was started.

On hospital day 6, the patient's condition was improved. The patient had daily chest x-rays from hospital days 7 through 9 with changes. However, on the morning of hospital day 13, the patient needed increased supplemental oxygen and laboratory values were concerning for a bacterial infection.

On hospital day 17, the patient was transferred from the intensive care unit to a medical unit. The patient continued to require supplemental oxygen during the majority of hospital days 17–32. On hospital day 32, the patient had a chest x-ray that a radiologist read as worse than the chest x-ray done eight days after admission but no clear diagnosis documented. A hospitalist (Hospitalist 2) documented the radiographic changes were consistent with COVID-19 pneumonia.

On hospital day 34, the patient was discharged to the CLC.

CLC Admission

The patient arrived at the CLC the same day and was admitted for short-term rehabilitation. The physical therapist performed an evaluation during which the patient refused evaluations of strength, mobility, balance, and gait. The physical therapist documented the patient had "weakness and deconditioning" and would benefit from both short-term and long-term therapy if compliant, and that the patient agreed with the plan.

On CLC day 2, the physician entered the admission history and physical and documented the patient had the capacity to make medical decisions, and documented discussions regarding end-of-life preferences. During the first session of physical therapy with the patient, the physical therapist performed a gait test with and without oxygen. During the test, the patient's oxygen saturation significantly decreased without oxygen with minimal walking and increased to low normal with supplemental oxygen. The physical therapist noted a rapid, irregular heart rate, associated with dizziness. There was no documentation in the EHR that the physical therapist notified the physician of low oxygen saturations or rapid, irregular heart rate during the session.

On CLC day 3, the patient refused to go to the dining room for meals or walk to the bathroom. The patient reported doing exercises in bed that were learned at the facility. An interdisciplinary

team (IDT) evaluated the patient and created a note titled "CLC Baseline Care Plan" with the goal documented as "Successful discharge to a private residence."[9]

On CLC day 5, during a physical therapy session, the physical therapist noted the patient was not cooperative. The physical therapist requested assistance from the CLC nurse manager (nurse manager) for the remainder of the session. The patient did not want to get out of a wheelchair and the physical therapist documented "manually transferred to standing assist x 2." The physical therapist's note listed the physician as an additional signer and was signed by the physician the next day. Further entries in the record showed no documentation of follow-up actions or conversations with the physician regarding this session.

On CLC day 6 the physical therapist again attempted a session, later documenting the patient was "not going to participate after [the patient] is in standing position and proceeds to sit down on floor refusing to get up." The physical therapist documented that nursing staff assisted during the session. After the session, the physical therapist discharged the patient from physical therapy with the reason "does not meet skilled rehab criteria" and signed the note the following day but did not list the physician as an additional signer. The physician did not document that the patient was discharged from physical therapy.

On CLC day 8, the physician documented speaking with the patient who insisted on going home. The physician encouraged the patient to stay to regain strength to be safe at home without help. With the patient's permission, the physician then phoned a family member who agreed to assist in persuading the patient to stay.

In the early hours of CLC day 9, a nurse noted that the patient "seemed very paranoid and delusional." The nurse documented the patient's oxygen saturation was low with supplemental oxygen and that increasing the oxygen had no effect. The nurse changed the nasal cannula to an oxygen mask, which improved the patient's oxygen saturation, and added the physician as an additional signer. The physician documented the nurse asked the patient if the patient was willing to have a chest x-ray and blood work done that day, but the patient refused.

Approximately 30 minutes later, the physician informed the patient that they would return to the facility that day. The physician documented the patient was "agreeing to the transfer and is eager to go." The physician documented that the patient was "a bit delusional" and "somewhat delusional" in the discharge summary, but there were no suggestions for medical or mental health follow-up.

Five days after the patient was discharged from the CLC, a second IDT note was entered that provided a summary of a meeting held on CLC day 7. The IDT note documented that the patient

[9] David Reuben et al., "Interdisciplinary Team Care," Portal of Geriatrics Online Education, 2014, accessed July 7, 2021, https://pogoe.org/productid/21709. A group of healthcare professionals with various areas of expertise who work together to care for patients are also referred to as an interdisciplinary team.

declined the meeting invitation, and the family was not available to attend. The meeting notes documented that the patient's mood fluctuated and the patient was independent with self-care but required supervision with walking. In addition, the IDT note documented that when the physician walked with the patient without oxygen, the patient's oxygen saturation dropped and did not resolve for over an hour with continuous oxygen.

Second Facility Hospitalization

Hospitalist 1, who had treated the patient during the first hospitalization, re-admitted the patient. Hospitalist 1's documented assessment of the patient was "Alert, pleasant, NAD [no acute distress]. Oriented. Cooperative. Reasonable insight" and "no hallucinations or delusions." Hospitalist 1 documented the admission chest x-ray had no new infiltrates and a "new/enlarged [right upper lung] nodule/mass may be present now" and to "anticipate eventual CT [computerized tomography] chest." The covering hospitalist (Hospitalist 3), who took over care, was added as an additional signer and signed the note two days later on hospital day 3.

On hospital day 2, Hospitalist 3 noted the patient continued to require oxygen. The patient disclosed to Hospitalist 3 being "glad to be here" and having felt like they were "in prison" at the CLC. Hospitalist 3 documented "I have reviewed [hospital day 1] CXR [chest x-ray] and am concerned for presence of [a] nodule in right upper lung, that has increased when compared to CXR [chest x-ray] several years ago. Formal read still pending." Hospitalist 3 documented the patient's hypoxemic respiratory failure was a "slow recovery from [the patient's] COVID pneumonia." Regarding the possible lung mass, Hospitalist 3 documented "Await formal read from radiology but might consider CT [computerized tomography] chest next week."

On hospital day 3, a facility physical therapist noted the patient declined physical therapy due to being "too weak to walk" and attempts at motivating the patient were not successful. On hospital day 4, another hospitalist took over care (Hospitalist 4). Hospitalist 4's assessment and plan included, "admission CXR [chest x-ray] unchanged bilateral patchy and linear opacities, possible small effusion." However, Hospitalist 4 neither addressed comments from Hospitalist 3's note regarding a possible lung mass, nor included the assessment of the formal read of the chest x-ray by the radiologist, which advised "consider CT [computerized tomography] for further evaluation."

On hospital day 6, Hospitalist 4 documented the patient having difficulty with motivation for physical therapy. On the same day, a physical therapist assistant documented the patient declined to participate in a full therapy session due to fatigue. On hospital day 7, Hospitalist 4 noted the patient to be "in better spirits" and the patient reported "walking and moving better all around."

On hospital day 10, the patient's oxygen saturations were improved. Hospitalist 4 documented concern regarding the patient's reluctance to get out of bed or work with physical therapy and that the patient "perked up" when an option for discharge to the state veterans home was presented. On hospital day 11, the patient was discharged to a state veterans home. The discharge

summary included the patient's active and chronic conditions but did not include a recommendation regarding a chest computerized tomography (CT) to evaluate the chest x-ray abnormality.

Seventeen days later, the patient presented to a community hospital emergency department and was diagnosed with septic shock pneumonia in both lungs and low blood pressure. The patient was admitted but the next day refused all care and was discharged back to the state veterans home. The patient returned later that evening to the community hospital emergency department and was admitted to the intensive care unit.

The following morning, a CT scan of the chest revealed a mass in the right upper lung field and excess fluid in the sac that surrounds the heart. The lung mass corresponded to the consolidation noted in the facility's chest x-ray during the patient's second facility admission and appeared to be metastatic cancer. The patient was offered a lung biopsy to determine the type and source of the cancer but declined. A drain was placed to remove the excess fluid around the heart and laboratory analysis of the fluid showed the presence of cancerous cells.

In mid-January, the patient was discharged back to the state veterans home on hospice care for lung cancer and excess fluid in the sac that surrounds the heart. The patient died four days later.

Figure 1. *Timeline of the Patient's Care.*
Source: The OIG's review of the patient's EHR.

Inspection Results

The OIG reviewed the patient's mistreatment incidents and quality of care and found deficiencies in the care at the CLC and facility. Additionally, the OIG found poor oversight of CLC processes, including failures in the leadership response and lack of review of the patient's care.

1. Community Living Center Quality of Care

The OIG substantiated that the physical therapist and nursing staff mistreated the patient by forcing the patient to participate in physical therapy during the CLC admission. The CLC nurse manager and CLC assistant nurse manager (nurse managers), and the physician failed to report the abuse allegations to facility leaders and related patient safety events to the patient safety manager, as required. The OIG found additional deficiencies in staff's quality of care. Specifically, nursing staff failed to follow the patient's plan of care by not reporting changes in the patient's status to the physician or family, and not documenting the patient's changes in condition in the EHR. The physician failed to document complete and accurate entries into the patient's EHR. During the inspection, the OIG identified that the CLC lacked an admission process and that IDT notes were not documented within required time frames.

VHA policy and VHA's culture of safety, embodied in the principles of a high reliability organization, require staff to incorporate high reliability into their daily duties.[10] Three key pillars of a high reliability organization are leadership commitment, safety culture, and continuous process improvement. High reliability requires "a work environment where employees at every level of our organization are empowered to speak up for safety and effect positive change."[11]

Mistreatment of the Patient

The OIG substantiated that the patient was mistreated by the physical therapist and two nurses during the CLC admission. Specifically, on two occasions, the physical therapist obtained assistance from nursing staff to force the patient to participate in physical therapy sessions after the patient refused.

[10] VA, VHA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2021: VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019. VHA's journey to become a high reliability organization began in 2019.

[11] VHA High Reliability Organization (HRO) Reference Guide.

VHA patients "have the right to accept or refuse any medical treatment or procedure recommended to them."[12] Providers are not permitted to "unduly pressure or coerce the patient into consenting to a particular treatment or procedure."[13]

The OIG learned that the physical therapist and nurses forced the patient to walk after the patient verbally refused and physically lowered to the floor. Staff reported the physical therapist and a nurse lifted the patient to stand and then pulled the patient's walker forward compelling the patient to walk. After the incident, the patient reported to staff that during the incident, a thumb was inserted in the patient's armpit to lift the patient to a standing position after the patient refused to participate. On CLC day 5, the physical therapist documented that, during a session, the patient displayed an "unwillingness to participate, transfer, look in direction of staff, open eyes, or any socially appropriate behavior." The physical therapist documented the review of the "agreed upon goals" and "calls [the patient] out about [the patients] behavior." The patient was allowed "15 further minutes to wrap [the patient's] mind around it." The physical therapist requested the assistance of the nurse manager to continue the physical therapy session. The session continued with the patient refusing to stand and being manually assisted to a standing position. The physical therapist included the physician on the EHR entry and the physician acknowledged receipt in an EHR entry the next day.

On CLC day 6, the physical therapist completed a session with the patient and documented the session the next day. The physical therapist documented assisting the patient with ambulation, which was met "with high levels of resistance" by the patient, and that the patient repeatedly refused to participate. The physical therapist documented that the patient, while attempting to throw a front-wheeled walker, had the ability to stand unsupported during the session. As part of the physical therapy assessment, the physical therapist documented the patient was "completely non-agreeable to any attempts at tasks" and "refuses attempts at care." The physical therapist involved the nursing staff and the nurse manager in the physical therapy session, and documented, "nursing and nursing mgr [manager] continue to verbalize goals and care expectations for [the patient] and [the] skilled stay." The physical therapist documented the patient was "discharged and does not meet skilled rehab[ilitation] criteria." After the session ended, the physical therapist documented the nursing staff and nurse manager were to "follow-up with veteran in regards to [the patient's] presentation." A VA police report documented bruises to both of the patient's arms and staff told the OIG that the patient sustained skin tear(s) during this session. Staff reported to the OIG that the patient was fearful following the mistreatment incidents.

[12] VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021.

[13] VHA Handbook 1004.01(5).

The OIG concluded that the physical therapist and nurses failed to respect the patient's right to refuse treatment and mistreated the patient with the assistance of nursing staff during two physical therapy sessions. Forcing the patient to participate in therapy is against VHA policy and violated the patient's trust and right to self-determination.

The OIG determined that this was not the first time that there were issues of patient abuse at the CLC; three previous investigations confirmed findings of mistreatment or abuse in the CLC.

- In 2018, a factfinding substantiated allegations of mistreatment of a patient by CLC nursing staff.[14]
- In August 2020, an administrative investigation substantiated that two CLC nurses were witnessed or observed "to be exhibiting behaviors consistent with Patient Abuse and Neglect."[15]
- At the end of November 2020, an administrative investigation was conducted and substantiated that the behavior of a CLC nurse met criteria for "serious offenses" of patient mistreatment.[16]

Two nurses involved in the mistreatment with this patient were also involved in two of the other incidents, one in the 2018 incident and both in the August 2020 incident.

Failure to Report Patient Abuse Allegations

The OIG determined that CLC staff did not report the patient abuse allegations as required. As a result, facility leaders did not have timely information available to take VHA-required action, including ensuring the safety of the patient.

VHA policy requires all employees to report any kind of patient mistreatment to their supervisor.[17] VHA requires that professional employees, including nurses and physicians, adhere to federal and state requirements and laws that govern the reporting of suspected cases of abuse and neglect.[18] Montana requires reporting when professionals "know or have reasonable cause to suspect that an older person…known to them in their professional or official capacities has been

[14] Specific findings were related to the care of the patient in which nurses disregarded provider orders and a food safety issue. The OIG categorized these behaviors as "mistreatment."

[15] Specific findings were related to two nurses leaving a patient on the floor after a fall. The review also found a nurse manager had improper communication regarding the investigation.

[16] Specific findings were related to a nurse hurting a patient during wound care and speaking "harshly and rudely" to multiple patients.

[17] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

[18] VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, November 28, 2017.

subjected to abuse."[19] In addition, VHA states a professional employee "who determines that facts exist that trigger the requirement for reporting abuse or neglect is responsible for promptly documenting all pertinent information about the abuse or neglect in the [EHR]."[20] Facility policy further describes that "health care practitioners, are responsible as 'mandatory reporters,' for documenting pertinent information about the abuse," in the EHR.[21]

Through interviews, the OIG learned that the nurse manager and the CLC assistant nurse manager (assistant nurse manager), who witnessed the mistreatment incidents that gave rise to the allegation of abuse, did not make a report or discuss the incidents with facility leaders either because they did not feel that the patient was mistreated or that they were sufficiently involved, respectively.

The OIG found, during interviews, that the physician did not make a report of the allegation to facility leaders. The OIG learned that the physician was made aware of the mistreatment incidents by a staff member on CLC day 7. Specifically, during an OIG interview, the staff member reported telling the physician of having concerns that the patient was declining emotionally and was scared and that there was no documentation regarding the mistreatment incidents. The physician told the OIG of being informed of the event and of not being "in a role to get involved…of things that I didn't witness." The physician reported discussing the event with the COS when contacted the next day. The COS told the OIG of being notified of the mistreatment events through the ADPCS and expecting the physician to at least have notified the chain of command, and, in the future, to contact facility leaders directly if similar incidents occurred in the CLC.

The staff member told the OIG of discussing with two nursing staff members their role as mandatory reporters and subsequently reporting the incident to a facility leader. The facility leader told the OIG of contacting the ADPCS, COS, VA Police, and an OIG criminal investigator the day the staff member reported the abuse allegations.

Although the allegations of abuse were reported to a facility leader days after the incident, the nurse managers and the physician were obligated to ensure prompt reporting of the incidents to facility leaders. The nurse managers' and physician's failure to report and document the mistreatment incidents that gave rise to the allegation of abuse delayed investigation and intervention for the patient. Additionally, the OIG concluded that staff's failure to report the abuse allegations does not align with VHA's culture of safety.

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[19] Montana Elder and Persons With Developmental Disabilities Prevention Act, Title 52, Chapter 3, Part 8. MCA § 52-3-811 "*Reports*", accessed October 19, 2022, https://leg.mt.gov/bills/mca/title_0520/chapter_0030/part_0080/section_0110/0520-0030-0080-0110.html.

[20] VHA Directive 1199.

[21] Facility MCM 11-22-207, *Suspected Abuse and Neglect: Identification, Evaluation, Treatment, Referral, and Reporting of Possible Victims*, January 29, 2019.

Lack of Safety Reporting

The OIG determined that the nurse managers and the physician failed to follow patient safety reporting requirements. Specifically, the nurse managers and physician did not initiate a Joint Patient Safety Report (JPSR) or a disruptive behavior report regarding the safety-related incidents.[22] Failures to report the patient safety events resulted in delays in patient safety staff and the Disruptive Behavior Committee being aware of the events and taking action as required.

Joint Patient Safety Reporting

Facility staff "[h]ave a duty to report patient safety incidents" and are required to utilize the JPSR system for reporting.[23] Patient safety training is required for all staff regarding how to report patient safety issues.[24] For example, the training emphasizes that "[i]t is everyone's responsibility to report unsafe practices."[25] According to VHA policy, the patient safety manager reviews JPSRs to determine appropriate next steps that may include a patient safety investigation or referral of the patient safety event to another program for action.[26]

The mistreatment incidents, including the incident that resulted in the patient's injuries, required reporting.[27] According to facility procedures, any staff with awareness of the incidents had "a duty to report."[28] The OIG found that one JPSR report detailing the patient's behaviors of attempting to hit the physical therapist and experiencing skin tears was submitted three days after the second mistreatment incident.[29] While the facility procedure does not specify a time frame for reporting patient safety events, the OIG expected reporting to occur sooner. A patient safety manager, who reviewed the JPSR, told the OIG of confirming with risk management staff that they were aware of the abuse allegations, and of closing the incident report pending further investigation.

During an OIG interview, the nurse manager reported not submitting a JPSR regarding the mistreatment incidents due to not feeling anything was done in error. The nurse manager was

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[22] Facility MCP 11-25-513, *Workplace Violence Prevention Program (WVPP)*, October 31, 2020. "disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities."

[23] Facility SOP Number 1, *Guidance for Reporting Patient Safety Incidents at Montana VA Health Care System*, September 24, 2021.

[24] Facility SOP Number 1.

[25] Talent Management System, Module VA 131001298 Updated - *Joint Patient Safety Reporting (JPSR) System - Reporting a Safety Event*, accessed May 13, 2022. This is an internal VA website and cannot be accessed by the public.

[26] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[27] Facility MCP 11-25-513.

[28] Facility SOP Number 1.

[29] While the reporter was not identified, the CLC physician, CLC nurse manager, and CLC assistant nurse manager told the OIG of not submitting a JPSR.

aware of the patient's skin tear. The assistant nurse manager told the OIG of hearing a mistreatment incident but not submitting a report due to not being involved. During OIG interviews, the nurse manager and assistant nurse manager reported having received training in the recognition of events when a JPSR should be submitted.

The physician told the OIG during an interview of hearing about the mistreatment incidents from two staff members. The physician did not report the patient's injury or dissatisfaction with the nursing staff and the physical therapist to leaders at the facility. When questioned by the OIG as to why the patient's injury and dissatisfaction were not reported, the physician stated that the rapid progression of events "short circuited my ability to discuss it with anyone."

Disruptive Behavior Report

Facility policy requires that staff "must report any instances or allegations of workplace violence, sexual assault incidents, patient abuse, and any other public safety incidents to supervisors."[30] "The Disruptive Behavior Reporting System (DBRS) is a VA-approved secure web-based reporting mechanism providing means for all VA employees to alert the DBC [Disruptive Behavior Committee]…about behaviors that cause a safety concern."[31] Disruptive behavior reports are submitted to the Disruptive Behavior Committee chair who is responsible for "reviewing within one business day of receipt every DBC-relevant DBRS event report."[32] Additionally, according to functional statements, nurse managers are tasked with maintaining patient and employee safety, recognizing and reporting unsafe conditions, and encouraging prompt reporting of unsafe conditions.

The nurse manager explained during an interview with the OIG that a disruptive behavior report should have been submitted because the patient attempted to hit staff. The assistant nurse manager also told the OIG that a disruptive behavior report should have been submitted but did not do so due to not being involved in the mistreatment incident.

During OIG interviews, the nurse managers reported having received training in the prevention and management of disruptive behavior. The nurse manager reported needing better education and support regarding disruptive behavior.

The OIG concluded that the nurse managers and the physician failed to follow facility procedures by not submitting a JPSR.[33] Additionally, the nurse managers failed to submit a disruptive behavior report documenting the mistreatment incidents. As a result, the patient safety

[30] Facility MCP 11-25-513. Reports of patients who exhibit disruptive behaviors are assessed, tracked, and managed by the facility's Disruptive Behavior Committee.

[31] VHA Directive 1160.08(1) *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2022. VHA Directive 5019.01 has been renumbered to 1160.08(1) but the content has not changed.

[32] VHA Directive 1160.08(1).

[33] Facility SOP Number 1.

manager and the Disruptive Behavior Committee chair did not receive timely information that may have led to safety reviews and efforts to prevent recurrence of the mistreatment incidents.

CLC Staff's Additional Quality of Care Deficiencies

The OIG found deficiencies in the quality of care by nursing staff and the physician, including failing to document and report changes in the patient's condition.

VA defines quality care as providing the right type of care for a patient's health condition, which keeps the patient safe from hazards and harm, is delivered to address the patient's concerns, needs and life goals; and results in the best possible outcome for the patient.[34]

Nursing

The OIG determined that nursing staff, including the nurse manager and a registered nurse, who cared for the patient, failed to provide quality care by not following the patient's plan of care to report changes in the patient's condition to the physician or patient's family, and by not documenting the changes in the patient's status in the EHR.

VHA requires the patient's care team to adhere to a plan of care for each patient that maximizes quality of life and focuses on improving clinical outcomes.[35] The CLC standard operating procedure (SOP) for nursing documentation requires the use of nurse care notes in EHRs to communicate changes in patients' conditions with other providers who are involved in the interdisciplinary care of the patient.[36] Nursing staff are required to document behaviors that are "out of ordinary" for the patient as well as interventions and outcomes of the interventions.[37] Nursing documentation entries into EHRs must be completed and signed by the end of the assigned shift and late entries are permitted only in the case of emergencies or unusual circumstances.[38] When a patient develops a new wound, nursing staff are to complete documentation that includes the description of the wound with measurements and a photograph of the wound.[39]

According to the patient's plan of care, nursing staff were required to notify the physician of changes in the patient's condition and to notify the patient's family of changes in the patient's

[34] "Quality of Care," VA Benefits and Health Care, accessed April 27, 2022, https://www.va.gov/QUALITYOFCARE/.
[35] VHA Handbook 1142.01.
[36] CLC SOP, *Unit Nursing Documentation Template*, March 9, 2021.
[37] CLC SOP, *Unit Nursing Documentation Template*.
[38] CLC SOP, *Unit Nursing Documentation Template*.
[39] CLC SOP, *Unit Nursing Documentation Template*.

behavioral status. Further, nursing staff were required to document changes in the patient's condition.[40]

Based on EHR review and interviews with the physician, the OIG determined that nursing staff failed to communicate changes in the patient's condition, verbally or through documentation, as required. Specifically, nursing staff did not communicate the decrease of oxygenation during activity, the patient's refusal to participate in physical therapy, and the patient's new skin tears. Nursing staff also failed to communicate changes in the patient's behavioral status to the patient's family. The OIG did not find evidence that nursing staff documented the mistreatment incidents in a nursing note or the skin tears in a wound care note as required.

On CLC day 5, the nurse manager participated in the physical therapy session with the patient and did not document in the EHR as required. During the physical therapy session on CLC day 6, when the patient sustained several skin tears and bruises on both arms, nursing staff participated in the session. Two days later, the nurse manager documented the interactions with the patient as an addendum to a nursing note including that the patient's arm was "scratched," but not the specific documentation regarding the skin tears, as required.

A registered nurse told the OIG of providing first aid for the patient's hand-skin tears sustained during the incident on CLC day 6. When the OIG asked about documenting in the EHR, the nurse manager and nurse recalled documenting, but the OIG did not find wound care documentation with the appearance and size of the skin tears and photographs of the wounds at the time of the mistreatment incidents as required.

The OIG concluded that gaps in the nursing staff's communication and documentation impacted the quality of the patient's care as well as compromised the continuity of care by not providing key information required for clinical decision-making.

Physician

The OIG determined that the physician, who was the only physician assigned to the CLC, failed to document complete and accurate entries into the patient's EHR.

The facility policy for providers' documentation standards states providers are responsible for the completion of accurate and clinically relevant entries into EHRs.[41] The provider engaged in a patient's care must ensure "each event of a patient's care" is entered into the patient's EHR.[42] EHR entries must provide a complete and concise record of care rendered to the patient to ensure continuity of care.[43]

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[40] CLC SOP, *Unit Nursing Documentation Template*.

[41] MCP 11-25-232, *Documentation Standards for Licensed Independent Practitioners*, August 14, 2020.

[42] MCP 11-25-232.

[43] MCP 11-25-232.

The OIG did not find documentation in the EHR of communication related to the patient's care and the mistreatment incidents. The physician told the OIG of being informed by a restorative certified nursing assistant that the patient did not want to perform any exercises or move from a recliner in the room.[44] The physician reported having a 45-minute talk with the patient regarding goals enabling a return home and that the patient said, "I don't want to do it." The physician did not recall documenting the conversation. The physician recalled, after the discussion with the patient, telling the nursing staff that the care team was "not going to force [the patient] to do it." The OIG did not find evidence that the physician documented the encounter with the patient, entered orders, or changed the patient's interdisciplinary plan of care in the EHR.

The physician told the OIG that on a subsequent visit with the patient, the patient was "very upset" and had a skin tear with a large area of discoloration to the right wrist. The physician told the OIG about not asking the nursing staff about the "details" of the injuries or asking the patient for an explanation of the injuries "because it was evident that something had transpired." The physician did not document the patient's injuries or change in demeanor in the EHR. When questioned related to the omissions, the physician stated, "I don't know that it would have really served any purpose to state that [the patient] was upset" and "I don't see how that would apply to to [*sic*] the current situation because it was already…the nursing staff was already aware of it."

The OIG concluded that the physician's failure to document the mistreatment incidents led to missed opportunities to address these quality-of-care deficiencies and ensure patient safety.

Lack of CLC Admission Process

The OIG determined that the facility did not have a designated screening and admissions process for reviewing appropriateness of CLC admissions.[45] The OIG did not find documentation of the patient's CLC admission evaluation in the EHR.

According to VHA, "[t]he need for placement into a VA CLC is based on an assessment of medical, nursing, and therapy needs; level of functional impairment; cognitive status; rehabilitation needs; and special emphasis care needs," such as end-of-life care.[46] Prior to admission to a CLC, VHA requires an evaluation of whether services available meet the care needs and requirements of the prospective patient.[47] This process can be conducted by either an

[44] VHA Directive 1170.03(1), *Physical Medicine and Rehabilitation Service*, November 5, 2019, amended April 4, 2022. Restorative care refers to actions taken by nursing staff to increase independence and promote improvement in function.

[45] VHA Handbook 1142.01.

[46] VHA Handbook 1142.01.

[47] VHA Handbook 1142.01.

IDT or an admissions coordinator.[48] The results of the admission evaluation must be recorded and include the anticipated length of stay as well as the reason for admission.[49]

The OIG heard conflicting information regarding the CLC admissions process. The assistant nurse manager told the OIG that the facility had a screening process for admissions, which involved initial screening of the patient by the nursing team and further discussion by the IDT. However, the physician described to the OIG a different process in which a facility social worker, the CLC social worker, the nurse manager, and the physician worked together to determine if a prospective patient met criteria for admission to the CLC. The OIG found the physician's description was problematic because staff told the OIG that the CLC lacked a permanently assigned social worker for over a year, including the time of the patient's admission.

The assistant nurse manager recalled that, prior to the patient's admission, the IDT evaluated the patient and determined that the care required by the patient could be provided by CLC staff. However, the OIG found no documentation in the EHR of an evaluation of the patient's suitability for CLC admission or whether the facility had the capability to provide the necessary care and services for the patient.

The OIG concluded that without a designated screening and admission process, CLC staff were unable to determine the patient's suitability for admission or need for the level of care being considered. These factors may have impacted the recognition of the care the patient needed to achieve goals in the plan of care.

Untimely IDT Documentation

The OIG learned the patient's IDT note for a discussion on CLC day 7, which may have provided relevant information regarding the patient's medical status to facility staff, was entered five days after the patient was discharged to the facility. Facility procedure requires IDT notes to be completed within 24 hours of the IDT meeting.[50]

During the onsite inspection, the OIG reviewed CLC operational and care delivery processes and identified IDT notes were not documented timely through interviews and onsite observations. The minimum data set coordinator told the OIG that the IDT care plan notes were captured on paper during the weekly IDT meeting and then entered into the EHR at a later date.[51] The

[48] VHA Handbook 1142.01.

[49] VHA Handbook 1142.01.

[50] CLC SOP, *Unit Nursing Documentation Template*.

[51] The Minimum Data Set, used in VHA CLCs, is a "core set of screening, clinical, and functional status elements that forms the foundation of this comprehensive assessment," accessed June 3, 2022, http://vaww.vhadataportal.med.va.gov/DataSources/RAIMDS.aspx. (This is an internal website not publicly accessible.)

minimum data set coordinator reported a delay in transferring the documentation to the EHR, which began in October 2021, due to lack of nursing coverage for the coordinator. The minimum data set coordinator stated that, at the time of the inspection, documentation was being input from January 2022. As a result, medical records were incomplete and prevented other providers from reviewing the medical information. The OIG concluded that delays in access to IDT notes in the EHR may have impacted the patient's quality of care.

2. Facility Hospitalist's Failure to Follow-up on Chest X-Ray Results

The OIG determined that Hospitalist 4 failed to communicate, through the discharge summary, recommendations for post-discharge follow-up of the patient's chest x-ray results to the provider at the state VA home. Specifically, Hospitalist 4 acknowledged not noting or reviewing the progress note by Hospitalist 3 indicating a possible lung mass. The OIG acknowledges the patient's course of assessment and treatment was confounded by COVID-19 and pneumonia symptoms, including shortness of breath and fatigue.

Patients with COVID-19 may "have new, recurring, or ongoing symptoms and clinical findings four or more weeks after infection" and "multiorgan system effects…in most, if not all, body systems."[52] After recovery from COVID-19, "CT is indicated in patients with functional impairment and/or hypoxemia."[53]

The OIG found that, during the patient's first hospitalization at the end of November 2021, a radiologist documented changes in the patient's chest x-ray results.[54] The patient received a negative COVID-19 test in early December 2021. Subsequently, after another chest x-ray, a CT scan was recommended by a radiologist in mid-December. On the following day, Hospitalist 3 reviewed the chest x-ray, documented a possible lung mass, and considered a chest CT scan.[55] Two days later, after the patient's care was transferred, Hospitalist 4 did not document follow-up for the chest x-ray changes or the possible lung mass. The OIG would expect a physician taking over care for the patient to review documentation of prior care and recommendations. The patient's lung mass and metastatic cancer was diagnosed by CT scan at the community hospital in early January 2022.

[52] Centers for Disease Control and Prevention, "Post-COVID Conditions: Information for Healthcare Providers," accessed March 4, 2022, https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fclinical-care%2Flate-sequelae.html.

[53] Geoffrey D. Rubin et al., "The Role of Chest Imaging in Patient Management During the COVID-19 Pandemic: A Multinational Consensus Statement From the Fleischner Society," *Chest* 158, no. 1 (July 2020):106-116; Bedirhan Ustun and Cille Kennedy, "What is 'functional impairment'? Disentangling disability from clinical significance," *World Psychiatry*, June 2009. "Functional impairment refers to limitations due to the illness."

[54] The patient had eight chest x-rays from October 30, through December 10, 2021.

[55] Hospitalist 3 provided intermittent weekend coverage.

Hospitalist 4 told the OIG of not noting Hospitalist 3's documentation regarding the lung mass concern. Hospitalist 4 reported determining the patient should receive further chest imaging in a few weeks when the COVID-19-related concerns were resolved and assessment for other conditions would be easier. Upon discharge from the second hospitalization, Hospitalist 4 documented in the discharge summary the patient's limitations included "persistent weakness" and "increased oxygen needs in the CLC." However, the OIG did not find evidence that Hospitalist 4 ordered the CT scan or communicated the expectation for a CT scan to a primary care physician or to staff at the state veterans home upon the patient's discharge.

Hospitalist 4 told the OIG of learning from the physician that the reason for the facility admission was not for "respiratory status" but rather the patient's "dissatisfaction with [the patient's] care there" at the CLC. The hospitalist's order indicating the reason for the patient's admission for the second hospitalization included the patient's "discontent" at the CLC. The hospitalist told the OIG of receiving a call from the physician regarding the patient's return to the facility. The physician documented the patient was "not cooperating with rehabilitation" and told the OIG that the patient was deconditioned and did not wish to participate.

Facility hospitalists and the associate chief of staff for medicine told the OIG that follow-up for the chest x-ray in mid-December was warranted. However, their recommendation for a chest x-ray or CT scan to be completed ranged from two weeks to twelve weeks after recovery from the COVID-19 pneumonia. Two hospitalists also said the CT scan would not have changed the patient's treatment except, as one of the two hospitalists' remarked, the CT scan would have diagnosed the lung mass and the patient may have been admitted to hospice earlier.

3. Facility Leaders' Oversight Failures

The OIG determined that facility leaders did not complete oversight processes for the CLC including intervening in prior findings of CLC patient mistreatment in 2018 and 2020. Facility leaders also failed to provide oversight for the physician's care of CLC patients. The lack of oversight prevented consideration for interventions related to the pattern of mistreatment, including staff disciplinary actions, and ensuring review of state licensing board reporting requirements.

Pattern of Mistreatment in the CLC

The OIG determined that facility leaders did not consider the pattern of patient mistreatment from three previous investigations in the CLC.

- In 2018, a factfinding substantiated allegations of mistreatment of a patient by CLC nursing staff.[56]
- In 2020, an administrative investigation substantiated that the behaviors of two CLC nurses met criteria for patient mistreatment.
- At the end of 2020, an administrative investigation was conducted and substantiated that the behavior of one CLC nurse met criteria for patient mistreatment.

Although facility leaders completed, in March 2022, an administrative investigation of the allegations of the patient's abuse that gave rise to this healthcare inspection, and took action, the OIG was concerned the pattern of mistreatment had not been recognized.[57]

To identify and correct individual and systemic deficiencies, VA established requirements for factfinding and administrative investigations.[58] VA leaders utilize these types of investigations in response to matters within their responsibility to determine the facts and the appropriate response to the matter.[59]

The integrity and compliance officer told the OIG of discussing the 2018 factfinding with the Facility Director. During a call with the OIG, the Facility Director reported being unaware of the 2018 factfinding. Furthermore, during a follow-up interview, the Facility Director recalled findings of mistreatment were not substantiated against two nurses in the 2020 investigation "…once ELR [employee labor relations] and OGC [Office of General Counsel] reviewed the evidence, they felt that there was not enough evidence that was substantiated that could support a proposed removal." The ADPCS told the OIG of proposing the removal of the nurse involved in the 2021 investigation. The Facility Director recalled that the 2021 proposed removal was substantiated and action was taken.

The OIG did not find evidence that facility leaders considered the pattern of patient mistreatment when evaluating the allegations that gave rise to this healthcare inspection. The OIG would have expected facility leaders to track and trend substantiated allegations of mistreatment to ensure appropriate corrective measures were taken.

[56] Specific findings were related to the care of the patient in which nurses disregarded provider orders and a food safety issue. The OIG categorized these behaviors as "mistreatment."

[57] The facility reported to the OIG that during this time frame "a contributing factor is the multiple changes in leadership. There had been four individuals that held the position for facility Director, five that held the position for Associate Director, eight that held the position for Chief of Staff, and three that held the position for Associate Director, Patient Care Services, in either an acting or permanent capacity."

[58] VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021; VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

[59] VA Directive 0700.

Noncompliance with State Licensing Board Reporting Policy

The OIG determined that facility leaders failed to comply with VHA's state licensing board reporting policy. Despite the previous incidents of mistreatment, the OIG found no documentation that the nursing staff involved underwent the review stages within VHA's state licensing board reporting process, and were, therefore, not reported to their respective state licensing boards.[60]

Reporting to state licensing boards is required by VHA when a licensed healthcare professional is found to have "significantly failed to meet generally accepted standards of clinical practice" and there is a concern for patient safety.[61] VHA established a five-stage process that includes facility reviews, a facility director decision, and, if appropriate, reporting to state licensing boards. According to VHA, the five stages should be completed in less than 100 calendar days.[62] Ultimately, the facility director makes the decision to report a healthcare professional to a state licensing board.

For the 2018 and 2020 mistreatments, the facility could not provide documentation to the OIG indicating that state licensing board reporting had been considered.[63] For the 2021 mistreatment, the facility provided an email from the ADPCS that stated that the mistreatment did not meet the criteria for reporting to the state licensing board. The OIG found no reason for the incident not meeting criteria and no evidence that the Facility Director finalized the reporting decision.

During the inspection, the OIG received correspondence from the VISN that a report was initiated to the respective state licensing boards for the two nurses and the physical therapist involved in the patient's mistreatment incidents. As of September 2022, the OIG received documentation that reporting of the actions of employees to state licensing boards as ongoing.

The OIG concluded that the failures to respond to a pattern of mistreatment and to follow the required VHA process for reviewing and reporting licensed healthcare professionals to state

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[60] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. VHA Handbook 1100.18 was in effect during a portion of the time frame for the review but was rescinded and replaced by VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. Both the handbook and directive contain the same or similar language related to state licensing board reporting.

[61] VHA Handbook 1100.18. "VA has broad authority to report to SLBs [State Licensing Boards] those currently appointed or separated licensed health care professionals whose behavior or clinical practice substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients." VHA Directive 1100.18.

[62] VHA Handbook 1100.18 noted "normally are completed in about 100 days." VHA Directive 1100.18 noted "should be completed in less than 100-calendar days."

[63] VA OIG, *Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities*, report No. 20-00827-126, April 7, 2022. The OIG published a report that revealed concerns about facility directors' noncompliance with VHA's state licensing board and the National Practitioner Data Bank reporting policies, suggesting potential systemic failures.

licensing boards may have fostered a culture of mistreatment at the CLC and, ultimately, led to continued incidents of mistreatment.

Lack of Oversight of CLC Physician Evaluations and Privileging

The OIG found that the COS failed to conduct required ongoing monitoring of the care provided by the physician. As a result, leaders lacked oversight to confirm the quality of care provided to patients at the CLC.[64]

VHA and the facility require that privileged providers have ongoing professional practice evaluations (OPPEs) to ensure the quality and safety of care provided to patients.[65] An OPPE is "an evidence-based privilege renewal process and is part of a decision-making process used on a semi-annual basis to continue a provider's existing privilege(s) or scope of practice"[66] The COS is responsible for oversight of CLC medical functions, such as completing or designating staff to complete the physician's OPPEs.[67]

The OIG reviewed the physician's OPPEs from October 2019 through December 31, 2021, and found that the OPPEs did not include evaluation of care provided at the CLC. The COS told the OIG of being hired into the position in summer of 2019. The OIG learned the only OPPEs completed on the physician were for the last few years for primary care provided at one of the facility's community-based outpatient clinics. The COS told the OIG during an interview that the OPPEs for the physician were done by primary care providers. The associate chief of staff for primary care and associate chief of primary care, who was the physician's supervisor, told the OIG that they had not performed OPPEs on the care that the physician provided to CLC patients because supervision for the physician's CLC care was under hospital medicine. However, the associate chief of staff for medicine told the OIG of never having done an OPPE for the physician and assumed the position fell directly under the COS.

The OIG concluded that, without oversight of the care provided by the physician in the CLC, leaders did not fully assess the physician's performance and competence.

Conclusion

The OIG substantiated the patient was mistreated by a physical therapist and nursing staff during the patient's CLC admission. The physical therapist did not allow the patient to refuse sessions,

[64] The physician had clinical privileges for primary care and geriatric medicine. The physician told the OIG of working 60 percent of the time in primary care at a facility outpatient clinic and 40 percent at the CLC.

[65] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, the credentialing portion of the handbook was superseded by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. Facility MCM 11-22-02, *Credentialing and Privileging of Licensed Independent Providers*, June 20, 2019.

[66] Facility *Bylaws and Rules of the Medical Staff*, updated June 2019.

[67] MCM 11-19-228, *Medical Supervision of Extended Care Residents*, July 1, 2016.

and obtained assistance from nursing staff to force the patient to participate. Forcing the patient to participate in physical therapy sessions violated the patient's trust and impacted the safety and quality of care provided.

CLC staff did not report the patient abuse allegations as required and, as a result, facility leaders did not have timely information available to take VHA-required action, including ensuring the safety of the patient. The nurse managers' and physician's failure to report and document the mistreatment incidents that gave rise to the allegation of abuse delayed investigation and intervention for the patient and does not align with VHA's culture of safety.

The OIG determined that the nurse managers and the physician failed to follow patient safety reporting requirements by not submitting a JPSR or disruptive behavior report documenting the mistreatment incidents. As a result, the patient safety manager and the Disruptive Behavior Committee chair did not receive timely information that may have led to safety reviews and efforts to prevent recurrence of the mistreatment incidents.

The facility did not have a designated screening and admissions process for reviewing suitability of CLC admissions. The OIG concluded that without a designated screening and admissions process, CLC staff were unable to determine the patient's acceptability for admission or need for the level of care being considered. The OIG concluded these factors may have impacted the recognition of the care the patient needed to achieve goals in the plan of care.

Nursing staff and the physician in the CLC failed to document entries into the patient's EHR related to the mistreatment incidents. Further, IDT notes were not documented timely. The OIG concluded that delays in access to patient care records in the EHR may have impacted the patient's quality of care.

The OIG determined that Hospitalist 4 did not document a follow-up plan for the chest x-ray changes or the possible lung mass to a primary care physician or to staff at the state veterans home upon the patient's discharge. While the OIG recognizes the identification of the patient's lung mass sooner would not have likely changed the outcome, the lack of care coordination did not afford the patient, and the patient's family member, the opportunity to determine the most appropriate care plan including hospice care.

During the review, the OIG discovered other findings related to facility oversight processes for the CLC. Facility leaders did not complete oversight processes for the CLC including intervening in prior findings of CLC patient mistreatment in 2018 and 2020. The OIG determined that the lack of oversight prevented consideration for interventions related to the pattern of mistreatment, including staff disciplinary actions, and ensuring review of state licensing board reporting. Facility leaders also failed to provide oversight for the physician's care of CLC patients, as required. The OIG concluded that, without oversight of the physician's care in the CLC, leaders did not fully assess the physician's performance and competence.

Recommendations 1–7

1. The Rocky Mountain Network Director reviews facility staff's actions taken in response to the allegations and concerns related to the patients identified in this report to ensure Veterans Health Administration and facility requirements were met including Montana elder abuse reporting requirements, and takes actions, such as reporting, disciplinary actions, peer reviews, and consultation with the Office of General Counsel, as needed.

2. The Montana VA Healthcare System Director ensures that the rights of community living center patients to refuse treatments or procedures are acknowledged and documented according to Veterans Health Administration requirements, and staff are educated on and adhere to the rights, as needed.

3. The Montana VA Healthcare System Director reviews the nursing care provided to the identified patient with respect to quality of care, including adhering to the patient's care plan, and reporting and documenting status changes, and takes actions as indicated.

4. The Montana VA Healthcare System Director reviews the physician's care provided to the identified patient with respect to quality of care, including documenting and reporting status changes and concerns, and takes actions as indicated.

5. The Montana VA Healthcare System Director reviews community living center screening and admission evaluation processes and ensures that the processes, including documentation of admissions decisions, roles, and responsibilities are established to meet the care needs of prospective patients, and are communicated with applicable staff, as needed.

6. The Montana VA Healthcare System Director reviews the patient's acute care, including actions to address medical recommendations, and takes actions as indicated.

7. The Montana VA Healthcare System Director ensures state licensing board processes related to the mistreatment incidents identified in this report are reviewed, deficiencies identified, and compliance processes completed.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 2, 2022

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL02)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed the findings, recommendations, and action plan of the VA Montana Health VA Health Care System in Miles City and Fort Harrison. I am in aggreeance with the above.

(*Original signed by:*)

Ralph T Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

VISN Director Response

Recommendation 1

1. The Rocky Mountain Network Director reviews facility staff's actions taken in response to the allegations and concerns related to the patients identified in this report to ensure Veterans Health Administration and facility requirements were met including Montana elder abuse reporting requirements, and takes actions, such as reporting, disciplinary actions, peer reviews, and consultation with the Office of General Counsel, as needed.

Concur.

Target date for completion: March 31, 2023

Director Comments

The VISN 19 Geriatrics and Extended Care (GEC) Lead, Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Risk Management (RM) Officer, and Human Resources (HR) will review actions taken by Montana VA Healthcare System to evaluate the actions for appropriate responses and reporting.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 28, 2022

From: Director, VA Montana Healthcare System (436)

Subj: Healthcare Inspection—Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison

To: Director, Rocky Mountain Network (10N19)

1. On behalf of Montana VA Health Care System, I would like to express our gratitude to the Office of Inspector General (OIG) team for the review. I reviewed the draft report and I concur with the recommendations. We appreciate the opportunity to improve the care we provide.
2. For the purposes of clarity, the statement on page i, paragraph two should go on to state that the facility did contact the Office of Healthcare Inspections to report the alleged patient abuse, as recommended by the OIG criminal investigators.
3. For the purposes of accuracy on page i, paragraph four, the facility would like to note previous issues identified were that of 'alleged' patient abuse.
4. For the purposes of confidentiality, the facility would like to note that the OIG team was informed of an individual's name being printed in the footnote of the draft report on pages i and 23.
5. For the purposes of clarity, the facility would like to note with respect to what is described on page viii, paragraph three, and pages 32 and 33, as failure of facility leaders to recognize a pattern of CLC patient mistreatment, between 2018 through May 2022 a contributing factor is the multiple changes in leadership. There had been four individuals that held the position for facility Director, five that held the position for Associate Director, eight that held the position for Chief of Staff, and three that held the position for Associate Director, Patient Care Services, in either an acting or permanent capacity.
6. For the purposes of clarity, the statement on page ix, paragraph one, should state "For the 2021 mistreatment, the facility provided an email from the ADPCS that stated that the mistreatment did not meet the criteria for reporting to the state licensing board" to be consistent with page 34, paragraph two.
7. For purposes of accuracy on page 13, 2nd paragraph, the facility would like to communicate that Montana VA Health Care System includes the facility, 13 community-based outpatient clinics, and the CLC. Additionally, the facility has 23 hospital beds, 6 intensive care unit beds, 24 domiciliary beds, and 17 CLC operating beds.

(*Original signed by*:)

Judy Hayman, Ph.D.
Executive Director, Montana VA Health Care System

Facility Director Response

Recommendation 2

The Montana VA Healthcare System Director ensures that the rights of community living center patients to refuse treatments or procedures are acknowledged and documented according to Veterans Health Administration requirements, and staff are educated on and adhere to the rights, as needed.

Concur.

Target date for completion: May 31, 2023

Director Comments

In May 2022, CLC staff received training on the Rights and Responsibilities of VA Patients and Residents of Community Living Centers (CLC). This training is incorporated into new employee orientation and annual staff education. Social Work provides a copy of resident rights and responsibilities to all CLC residents on admission and documents discussion in the resident's electronic medical record. Compliance of appropriate documentation of Veterans rights and responsibility discussion will be monitored through monthly CLC medical record audits completed by Unit Managers with an expected compliance rate of 90% for two consecutive quarters.

Recommendation 3

The Montana VA Healthcare System Director reviews the nursing care provided to the identified patient with respect to quality of care, including adhering to the patient's care plan, and reporting and documenting status changes, and takes actions as indicated.

Concur.

Target date for completion: May 31, 2023

Director Comments

On March 28, 2022, the nursing care provided to the identified patient with respect to quality of care, including adhering to the patient's care plan, and reporting and documenting status changes was reviewed. Gaps identified within this review were utilized in developing comprehensive nursing staff education that occurred May 16–18, 2022, and again August 29 – September 1, 2022, which included proper documentation, reporting procedures for changing conditions, and adherence to patient care plans. CLC leadership began utilizing watchlist huddles on September 22, 2022, to communicate status changes in residents among the members of the interdisciplinary team. This process is followed through until identified issues are resolved, and changes to the

plan of care are made with the input of the interdisciplinary team, resident, and residents' family when available. Compliance of appropriate documentation of status changes, and communication between residents and the interdisciplinary care team will be monitored through monthly CLC medical record and observation audits completed by Unit Managers with an expected compliance rate of 90% for two consecutive quarters.

Recommendation 4

The Montana VA Healthcare System Director reviews the physician's care provided to the identified patient with respect to quality of care, including documenting and reporting status changes and concerns, and takes actions as indicated.

Concur.

Target date for completion: March 31, 2023

Director Comments

On April 22, 2022, the physician's care provided to the identified patient was reviewed. On November 22, 2022, the Interim Chief of Staff (COS) reviewed with the physician the requirements for documenting and reporting status changes and concerns. The Interim COS will assign a management review for a comprehensive review of the care provided to the identified patient, including documenting and reporting status changes and concerns. The completed review will be submitted by January 17, 2023, to the Executive Committee of the Medical Staff (ECOMS) and will be followed through to completion including actions by the ECOMS.

The Interim COS will appoint a physician familiar with the CLC patient population to review a random sampling of the physician's documentation for quality and appropriateness with an expected compliance rate of 90% for two consecutive quarters.

Recommendation 5

The Montana VA Healthcare System Director reviews community living center screening and admission evaluation processes and ensures that the processes, including documentation of admissions decisions, roles, and responsibilities are established to meet the care needs of prospective patients, and are communicated with applicable staff, as needed.

Concur.

Target date for completion: May 31, 2023

Director Comments

On March 28, 2022, CLC screening and admission evaluation processes were reviewed in consultation with the VA Central Office of Geriatrics and Extended Care, and Standardized

Operating Procedure (SOP) "Community Living Center Long Stay Services Admission Criteria and Process" was developed and implemented on July 27, 2022. The SOP includes procedures for screening all potential admits by the interdisciplinary team, and roles for the medical provider, nursing staff, and social work ensuring the Veteran meets eligibility, and the CLC has the appropriate resources to provide quality care to the potential admission. The decision process is documented by the CLC Social Worker. Compliance with documentation of the CLC screening and admission evaluation process will be monitored through monthly documentation audits completed by Unit Managers with an expected compliance rate of 90% for two consecutive quarters.

Recommendation 6

The Montana VA Healthcare System Director reviews the patient's acute care, including actions to address medical recommendations, and takes actions as indicated.

Concur.

Target date for completion: August 10, 2022

Director Comments

The Montana VA Health Care System follows VHA Directive 1190, Peer Review for Quality Management. Considering the seriousness of the concerns regarding this patient's care, Medical Staff leadership completed a review of the continuum of care for this patient on April 22, 2022. The Leadership Reviewer provided education to the treating physician and recommended an external peer review of the patient's acute care, including actions to address medical recommendations. The external peer review was completed and returned on August 10, 2022. No further action was recommended by the external review.

OIG Comment

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

Recommendation 7

The Montana VA Healthcare System Director ensures state licensing board processes related to the mistreatment incidents identified in this report are reviewed, deficiencies identified, and compliance processes completed.

Concur.

Target date for completion: January 31, 2023

Director Comments

The Montana VA Health Care System recognizes the importance of adhering to requirements for reporting incidents of mistreatment to the State Licensing Board as outlined in VHA Directive 1100.18, Reporting and Responding to State Licensing Boards. The Interim Chief of Staff (COS) and the Associate Director, Patient Care Services will ensure the appropriate State Licensing Board reporting processes are followed for the clinicians and nursing staff identified in this report related to the mistreatment incidents. A regular status update is provided to the Montana VA Health Care System Director on pending State Licensing Board reports.

Glossary

To go back, press "alt" and "left arrow" keys.

atrial fibrillation. An irregular heartbeat in which the heart's upper two chambers (the atria) beat irregularly and out of coordination with the heart's lower two chambers (the ventricles). It increases the risk of stroke and other heart-related complications.[68]

biopsy. "The removal and examination of tissue, cells, or fluids from the living body."[69]

chronic obstructive pulmonary disease (COPD). A "chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing. It [is] caused by long-term exposure to irritating gases or particulate matter, most often from cigarette smoke. People with COPD are at increased risk of developing heart disease, lung cancer, and a variety of other conditions."[70]

computerized tomography (CT) scan. "Combines a series of x-ray images taken from different angles around [the] body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues."[71]

COVID-19. An infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."[72]

delusion. "A false belief regarding the self or persons or objects outside the self that persists despite the facts and occurs in some psychotic states."[73]

effusion. "The escape of a fluid from anatomical vessels by rupture or exudation."[74]

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[68] Mayo Clinic, "Atrial fibrillation," accessed June 9, 2020, https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624.

[69] *Merriam-Webster.com Dictionary*, "biopsy," accessed January 11, 2021, https://www.merriam-webster.com/dictionary/biopsy.

[70] Mayo Clinic, "COPD," accessed September 27, 2019, https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679.

[71] Mayo Clinic, "CT scan," accessed May 15, 2020, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

[72] Mayo Clinic, "Coronavirus disease 2019 (COVID-19)," accessed September 28, 2022, https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963#:~:text=In%202019%2C%20a%20new%20coronavirus,2019%20(COVID%2D19).

[73] *Merriam-Webster.com Dictionary*, "Medical definition of delusion," accessed May 25, 2022, https://www.merriam-webster.com/dictionary/delusion.

[74] *Merriam-Webster.com Dictionary*, "Medical definition of effusion," accessed May 24, 2022, https://www.merriam-webster.com/dictionary/effusion.

follicular lymphoma. "A very slow growing cancer that may appear in [the] lymph nodes, [the] bone marrow, and other organs."[75]

hospitalist. A physician "whose primary professional focus is the general medical care of hospitalized patients."[76]

hypoxemia. "A below-normal level of oxygen in [the] blood, specifically in the arteries."[77]

metastatic. "Cancer cells break away from where they first formed and form new tumors in other parts of the body."[78]

nasal cannula. A small tube with two plastic prongs that are inserted into each nostril used to deliver oxygen.[79]

pneumonia. "Pneumonia is an infection that inflames the air sacs in one or both lungs. The air sacs may fill with fluid or pus (purulent material), causing cough with phlegm or pus, fever, chills, and difficulty breathing."[80]

septic shock. A life-threatening form of sepsis that is characterized by decreased blood flow to organs and tissue, impaired mental status, and multisystem organ failure.[81]

thrombocytopenia. A condition in which a person has a low blood platelet count. Platelets "are colorless blood cells that help blood clot."[82]

[75] Cleveland Clinic, "Follicular Lymphoma," accessed May 23, 2022, https://my.clevelandclinic.org/health/diseases/22606-follicular-lymphoma.

[76] University of California, San Diego Department of Medicine, "About Us: What is a hospitalist?," accessed March 4, 2019, https://hospitalmedicine.ucsd.edu/about/index.html.

[77] Mayo Clinic, "Hypoxemia," accessed May 22, 2022, https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930?p=1.

[78] National Cancer Institute, "Metastatic Cancer: When cancer Spreads," accessed September 28, 2022, https://www.cancer.gov/types/metastatic-cancer.

[79] Shijing Jia, Robert Hyzy "Noninvasive Support of Oxygenation" in Murray & Nadel's Textbook of Respiratory Medicine, 7th ed., Volumes 1 and 2, eds. V Courtney Broaddus, et al., (May 17, 2021):1931-1938.e3.

[80] Mayo Clinic, "Pneumonia" accessed April 26, 2019, https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204.

[81] *Merriam-Webster.com Dictionary*, "septic shock," accessed May 15, 2020, https://www.merriam-webster.com/dictionary/septic%20shock.

[82] Mayo Clinic, "Thrombocytopenia (low platelet count)," accessed November 26, 2019, https://www.mayoclinic.org/diseases-conditions/thrombocytopenia/symptoms-causes/syc-20378293.

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Director, Rocky Mountain Network (10N19)
Director, VA Montana Healthcare System (436/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Steve Daines, Jon Tester
U.S. House of Representatives: Matthew M. Rosendale, Ryan Zinke

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