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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at the VA Southern Nevada Healthcare System in Las Vegas

Healthcare Inspection | **24-00193-186** | **August 6, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Southern Nevada Healthcare System (facility) in Las Vegas to analyze facility leaders' response to allegations that a dental hygienist failed to follow Veterans Health Administration (VHA) and facility policies and provide quality care.[1] From April 2021 through April 2023, the dental hygienist's supervisors (supervisors) became aware of the dental hygienist's

- infection control violations, which included not maintaining cleanliness of operatory space and equipment, wearing contaminated gloves in the hallways, and using poor hand washing practices;
- medication storage policy violations that included improper storage of anesthetic medications;
- clinical practice concerns that included patient complaints of rough and painful teeth cleanings, the under- or overuse of local anesthesia medication, teeth cleanings of poor quality or short duration, and failure to provide proper care to a patient with special medical needs; and
- false documentation in a patient's electronic health record (EHR).

The OIG determined that supervisors did not ensure the correction of patient safety concerns. Additionally, the Chief of Staff (COS) did not ensure the completion of a management review and seek knowledge of the extent of the patient safety concerns. When the OIG asked about the care that was provided to patients, the dental hygienist reported not recalling specifics.

Factfinding: Falsification of a Medical Record Not Addressed and Medication Storage Violations Not Reviewed

Factfindings are a type of administrative investigation used to collect and analyze evidence that may be used to support administrative or disciplinary actions and should be completed as promptly as possible, usually in one day or up to three weeks. VHA supervisors may use

[1] VHA defines quality as the delivery of "highly reliable health care services that are safe, timely, effective, efficient, equitable and patient-centered"; VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. This directive was in place during the time of the events discussed in this report. It was amended by VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language as the amended directive; Facility Standard Operating Procedure 160-22-18, "Dental Service Infection Control," November 1, 2022; VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015; Facility Policy 139-21-36, *Disposal of Hazardous and Non-Hazardous Pharmaceutical Drugs*, March 17, 2021; The chief of dental told the OIG the dental hygienist stopped providing patient care while on extended leave in spring 2023 and then retired in early 2024.

information from factfindings to support administrative or disciplinary actions.[2] As the supervisor, the chief of dental service (chief of dental) became aware of a medication storage violation in April 2022, notified VA police, and provided medication storage reeducation for all staff.[3] In the summer of 2022, the chief of dental requested a factfinding to review concerns related to conduct, privacy violations, and an instance of medical record falsification by the dental hygienist. After initiating the factfinding in September 2022, the chief of dental learned of two additional medication storage violations and requested that the violations be included in the factfinding. However, the medication storage violations were not included because the designated factfinder believed, based on consultation with a human resources staff member, that the violations had been previously addressed. The Deputy Chief of Staff (DCOS) became the dental hygienist's supervisor in October 2022. The factfinding was not completed until November 2022, over two months after the factfinding's initiation, due to a lack of available factfinders. The factfinding substantiated conduct concerns, privacy violations, and falsification of a medical record.[4]

In late fall 2022, the DCOS issued the dental hygienist a written counseling for conduct and privacy concerns but did not address the medical record falsification. The DCOS told the OIG of relying on human resources staff to draft the written counseling letter. Conversely, the human resources staff member stated the letter was prepared and issued by the DCOS. The OIG would have expected the DCOS to have ensured that the falsification of the medical record was included in the written counseling or taken other action to address the deficiency.

Performance Improvement Plan Not Issued to Address Infection Control and Clinical Practice Concerns

Supervisors who are aware of unacceptable performance may give the employee an opportunity to improve through a performance improvement plan (PIP), which clarifies expectations, identifies how performance will be monitored, and tracks improvement progress.[5] The DCOS's attempts to correct clinical practice concerns and infection control violations were not successful. Therefore, the DCOS consulted with a human resources staff member in January 2023 and made the decision to place the dental hygienist on a PIP.[6] The DCOS told the OIG the PIP was not issued as the dental hygienist was on extended leave and due to a pending administrative action

[2] VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

[3] VA police found no criminality regarding the violation.

[4] During an OIG interview, the dental hygienist was unable to recall falsifying a patient's record but noted that a documentation error could have mistakenly occurred.

[5] VA Directive 5013, *Performance Management Systems*, April 15, 2002.

[6] Prior to consulting with human resources, the DCOS completed chart reviews and discussed learning opportunities with the dental hygienist to correct clinical practice concerns and provided counseling and education to correct infection control violations. Efforts did not correct the deficiencies and patient safety concerns continued to be reported.

filed by the dental hygienist. However, the dental hygienist was still working in the dental clinic until April 2023, and the DCOS had a duty to ensure the correction of clinical practice concerns and infection control violations.

State Licensing Board Reporting Process Not Initiated

VHA policy states that, upon awareness that a licensed health care professional failed to meet generally acceptable standards of care, supervisors must notify the credentialing and privileging manager to initiate the state licensing board (SLB) reporting process.[7] The DCOS was aware of the falsification of a patient's EHR; repeated clinical practice concerns, infection control and medication storage violations; and of the chief of dental's opinion that the repeated infection control violations created a concern for the safety of patients. The DCOS told the OIG of recommending a comprehensive review of the dental hygienist's care, a step in the SLB reporting process, to the credentialing and privileging manager. However, the credentialing and privileging manager was unable to recall being contacted regarding the initiation of the SLB reporting process.

Supervisors must complete an exit review form for all licensed health care professionals who leave employment at the facility. Supervisors are required to document on the form when a provider fails to meet generally accepted standards of practice as to raise reasonable concern for the safety of patients, thus initiating the SLB reporting process.[8] The chief of dental told the OIG of returning to the role of the dental hygienist's supervisor in early 2024, and the dental hygienist left employment at the facility two days later. The chief of dental completed the provider exit review form a few days later without notating any clinical care deficiencies or clinical care concerns despite acknowledging to the OIG that the dental hygienist failed to meet generally accepted standards of clinical practice. The chief of dental explained that the credentialing and privileging manager provided advisement to select that the dental hygienist "met generally accepted standards" because substantial personnel action had not been implemented. However, the credentialing and privileging manager was unable to recall the contents of that discussion. The credentialing and privileging manager told the OIG that "disciplinary action could be a determining factor if it raised reasonable concern for the safety of patients," but was unaware if substantial personnel action was a requirement. The VA Deputy Director for Adverse Privileging Actions and SLB / NPDB [National Practitioner Data Bank] confirmed to the OIG that there is no such requirement.

[7] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.
[8] VHA Directive 1100.18.

Patient Safety Reporting Not Completed

The OIG also found that supervisors did not ensure patient safety concerns regarding the dental hygienist were reported through the Joint Patient Safety Reporting (JPSR) system as required by facility policy, thus limiting senior leaders awareness and further assessment of the dental hygienist's care.[9] Facility policy requires staff to report patient safety events utilizing the JPSR system, and service chiefs are responsible to ensure compliance with facility policy for reporting.[10] From April 2021 through January 2024, the supervisors learned of 35 separate instances of care concerns regarding the dental hygienist. The OIG found that facility staff only submitted one patient safety concern through the JPSR system in the summer of 2021, regarding the dental hygienist. Supervisors acknowledged there were patient safety concerns regarding the dental hygienist, however, did not submit concerns through the JPSR system, advise staff to use the JPSR system, or notify patient safety, believing the incidents did not warrant reporting. Notably, the facility's patient safety manager told the OIG that all the dental hygienist's clinical practice concerns identified in this report warranted reports submitted through the JPSR system.

Management Review Not Considered

VHA guidance states that the peer review process includes an evaluation of a provider's care to determine whether the standard of care was met.[11] According to the facility's Peer Review Committee Charter, if a provider at the facility receives two level 3 peer reviews within a rolling 12-month period, the consideration of a focused review (management review) is indicated.[12] The OIG learned that two peer reviews related to care provided by the dental hygienist were completed. Later that year (2023), the facility risk managers received and reviewed another patient care concern and recommended a management review of the dental hygienist's care. The COS told the OIG that a management review was not completed because the dental hygienist

[9] VHA Directive 1050.01. The JPSR system is a web-based patient safety reporting system used in VHA to capture real time incident reporting data; Facility Policy MCP PS-21-01, *Patient Safety Event Reporting System*, April 21, 2021.

[10] Facility Policy MCP PS-21-01; VHA Directive 1050.01. According to VHA policy, a patient safety event "is an event, incident or condition, directly associated with care or services provided to a patient, that could have resulted or did result in unintentional harm."

[11] VHA Directive 1190, *Peer Review for Quality Management, November 21, 2018.* This directive was in place during the time of the events discussed in this report. It was amended by VHA Directive 1190 (1), *Peer Review for Quality Management*, July 19, 2024. Unless otherwise specified, the 2018 directive contains the same or similar language as the amended directive. A peer review is given a level of care rating of 1–3. Level 2 categorization is defined as "most experienced and competent clinicians might have managed the case differently, but it remains within the standard of care." Level 3 categorization is defined as "most experienced and competent clinicians would have managed the case differently."

[12] VHA Directive 1190. A management review is a non-protected review of clinical care that may provide a basis for a personnel action. A focused clinical care review is a type of management review that is defined as a "clinician-specific comprehensive clinical care review of a specific area of practice, a specific time period of practice, or both, when there is an identified concern or issue."

was not performing duties at the facility. However, a period of absence from the facility does not prohibit a management review from being conducted, as the management review may reveal patient harm and the need for related disclosures, follow-up care, and initiation of the SLB reporting process.[13] Further, the COS is responsible for addressing concerns related to perceived or actual compromises to patient safety and quality of care.[14]

Chief of Staff Unaware of the Extent of the Concerns

To promote a culture of safety, facility leaders should consider the high reliability organization (HRO) principles of being engaged and actively seeking knowledge through bidirectional communication.[15] WECARE leadership rounding is a method leaders may utilize to actively engage employees and patients and seek feedback; allowing leaders an opportunity to follow up on patient safety concerns.[16] The COS lacked knowledge of multiple deficiencies outlined in this report including infection control violations, false documentation in a patient's EHR, and patients' complaints of rough and painful cleanings. The COS knew of care deficiencies regarding the dental hygienist through VHA's peer review process and of medication storage violations. However, the COS did not utilize bidirectional communication to seek information from staff and did not participate in WECARE rounding; both of which could have led to increased knowledge of the scope of deficiencies regarding the dental hygienist's care. During an OIG interview, the COS reported relying on patient safety reports, the DCOS, and service chiefs to learn of persistent concerns regarding a provider's care. However, only one patient safety report was submitted, and the COS told the OIG that the DCOS only provided notification of a personnel action related to the dental hygienist's misconduct. The COS told the OIG that no additional action was taken to seek more information because the dental hygienist had left facility employment. The OIG would have expected the COS to gain a comprehensive

[13] Disclosures to patients or their personal representatives are required for the occurrence of "harmful or potentially harmful adverse events to patients or their personal representatives" and should be initiated "as soon as reasonably possible. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[14] VHA Directive 1900(3), *VA National Standards of Practice*, August 30, 2023; VHA Directive 1190.

[15] "An HRO is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results." "VHA's Vision for a High Reliability Organization," Health Services Research and Development, accessed November 6, 2023, https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm?ForumMenu=summer20-1; "The three pillars of the VHA's HRO strategy are leadership commitment, a culture of safety, and continuous process improvement." Gerard Cox and Leigh Starr, "VHA's Movement for Change: Implementing High-Reliability Principles and Practices," *Journal of Healthcare Management*, 68 no. 3 (May 31, 2023):151–157, https://doi.org/10.1097/JHM-D-23-00056; The Joint Commission, *Sentinel Event Alert,* Issue 57, March 1, 2017, (revised June 18, 2021).

[16] VA defines WECARE leadership rounding as a process in which facility leaders and managers conduct rounds in work and patient care areas to gather feedback from employees and patients. "WECARE Leadership Rounding," VA Diffusion Marketplace, accessed December 19, 2024, https://marketplace.va.gov/innovations/wecare-leadership-rounding.

understanding of the full scope of concerns related to the dental hygienist to be able to ensure patient safety and take actions as warranted.

The OIG made eight recommendations to the Facility Director related to addressing concerns substantiated in factfindings, identifying staff to serve as factfinders, ensuring timely action to address patient safety concerns, initiating the SLB reporting process, completing provider exit review forms, submitting patient safety reports, completing management reviews, and utilizing HRO principles.

VA Comments and OIG Response

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

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

COS	Chief of Staff
COPD	chronic obstructive pulmonary disease
EHR	electronic health record
HRO	high reliability organization
JPSR	Joint Patient Safety Reporting
OIG	Office of Inspector General
PIP	performance improvement plan
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Southern Nevada Healthcare System (facility) in Las Vegas to analyze facility leaders' response to allegations that a dental hygienist failed to follow Veterans Health Administration (VHA) and facility policies and provide quality care.[1]

Background

The facility is part of Veterans Integrated Service Network (VISN) 21 and is designated as a level 1b, high complexity facility.[2] The facility has seven outpatient clinics located in Las Vegas, Laughlin, Pahrump, and West Cheyenne. The main campus has a medical center that provides services to include medical, surgical, mental health, and dental. In calendar year 2023, the dental clinic completed 16,256 visits.

Dental Hygienist

A dental hygienist is a licensed healthcare provider and works under the general direction of a dentist or periodontist.[3] According to VHA policy, dental hygienists require credentialing and must practice within the scope of duties established by the state in which they are licensed.[4] Dental hygienists provide oral care including teeth cleanings, preventive dental care, and oral

[1] VHA defines quality as the delivery of "highly reliable health care services that are safe, timely, effective, efficient, equitable and patient-centered"; VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. This directive was in place during the time of the events discussed in this report. It was amended by VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language as the amended directive; Facility Standard Operating Procedure 160-22-18, "Dental Service Infection Control," November 1, 2022; VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015; Facility Policy 139-21-36, *Disposal of Hazardous and Non-Hazardous Pharmaceutical Drugs*, March 17, 2021; The chief of dental told the OIG the dental hygienist stopped providing patient care while on extended leave in spring 2023 and then retired in early 2024.

[2] VHA Office of Productivity, Efficiency and Staffing (OPES), "Facility Complexity Level Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

[3] A periodontist is a dentist specializing in the care of the gums or gingiva. "Dental Hygienists," Cleveland Clinic, accessed February 26, 2024, https://my.clevelandclinic.org/health/articles/dental-hygienist; "Periodontics/Periodontist," Cleveland Clinic, accessed February 26, 2024, https://my.clevelandclinic.org/health/articles/23461-periodontics-periodontist; VHA Directive 1130(1), *Veterans Health Administration Dental Program*, March 6, 2020; VHA Handbook 5005, *Staffing*, April 15, 2002.

[4] VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. Credentialing is "the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system"; VHA Directive 1100.21(1), *Privileging*, March 2, 2023; VHA Directive 1130(1).

hygiene instructions to patients.[5] In some states, a dental hygienist may administer injections of local anesthetic that can assist with patient comfort during dental procedures.[6]

Prior OIG Reports

In 2023, the OIG published a report identifying a concern that facility leaders did not initiate the state licensing board (SLB) process for a primary care provider who falsified blood pressure readings in patients' electronic health records (EHRs). The OIG made five recommendations, including a recommendation for the Facility Director to consider the need to report the primary care provider to the SLB. All five recommendations have been closed.[7]

Allegations and Related Concern

On September 7, 2023, the OIG Office of Investigations notified the OIG Office of Healthcare Inspections of allegations that a dental hygienist provided inadequate care, failed to follow infection control practices, and violated medication storage protocols. The OIG contacted the facility's Deputy Chief of Staff (DCOS) and identified a lack of actions taken by facility leaders to address the allegations.[8] On October 23, 2023, the OIG opened an inspection to assess concerns related to facility leaders' response to the allegations.

The OIG also assessed an additional concern identified during the inspection related to leaders' response to the dental hygienist falsifying a patient's EHR.[9]

Scope and Methodology

The OIG completed a site visit at the facility from December 12 through December 14, 2023. Additional virtual interviews were conducted prior to and after the site visit.

The OIG interviewed the VA Central Office of Dentistry Director of Business Operations, the VISN 21 Lead Dentist, and facility senior leaders; current and former service chiefs, supervisors,

[5] "Dental Hygienists," Cleveland Clinic, accessed November 1, 2023, https://my.clevelandclinic.org/health/articles/dental-hygienist.

[6] VA Directive 5005, *Staffing*, April 15, 2002. The licensed dental hygienist referenced in this report was certified to administer local anesthesia.

[7] VA OIG, *Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada*, Report No. 22-00707-44, January 25, 2023.

[8] The facility's former Deputy Chief of Staff (DCOS), referred to as the DCOS for the purposes of this report, informed the OIG of having vacated the position in late 2023.

[9] The concern regarding falsification of an EHR was founded in the facility's factfinding report. The OIG did not verify the information contained in the report.

and supervisory support staff; quality management, human resources, and front-line dental clinical staff; and the dental hygienist.[10]

The OIG reviewed VHA and facility policies and standard operating procedures specific to dental care, infection control practices, and medication handling procedures; external dental care standards and literature reviews; patient EHRs; police reports, personnel and credentialing records; staff training records; and quality management reviews.

The OIG made multiple attempts to interview the dental hygienist after the dental hygienist retired from the VA. As the OIG's attempts to interview the dental hygienist were unsuccessful, the OIG issued a subpoena to compel testimony and scheduled an interview in May 2024. The dental hygienist was unavailable in May 2024. Over the next few months, the OIG made numerous attempts to personally serve the subpoena, exhausting all traditional methods to effectuate service. All such attempts proved unsuccessful for lack of response or refusal of service acceptance. The United States Attorney, District of Nevada, filed an action requesting permission to effectuate service of the subpoena by alternative means, specifically, the dental hygienist's personal email. A United States District Court Magistrate Judge issued an Order, dated September 9, 2024, granting permission for the OIG to serve the dental hygienist by personal email. The subpoena was emailed to the dental hygienist's personal email effectuating service on September 13, 2024. The interview was conducted on October 29, 2024. When the OIG asked about the care that was provided to patients, the dental hygienist reported not recalling specifics.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. 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.

[10] Facility senior leaders referenced in this report are the Facility Director and Chief of Staff. The OIG used its testimonial subpoena authority to compel the dental hygienist and former chief of dental to testify.

Inspection Results

The OIG determined that the dental hygienist's supervisors (supervisors) did not ensure the correction of patient safety concerns related to the dental hygienist. Although the supervisors and staff identified clinical concerns related to the dental hygienist's practice for over two years, the Chief of Staff (COS) did not ensure the completion of a management review nor seek knowledge of the extent of the patient safety concerns.

From April 2021 through April 2023, three supervisors became aware of several patient care concerns regarding the dental hygienist that included 12 infection control violations, 6 medication storage policy violations, 16 clinical practice concerns, and 1 occurrence of falsifying medical record documentation.[11] The supervisors learned of the concerns through an audit, observations, and reports by dental clinical staff and patients.[12] See appendix A for a supervisory timeline.[13]

Supervisory Deficiencies

The OIG found that after identification, each patient safety concern was not reviewed and corrected, and concerns about the dental hygienist continued to be reported. Specifically, the OIG found that the supervisors did not

- take action after the falsification of a patient's EHR was substantiated and did not identify that two medication storage violations had erroneously been omitted from a factfinding that was not completed timely,
- correct repeated infection control violations and clinical practice concerns through a performance improvement plan (PIP) as intended,
- initiate the SLB reporting process, and
- ensure patient safety reporting.[14]

[11] The former DCOS served as one of the direct supervisors of the dental hygienist and is therefore noted in this report as one of the supervisors.

[12] Based on interviews with the OIG, the facility dental supervisors confirmed some instances when the dental hygienist violated infection control and medication storage policies, had deficiencies in clinical practice, and falsely documented in a patient's EHR. The OIG did not verify if facility dental supervisors substantiated each individual concern and patient complaint identified in this report.

[13] The underlined terms are hyperlinks to another section of the report. To return to point of origin, press and hold the "alt" and "left arrow" keys together.

[14] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. Medical facilities may report a provider after the completion of VHA's SLB process. This process includes a comprehensive review, and the objective of the review is " … is to present a balanced and complete picture in the file of the circumstances that formed the basis for the concern."

VA requires supervisors to facilitate prompt corrective actions when employees do not meet standards and take action if performance does not improve.[15]

Factfinding: Falsification of a Medical Record Not Addressed and Medication Storage Violations Not Reviewed

The OIG determined the chief of dental service (chief of dental) initiated a factfinding that substantiated the dental hygienist falsified a patient's EHR, however, action was not taken to address the false documentation. Additionally, the factfinding was not completed timely and did not include a review of medication storage violations as requested.

A factfinding is a type of administrative investigation used to collect and analyze evidence, "should be completed as promptly as possible," (usually within one day or up to three weeks), and may be used to support administrative or disciplinary actions.[16] VHA states that after substantiation of an allegation, a responsible official should initiate an action per policy.[17] VHA requires EHR notes to be accurate, clinically relevant, and contain pertinent facts about health history, examinations, and treatments.[18] The Centers for Medicare and Medicaid Services states, "inaccurate documentation can result in unintended and even dangerous patient outcomes."[19] Safe medication storage requirements assist in maintaining medication integrity and reducing dispensing errors.[20] Facility policy states that unused medications will be returned to the automated dispensing cabinet each day.[21]

Through document review, the OIG found that the dental hygienist improperly stored anesthetic medications. In April 2022, the chief of dental became aware of a medication storage violation in which anesthetic carpules were discovered in a cup, by another dental staff member, in an unlocked cabinet within the dental hygienist's operatory.[22] The VA police investigated and found

[15] VA Directive 5013, *Performance Management Systems*, April 15, 2002; VA Directive 5021, *Employee/Management Relations*, April 15, 2002.

[16] VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

[17] VA Directive 5021, *Employee/Management Relations, April 15, 2002.*

[18] VHA Program Guide, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023.

[19] Centers for Medicare and Medicaid Services, *Documentation Matters Toolkit*, September 10, 2024.

[20] The Joint Commission, *Medication Management & Storage in Ambulatory Healthcare Settings*, July 7, 2022.

[21] Facility Policy 119-22-23, *Medication Administration*, April 6, 2022; Facility Policy 119-20-07, *Pharmacy Automated Dispensing Cabinets (ADCs)*, May 6, 2020. An automatic dispensing cabinet is a "a drug storage device or cabinet that electronically dispenses medications in a controlled fashion and tracks medication use."

[22] Dental carpules are small glass tubes containing anesthetic medications. The carpules are screwed onto a dental syringe and injected into the patients by the practitioner. US Department of Labor, Occupational Safety and Health Administration, *Standards Interpretations letter to Kendall Mower*, January 9, 2007, accessed February 14, 2024, https://www.osha.gov/laws-regs/standardinterpretations/2007-01-09-0; An operatory is a "working space" for a dentist, *Merriam-Webster.com Dictionary*, "operatory*,"* accessed March 11, 2024, https://www.merriam-webster.com/medical/operatory.

no criminality regarding the violation. The chief of dental provided medication storage reeducation for all dental staff that same month.

The OIG learned that the chief of dental requested a factfinding related to assessing conduct concerns, privacy violations, and the falsification of a patient's EHR in June 2022. However, according to the executive assistant to the DCOS, the factfinding was not initiated until September 2022 due to a lack of experienced and available factfinding investigators.

Following the request for the factfinding, the chief of dental became aware of two additional instances of medication storage violations in which dental staff discovered anesthetic carpules improperly stored in cups in unlocked areas of the dental hygienist's operatory, and emailed the information to the factfinder for review. However, the designated factfinder told the OIG the concerns were not reviewed or included in the final report because a human resources staff member reported that both violations had been previously addressed.[23] Contrary to the belief that both violations had been previously addressed, the OIG found that the medication storage violations sent to the factfinder for inclusion in the factfinding were not the same medication storage violations that were previously addressed. During an interview with the OIG, the chief of dental reported not supervising the dental hygienist when the factfinding was completed and therefore, was not made aware of the factfinding results. The chief of dental did not become aware that the two additional medication storage violations were not incorporated into the factfinding and remained unaddressed.

In an interview with the OIG, the DCOS reported becoming the dental hygienist's supervisor in October 2022. In November 2022, over six months after the initial request, the factfinding was completed and substantiated conduct concerns, privacy violations, and falsification of a medical record.[24] In response, the DCOS recommended disciplinary action, however, stated that due to human resources staff's guidance and consideration for delays with the factfinding, a written counseling was issued. The OIG reviewed the written counseling and noted that the counseling did not address the medical record falsification. The DCOS told the OIG of relying on human resources staff to draft the written counseling letter but the human resources staff member stated the letter was prepared and issued by the DCOS. The OIG would have expected the DCOS to have ensured that the medical record falsification was included in the written counseling or taken other action to attempt to correct the deficiency.

The OIG concluded that the DCOS did not initiate an action after the factfinder substantiated the allegation that the dental hygienist entered false documentation in a patient's EHR. Additionally, due to misinformation, two instances of medication storage violations were not investigated.

[23] The prior medication storage violations that had been addressed occurred in April 2021 and April 2022.

[24] During an OIG interview, the dental hygienist was unable to recall falsifying a patient's record but noted that a documentation error could have mistakenly occurred.

Performance Improvement Plan Not Issued to Address Infection Control and Clinical Practice Concerns

The OIG determined that the DCOS failed to follow through with an intention to place the dental hygienist on a PIP after repeated clinical practice concerns and infection control violations. Notably, the clinical practice concerns and infection control violations were not addressed in the factfinding previously referenced in this report.

The American Dental Association states dental cleanings are important, as "significant associations between oral health status and a number of systemic diseases have been established, including but not limited to cardiovascular diseases, Alzheimer's disease and dementia, obesity, diabetes and metabolic disorders, rheumatoid arthritis, and several cancers."[25] Infection control violations can place patients, families, and healthcare workers at risk for transmissible diseases and other infectious microorganisms.[26]

Supervisors who are aware of unacceptable performance or failure to meet performance standards may give the employee an opportunity to improve through a PIP, which clarifies expectations, identifies how performance will be monitored, and reviews the employee's progress.[27]

The OIG reviewed facility documents and found that most of the clinical practice concerns and infection control violations were reported from October 2022 through March 2023, during the time the DCOS supervised the dental hygienist. Clinical practice concerns included patient complaints of teeth cleanings of poor quality or short duration, rough and painful teeth cleanings, the under- or overuse of local anesthesia medication, and failure to provide proper care to a patient with special medical needs.[28]

Specifically, the chief of dental told the OIG that scaling and root planing of the entire mouth should take 50 minutes to complete, and the dental hygienist was completing this procedure in 15–20 minutes.[29] The Director of Business Operations from the VHA Office of Dentistry told the

[25] American Dental Association, "Oral-Systemic Health," accessed October 21, 2024, https://www.ada.org/resources/ada-library/oral-health-topics/oral-systemic-health.

[26] VA Dentistry, *Infection Control Standards for VA Dental Clinics*, September 11, 2015, revised May 9, 2024.

[27] VA Directive 5013.

[28] A local anesthetic is "usually a one-time injection of medicine that numbs a small area of the body." "Local Anesthesia," American Society of Anesthesiologist, accessed November 2, 2023. https://www.asahq.org/madeforthismoment/anesthesia-101/types-of-anesthesia/local-anesthesia/. The dental hygienist referenced in this report was permitted to administer injections of local anesthesia by licensure and prior training.

[29] "Scaling and root planing are otherwise known as a deep cleaning in dentistry." "Tooth scaling removes tartar from the surface of your teeth that you see when you smile." "Root planing removes tartar from the roots of your teeth below your gum line." Cleveland Clinic, "Tooth Scaling and Root Planing," accessed November 2, 2023, from https://my.clevelandclinic.org/health/treatments/23983-tooth-scaling-and-root-planing.

OIG that if the dental hygienist was finishing cleanings in 15 to 20 minutes, there would be concerns regarding the quality of the cleanings, adherence to infection control standards, and proper review of the patient's medical history.[30]

The OIG evaluated two patients' written complaints submitted to the facility stating that rough and painful cleanings performed by the dental hygienist resulted in injury—a cut gum and a chipped tooth. Another example of a clinical practice concern involved a patient's (Patient A) report that the dental hygienist's care at a prior visit resulted in "excessive amounts of bleeding" and a "significant loss of gum tissue" that required a corrective procedure. The OIG reviewed Patient A's EHR and found that after receiving the complaint, the chief of dental referred Patient A to a community periodontist for additional care.[31]

A patient (Patient B), with moderate periodontitis, alleged that the dental hygienist administered multiple local anesthetic injections during one visit.[32] The chief of dental told the OIG of interpreting Patient B's allegation as indicating that the dental hygienist over administered local anesthetic medication. The OIG reviewed Patient B's EHR and found that the dental hygienist used five carpules of injectable anesthetic medication, whereas other providers either used topical anesthetic or less of the injectable medication during prior cleanings. In addition, after the completion of a mandibular arch cleaning, the dentist recommended a return for a complete maxillary arch cleaning.[33] However, during the follow-up visit, the dental hygienist performed another cleaning on the mandibular arch and neglected to clean the maxillary arch as planned by the dentist. If left untreated, moderate periodontitis can result in the erosion of ligaments, soft tissues, and bones that hold teeth in place.[34]

[30] The Cleveland Clinic states, "On average, routine dental cleanings take between 30 minutes and an hour. If you're undergoing debridement or scaling and root planing, it could take longer." Cleveland Clinic, "Dental Cleaning," accessed February 19, 2025, https://my.clevelandclinic.org/health/treatments/11187-dental-check-up.

[31] "Periodontics is the branch of dentistry that focuses on the health of your gums and jawbone–the tissues that support |your| teeth.", Cleveland Clinic, accessed February 26, 2024, "Periodontitis," https://my.clevelandclinic.org/health/articles/23461-periodontics-periodontist.

[32] "Periodontitis is an oral health condition that causes sore, bleeding, swollen gums. Left untreated, periodontitis can lead to tooth loss, bone loss, bad breath, and other oral health problems. You can manage mild periodontitis with a deep dental cleaning. More severe cases require surgery." "Periodontitis," Cleveland Clinic, accessed February 24, 2025, "https://my.clevelandclinic.org/health/diseases/16620-periodontitis.

[33] The maxillary arch is the upper jaw and teeth; the mandible arch is the lower jaw and teeth. The dentist performed scaling and root planing of the mandibular arch in early 2023 and documented a plan for a complete maxillary arch scaling and root planing two months later. The dental hygienist performed scaling and root planing of the mandibular arch.

[34] Cleveland Clinic, "Periodontal Disease (Gum Disease)," accessed February 24, 2025, https://my.clevelandclinic.org/health/diseases/21482-gum-periodontal-disease.

Care received by patients A and B was referred for peer review for quality management; the dental hygienist went on extended leave prior to the completion of the peer review process.[35] To address other clinical practice concerns, the DCOS reported contacting the patients who had expressed concerns regarding care, completing reviews of the care provided, and reviewing cases with the dental hygienist.

The OIG also learned that the dental hygienist violated infection control protocols by not maintaining clean operatory space and equipment, wearing contaminated gloves in the hallways, and using poor hand washing practices. A staff dentist told the OIG of one instance when the dental hygienist's operatory chair and lines for the evacuation system trap were found to be dirty.[36] The dental hygienist failed a hand hygiene audit and was also observed on multiple occasions wearing soiled gloves in the hallway while escorting patients. The infection prevention and control manager told the OIG that failing to clean equipment and wearing soiled gloves may result in the transmission of microorganisms and increase the risk to patients.

To correct infection control violations, the DCOS told the OIG of providing verbal counseling and education to the dental hygienist. The chief of dental also arranged for infection control training for all dental clinic staff. After additional infection control violations, the dental hygienist was scheduled for individual infection control training, however, the DCOS reported that the dental hygienist did not attend due to being on extended leave from the facility. Contrary to the DCOS's claim, facility documentation reflected that the training was scheduled in early spring 2023, prior to the dental hygienist's extended leave, and that the dental hygienist declined to attend.

The DCOS explained that after consultation with human resources staff in January 2023, the decision was made to place the dental hygienist on a PIP to correct the clinical practice concerns and infection control violations and would include retraining, post teeth-cleaning evaluations, and monitoring of infectious disease protocols. The DCOS stated that the PIP was not issued as the dental hygienist was on extended leave and had filed an administrative action that was

[35] A peer review's "primary focus is whether the clinical decisions and actions of a clinician during a specific clinical encounter met the standard of care." Standard of care "is a diagnostic and/or treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance. It is how similarly qualified clinicians would have managed the patient's care under the same or similar circumstances." VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018. This directive was in place during the time of the events discussed in this report. It was amended by VHA Directive 1190 (1), *Peer Review for Quality Management*, July 19, 2024. Unless otherwise specified, the 2018 directive contains the same or similar language as the amended directive.

[36] The evacuation system contains a saliva ejector; lines that carry the water, debris, and particles away from the patient; and an internal trap to catch debris. A saliva ejector instrument is used "to remove excess saliva or water from the oral cavity during dental procedures." "Quiz: How Well Do You Know Your Dental Instruments?", Blake Austin College, accessed November 7, 2024, https://blakeaustincollege.edu/how-well-do-you-know-your-dental-instruments/. Facility SOP 160-22-12, *Preventative Maintenance of Dental Equipment used within the Dental Service*, November 1, 2022; Two staff dentist and the infection control coordinator told the OIG, possible fungal or respiratory infections were a risk to patients if the evacuation system was not maintained.

pending. However, the OIG found that the dental hygienist was working in the dental clinic until April 2023. Notably, six additional clinical practice concerns and five additional infection control violations were reported after the DCOS's consultation with the human resources staff member. The OIG noted the DCOS had a duty to ensure correction of clinical practice concerns and infection control violations while the dental hygienist continued to provide patient care.

The OIG concluded that the DCOS did not initiate a PIP as planned to correct the dental hygienist's performance. Failure to ensure the correction of the dental hygienist's deficiencies placed additional patients at risk.

State Licensing Board Reporting Process Not Initiated

The OIG was unable to determine whether the DCOS contacted the credentialing and privileging manager to initiate the SLB reporting process due to lack of recollection and documentation. Additionally, the chief of dental did not accurately reflect the failure to meet generally accepted standards of practice on the provider exit review form following the dental hygienist's separation from the facility. An accurate provider exit review form would have prompted initiation of the SLB reporting process.[37]

Notification to the Credentialing and Privileging Manager

According to VHA policy, supervisors must notify the credentialing and privileging manager upon awareness that a licensed healthcare professional failed to meet generally acceptable standards of care to initiate the SLB reporting process.[38] Falsification of medical records and significant deficiencies in clinical practice create a concern for patient safety and should be reported to the SLB.[39]

The following are patient safety concerns that the DCOS was aware of and should have considered reporting to the credentialing and privileging manager:

- In November 2022, the DCOS signed the finalized factfinding report related to the dental hygienist that identified an occurrence of false documentation in a patient's EHR.

[37] VHA Directive 1100.18. The provider exit review form is a review that "must be conducted to confirm that the licensed provider's clinical practice met the standard of care during the provider's professional relationship with the facility."

[38] VHA Directive 1100.18.

[39] VHA Directive 1100.18.

- From December 2022 through March 2023, the DCOS became aware of repeated clinical practice concerns and medication storage and infection control violations regarding the dental hygienist.[40]
- In February 2023, the chief of dental notified the DCOS of multiple documented infection control violations and emphasized that the violations "can have damaging effects to our veteran patients."

The DCOS described patient complaints as "veteran experience issues that required service level recovery" and initially told the OIG of the belief that SLB reporting was not warranted. Later the DCOS told the OIG of the intention to initiate the SLB reporting process. Specifically, the DCOS told the OIG of recommending a comprehensive review of the dental hygienist's care, a step in the SLB reporting process, to the credentialing and privileging manager. The DCOS reported receiving a recommendation instead to bring cases forward for peer review. The credentialing and privileging program manager was unable to recall being contacted regarding the initiation of the SLB reporting process, and the DCOS was unable to provide the OIG with written documentation of the notification.

The OIG would have expected that due to the awareness of care deficiencies and the safety concern relayed by the chief of dental, the DCOS would have initiated the SLB reporting process by notifying the credentialing and privileging manager of the patient safety concerns. However, due to conflicting recollections and lack of documentation, the OIG was unable to determine whether the DCOS contacted the credentialing and privileging manager.

Inaccurate Completion of the Provider Review Form

VHA policy states that an employee's supervisor must complete an exit review form for all licensed healthcare professionals who leave employment at the facility.[41] The supervisor should document on the form when a provider fails to meet generally accepted standards of practice as to raise reasonable concern for the safety of patients, thus initiating the SLB reporting process.[42] Exit review forms are a part of the healthcare professional's credentialing file, which can be shared with other VA facilities upon request, particularly when a provider transfers to another

[40] Two more medication storage violations were reported in March 2023 and were also referred to VA police. The DCOS told the OIG of an intention to administer disciplinary action upon the dental hygienist's return from extended leave.

[41] VHA Directive 1100.18.

[42] VHA Directive 1100.18; VHACO Medical Staff Affairs, VHA Credentialing Directive 1100.20: Standard Operating Procedure - *C35 Inactivation in VetPro*, May 13, 2021.

VA facility. Additionally, human resources staff may view the file as a part of the hiring process if the provider seeks to return to VA service.[43]

The chief of dental told the OIG of returning to the role of the dental hygienist's supervisor in early 2024, and the dental hygienist left employment at the facility two days later. The chief of dental completed the provider exit review form a few days after the dental hygienist left employment without notating any clinical care deficiencies or clinical care concerns.

During a discussion with the OIG, the chief of dental acknowledged that the dental hygienist failed to meet generally accepted standards of clinical practice, particularly related to the repeated infection control violations. Further, the chief of dental acknowledged that the infection control issues raised concern for the safety of patients. The chief of dental told the OIG of consulting with the credentialing and privileging manager and being advised to select the "generally met accepted standards of clinical practice" option on the form because substantial personnel action had not been taken against the dental hygienist. The credentialing and privileging manager recalled having a discussion with the chief of dental but was unable to recall the content of the discussion. When asked if a substantial personnel action was required to select that clinical standards were not met, the credentialing and privileging manager replied that "disciplinary action could be a determining factor if it raised reasonable concern for the safety of patients," but was unaware if substantial personnel action was a requirement. The VA Deputy Director for Adverse Privileging Actions and SLB / NPDB [National Practitioner Data Bank] confirmed to the OIG that there is no such requirement. Due to the totality of deficiencies documented and acknowledgment of patient safety concerns, the OIG would have expected the chief of dental to have selected "failed to meet generally accepted standards of practice as to raise reasonable concern for the safety of patients" on the provider exit review form.

The OIG concluded that the SLB reporting process was not initiated, potentially preventing other VA and non-VA facilities from being alerted to clinical care concerns involving the dental hygienist, therefore placing future patients at risk. In addition, if the dental hygienist seeks employment at another VA facility, the exit review form will not alert the facility of any clinical care concerns.

Lack of Patient Safety Reporting

The OIG determined that the supervisors did not ensure that patient safety concerns regarding the dental hygienist were reported through the Joint Patient Safety Reporting (JPSR) system as

[43] VHA Directive 1100.20. "Credentials are documented evidence of licensure, education, training, experience, or other qualifications." VetPro is "VHA's mandatory credentialing software platform to document the credentialing of VHA health care providers."

required by facility policy.[44] Failure to report patient safety concerns limited senior leaders' awareness and further assessment of the dental hygienist's care.

Facility policy requires staff to report patient safety events utilizing the JPSR system.[45] Service chiefs are responsible to ensure compliance with facility policy for reporting. Upon receiving patient safety reports, the patient safety manager reviews and coordinates further assessment and actions needed.[46]

The OIG reviewed facility documents and found a staff member submitted one patient safety report in summer 2021 regarding the dental hygienist. One dental clinic staff member reported being unfamiliar with the JPSR system, and another reported receiving instruction to relay concerns to the administrative officer. Multiple staff reported notifying supervisors of patient safety concerns. Supervisors acknowledged becoming aware of patient safety concerns regarding the dental hygienist, but did not submit JPSRs. Instead, supervisors addressed the safety concerns through either education or verbal counseling. The chief of dental told the OIG of the belief that the incidents did not meet criteria for reporting. The DCOS told the OIG that JPSR reports were not entered for patient complaints of clinical practice concerns as "these were veteran experience issues that required service level recovery." However, the OIG found that multiple clinical practice concerns were related to quality of care and patient safety, as opposed to veteran experience.[47] The patient safety manager informed the OIG that clinical practice concerns regarding the dental hygienist identified during this inspection justified patient safety reporting.

The patient safety manager also told the OIG that patient safety reports are presented daily to senior leaders; if the reports identify any trends specific to a provider, the information is forwarded to risk managers and the chief of quality for review and potential escalation to the COS or Facility Director. The COS and the chief of quality reported not being aware of all the patient safety concerns identified in this report. The COS told the OIG of being aware of all

[44] VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The JPSR system is a web-based patient safety reporting system used in VHA to capture real time incident reporting data; Facility Policy MCP PS-21-01, *Patient Safety Event Reporting System*, April 21, 2021.

[45] Facility Policy MCP PS-21-01; VHA Directive 1050.01. According to VHA policy, a patient safety event "is an event, incident or condition, directly associated with care or services provided to a patient, that could have resulted or did result in unintentional harm."

[46] VHA Directive 1050.01; Facility Policy MCP PS-21-01.

[47] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020; VA defines patient experience as "the sum of all interactions shaped by the organization's culture, that influence Veterans' and their families' perceptions along their healthcare journey. Patient experience is the organizational alignment of people, processes, and culture around the common goal of creating a consistent, exceptional experience for Veterans, their families, caregivers and survivors." "Using Data, Tools, and Technology to Improve the Patient Experience," VA Health Systems Research, Fall 2020, accessed February 6, 2025, https://www.hsrd.research.va.gov/publications/forum/fall20/default.cfm?ForumMenu=fall20-1#:~:text=The%20VA%20Patient%20Experience%20framework,the%20patient%20experience%20across%20VHA.

patient safety reports that are entered in the JPSR system and confirmed the expectation that the JPSR system be utilized.

The OIG concluded that although staff reported multiple patient safety concerns to the supervisors, only one JPSR report was submitted. Due to the failure to submit patient safety reports, the patient safety manager, chief of quality, and facility leaders had limited awareness of patient safety concerns related to the dental hygienist's care and, therefore, did not further assess the concerns.

Chief of Staff's Inaction

The OIG determined the COS did not conduct a follow-up review of a concern related to the care the dental hygienist provided to a patient with special medical needs and effectively utilize high reliability organization (HRO) principles to become aware of the full extent of the patient safety concerns.[48]

The COS has a core responsibility to oversee the quality and safety of clinical care and services provided to patients at the facility, and review and address concerns related to perceived or actual compromises to patient safety and quality of care.[49]

Management Review Not Considered

According to the American Dental Hygienists' Association Standards for Clinical Dental Hygiene Practice, the care provided by a dental hygienist should be delivered in a manner that minimizes risks and should consider factors including diseases or conditions such as chronic obstructive pulmonary disease (COPD), or a physical disability.[50]

VHA guidance states that the peer review process includes an evaluation of a provider's care to determine whether the standard of care was met.[51] The facility's Peer Review Committee Charter

[48] "An HRO is an organization that experiences fewer than anticipated accidents or events of harm despite operating in highly complex, high-risk environments where even small errors can lead to tragic results." "VHA's Vision for a High Reliability Organization," Health Services Research and Development, accessed November 6, 2023, https://www.hsrd.research.va.gov/publications/forum/summer20/default.cfm?ForumMenu=summer20-1.

[49] VHA Directive 1900(3), *VA National Standards of Practice*, August 30, 2023; VHA Directive 1190.

[50] Patient-centered care asserts that the patient "is the main focus of attention," and their "needs are of utmost importance in providing evidence-based care." American Dental Hygienists' Association, "Standards for Clinical Dental Hygiene Practice," revised 2016, accessed October 26, 2023, https://www.adha.org/wp-content/uploads/2022/11/2016-Revised-Standards-for-Clinical-Dental-Hygiene-Practice.pdf.

[51] VHA Directive 1190. A peer review is given a level of care rating of 1–3. Level 2 categorization is defined as "most experienced and competent clinicians might have managed the case differently, but it remains within the standard of care." Level 3 categorization is defined as "most experienced and competent clinicians would have managed the case differently."

outlines that if a provider receives two level 3 peer reviews within a rolling 12-month period, the consideration of a focused review (management review) is indicated.[52]

The OIG learned that two peer reviews related to care provided by the dental hygienist were completed. Additionally, the OIG learned that the facility risk managers became aware of another care concern involving a patient (Patient C) with end-stage oxygen-dependent COPD who reported that during a teeth-cleaning procedure, the dental hygienist delivered too much water, making it hard for the patient to breathe.[53] Patient C reported difficulty breathing to the dental hygienist who continued to administer water. Patient C was admitted to the hospital five days after the cleaning with a diagnosis of respiratory failure and pneumonia.[54] The consulting pulmonary provider noted in Patient C's EHR the worsening of the patient's severe COPD was likely related to aspiration pneumonia after a "recent dental procedure."[55]

A risk manager notified the COS that the dental hygienist exceeded the quality indicator threshold and recommended a management review of the dental hygienist's care.[56] The COS told the OIG that a management review was not completed because the dental hygienist was not performing duties at the facility at that time due to being on extended leave. During an interview, however, the COS recognized that a review of care could still be completed and may identify patient harm incidents. The OIG determined that a period of absence from the facility does not prohibit a management review from being conducted, which may reveal patient harm and the need for related disclosures, follow-up care, and possible initiation of the SLB reporting process.[57]

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[52] VHA Directive 1190. A management review is a non-protected review of clinical care that may provide a basis for a personnel action. A focused clinical care review is a type of management review that is defined as a "clinician-specific comprehensive clinical care review of a specific area of practice, a specific time period of practice, or both, when there is an identified concern or issue."

[53] "Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing.", Mayo Clinic, *COPD*, accessed March 11, 2024. https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679.

[54] Pneumonia is inflammation and fluid in the lungs that can be caused by a bacterial, viral, or fungal infection and can affect one or both lungs. Cleveland Clinic, *Pneumonia*, accessed March 12, 2034, https://my.clevelandclinic.org/health/diseases/4471-pneumonia#additional-common-questions; Respiratory failure is a condition where there is not enough oxygen in the tissues in the body or when there is excess carbon dioxide in the body. Respiratory failure can occur acutely or chronically. Cleveland Clinic, *Respiratory Failure*, accessed March 12, 2024, https://my.clevelandclinic.org/health/diseases/24835-respiratory-failure.

[55] "Aspiration pneumonia is an infection of the lungs caused by inhaling saliva, food, liquid, vomit and even small foreign objects." Cleveland Clinic, *Aspiration Pneumonia*, accessed March 11, 2024, https://my.clevelandclinic.org/health/diseases/21954-aspiration-pneumonia.

[56] VHA Directive 1190.

[57] Disclosures to patients or their personal representatives are required for the occurrence of "harmful or potentially harmful adverse events to patients or their personal representatives" should be initiated "as soon as reasonably possible." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

The OIG concluded that the COS did not ensure a management review was considered after the dental hygienist exceeded quality review indicators due to the misbelief that active performance of duties was required.

Unaware of the Extent of the Concerns

According to facility documents, the COS is responsible for providing oversight of all clinical operations and ensuring patients receive quality care. Therefore, it is incumbent on the COS to have an awareness of providers who are not providing quality care at the facility. To promote a culture of safety, facility leaders should consider the use of HRO principles of being engaged and actively seeking knowledge through bidirectional communication.[58] WECARE leadership rounding is a method leaders may utilize to actively engage employees and patients and seek feedback, allowing leaders an opportunity to follow up on concerns.[59]

From April 2021 through January 2024, the supervisors learned of 35 separate instances of care concerns regarding the dental hygienist. During an OIG interview, the COS reported relying on patient safety reports, the DCOS, and service chiefs to learn of persistent concerns regarding a provider's care. However, only one patient safety report was submitted, and the COS told the OIG that the DCOS only provided notification of a personnel action related to the dental hygienist's misconduct. The COS learned of care deficiencies related to patients A, B, and C following submissions by the chief of dental and risk managers requesting clinical review of the care provided by the dental hygienist. In December 2024, the COS told the OIG of becoming aware of medication storage violations and of teeth cleanings that were short in duration.[60] However, the OIG is concerned the COS lacked knowledge of the other deficiencies outlined in this report including

- multiple infection control violations,
- a factfinding that substantiated an occurrence of false documentation in a patient's EHR, and

[58] "The three pillars of the VHA's HRO strategy are leadership commitment, a culture of safety, and continuous process improvement." Gerard Cox and Leigh Starr, "VHA's Movement for Change: Implementing High-Reliability Principles and Practices," *Journal of Healthcare Management*, 68 no. 3 (May 31, 2023):151–157, https://doi.org/10.1097/JHM-D-23-00056; The Joint Commission, *Sentinel Event Alert,* Issue 57, March 1, 2017 (revised June 18, 2021).

[59] VA defines WECARE leadership rounding as a process in which facility leaders and managers conduct rounds in work and patient care areas to gather feedback from employees and patients. "WECARE Leadership Rounding," VA Diffusion Marketplace, accessed December 19, 2024, https://marketplace.va.gov/innovations/wecare-leadership-rounding.

[60] A facility staff dentist told the OIG that taking inadequate time to remove deposits from the teeth may place patients at risk for bacterial transmission to the heart. The COS could not recall the period over which the complaints were made about the dental hygienist's teeth cleanings that were short in duration.

- multiple patient complaints of rough and painful teeth cleanings.

The OIG found that the COS did not utilize bidirectional communication with the chief of dental and DCOS to seek additional knowledge after learning of three patient care concerns, conduct concerns, and receiving a recommendation for a management review. The COS told the OIG that no additional action was taken to engage staff and seek more information because the dental hygienist had left employment.

In September 2020, VHA promoted the adoption of WECARE leadership rounding by facility leaders.[61] WECARE rounding aligns with HRO principles by strengthening leaders' commitment to continuous improvement and communication.[62] The facility was listed as successfully adopting the WECARE rounding process.[63] The OIG reviewed rounding documentation from January 2022 through December 2023, and found that the COS was not listed as having participated in WECARE rounding in the dental clinic. Although the COS told the OIG of conducting walk-throughs of various services, including the Dental Service, WECARE rounding to actively engage patients and staff may have provided the COS with an opportunity for increased awareness. The COS told the OIG that if aware of care concerns involving the dental hygienist, additional reviews and potential disclosures would have resulted.

The OIG concluded that the COS did not effectively utilize bidirectional communication and rounding. The COS must seek a comprehensive understanding of ongoing care concerns related to providers at the facility to be able to ensure patient safety and take actions as warranted.

Conclusion

The supervisors did not ensure the correction of patient safety concerns related to the dental hygienist, which included infection control, medication storage, clinical care, and documentation. The DCOS did not take appropriate action following substantiation that the dental hygienist entered false documentation in a patient's EHR. Additionally, the DCOS did not routinely monitor the dental hygienist's infection control and clinical practices and utilize a PIP to correct performance deficits.

Given the totality of the clinical and safety concerns identified in this report, the OIG would have expected the SLB reporting process to have been initiated and the provider exit review form to have reflected that the dental hygienist failed to meet generally accepted standards of practice. Failure to initiate the SLB reporting process and document patient safety concerns on the

[61] "WECARE Leadership Rounding," VA Diffusion Market Place.
[62] "WECARE Leadership Rounding," VA Diffusion Market Place.
[63] "WECARE Leadership Rounding," VA Diffusion Market Place.

provider exit review form may prevent other VA and non-VA facilities from being informed that a healthcare professional's previous practice raised patient safety concerns.

The supervisors did not ensure that patient safety reports were submitted through the JPSR system, limiting quality management and facility leaders' awareness of patient safety concerns regarding the dental hygienist's care. The COS also did not ensure that a management review was considered for the dental hygienist's care or effectively utilize HRO principles to become aware of the full extent of the patient safety concerns. The failures of supervisors and the COS in monitoring and addressing the dental hygienist's known deficiencies in clinical practice placed patients at risk.

Recommendations 1–8

1. The VA Southern Nevada Healthcare System Director ensures that clinical service chiefs take action to address concerns substantiated in factfindings, and that all patient safety concerns identified in factfindings are reviewed and addressed.
2. The VA Southern Nevada Healthcare System Director evaluates the need for additional factfinders, and takes action as warranted.
3. The VA Southern Nevada Healthcare System Director ensures that clinical service chiefs take action timely when aware of patient safety concerns.
4. The VA Southern Nevada Healthcare System Director reviews the information outlined in this report, determines the need to initiate the state licensing board reporting process, and takes action as warranted.
5. The VA Southern Nevada Healthcare System Director requires clinical service chiefs and credentialing and privileging managers to receive education on the completion of provider exit review forms and that, when supervisory staff contact credentialing and privileging staff for initiation of the state licensing board reporting process, a process is in place to ensure the message is clear and received.
6. The VA Southern Nevada Healthcare System Director ensures that clinical service chiefs and staff are educated on the need and process for submitting Joint Patient Safety Reporting reports upon awareness of patient safety events in accordance with facility policy.
7. The VA Southern Nevada Healthcare System Director educates the Chief of Staff on the need to complete management reviews when warranted, ensures that a review occurs of the dental hygienist's care of Patient C, and ensures disclosure is provided if warranted.
8. The VA Southern Nevada Healthcare System Director makes certain that the Chief of Staff utilizes high reliability organization principles and establishes a process for the communication of pervasive concerns regarding a provider's care.

Appendix A

Table A.1. Supervisory Timeline

Dental Hygienist's Supervisor	Dates of Supervision
Former chief of dental*	2013–July 2021
Chief of dental‡	July 2021–October 2022; January 2024
Deputy Chief of Staff§	October 2022–December 2023

Source: OIG document reviews and interviews.

**The former chief of dental reported transitioning from full time to part time in mid-2020.*

‡The chief of dental was detailed to the chief of dental position in July 2021 and permanently appointed in September 2021.

§The DCOS became the direct supervisor of the dental hygienist (October 2022); however, the chief of dental continued to provide clinical oversight of the dental hygienist during this time and reported any concerns to the DCOS.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 24, 2025

From: Director, Sierra Pacific Network (10N21)

Subj: Department of Veterans Affairs (VA) Office of Inspector General (OIG) Healthcare Inspection—Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at the VA Southern Nevada Healthcare System in Las Vegas

To: Director, Office of Healthcare Inspections (54HL10)
Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed the draft report Healthcare Inspection – Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at VA Southern Nevada Healthcare System in Las Vegas.

2. The VA Southern Nevada Healthcare System is committed to honoring the Nation's Veterans by ensuring they receive high-quality health care services. I support the Director's response and the action plan of the VA Southern Nevada Healthcare System in Las Vegas.

3. I would like to thank the Office of Inspector General for their thorough review of this case. If you have any additional questions, please contact the VISN 21 Quality Management Officer (QMO).

(*Original signed by:*)

Ada Clark, FACHE, MPH

[OIG comment: The OIG received the above memorandum from VHA on June 30, 2025.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 24, 2025

From: Director, VA Southern Nevada Healthcare System

Subj: Healthcare Inspection—Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at the VA Southern Nevada Healthcare System in Las Vegas

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report from the OIG Office of Healthcare Inspections on-site visit conducted at the VA Southern Nevada Healthcare System from December 12 through December 14, 2023.

2. As a high reliable organization, VA Southern Nevada Healthcare System is committed to fostering a culture of safety-focused leadership and staff accountability, and continuous improvement, driving excellence in patient care and outcomes. Joint Patient Safety Reporting (JPSR) is a cornerstone of a high reliable health care system as it fosters transparency, encouraging open communication among staff.

3. The VA Southern Nevada Healthcare System JPSR reporting was one of the highest in Veterans Integrated Service Network (VISN) 21 in fiscal year 2024. Additionally, the VA Southern Nevada Healthcare System's close call/adverse event ratio is above both National and VISN 21 benchmarks. JPSR training continues to be included in New Employee Orientation and was an agenda item on previous monthly Safety Forums.

4. We find the overarching conclusions valuable and appreciate the comprehensive and thorough analysis. Please find the attached response to each recommendation included in the report. We will take actions as recommended by the OIG to strengthen the care we provide.

5. If you have any additional questions, please contact the Quality Management Officer (QMO).

(*Original signed by*:)

Michael L. Kiefer, MHA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on June 30, 2025.]

Facility Director Response

Recommendation 1

The VA Southern Nevada Healthcare System Director ensures that clinical service chiefs take action to address concerns substantiated in factfindings, and that all patient safety concerns identified in factfindings are reviewed and addressed.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System's Director will ensure that clinical service chiefs take action to address the concerns the fact findings substantiated and that all patient safety concerns, which fact findings identified, are reviewed and addressed. Facility leaders took appropriate corrective actions in collaboration with Employee Relations Labor Relations (ERLR)/Human Resources (HR). On August 26, 2024, the Executive Leadership Board approved a new facility Standard Operating Procedure (SOP) 00-09 titled Fact Finding/Inquiry Procedures. This SOP outlines the process for conducting fact finding at the facility level and requires supervisors and management officials to consult with ERLR/HR to determine appropriate corrective actions, potentially including disciplinary or adverse actions when allegations are substantiated by evidence and facts. These procedures also encompass concerns related to patient safety. On September 12, 2024, the SOP was published on the facility's intranet, and all staff received an email containing the link to the facility intranet. Leaders, including supervisors and management officials and clinical service chiefs, are expected to adhere to these established processes as outlined in SOP 00-09. A retrospective review of a sample of completed fact-findings over the last 12 months will be conducted to determine if all patient safety concerns were reviewed and addressed. HR will provide retraining on fact finding as per SOP 00-09 to address any identified shortcomings. Unresolved patient safety concerns will be reviewed with HR and relevant leadership to determine next steps. Audit results will be reported to the Executive Leadership Board.

Recommendation 2

The VA Southern Nevada Healthcare System Director evaluates the need for additional factfinders and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System's Director evaluated the need for additional factfinders and acted as warranted. Prior to these recommendations, the facility has taken steps to ensure the availability of additional factfinders. There were approximately eight factfinders during the time the concerns with this dental hygienist were identified in June 2022. VA Southern Nevada Healthcare System arranged for the Law Enforcement Training Center (LETC) to conduct additional fact-finding trainings onsite on December 13-15, 2022, July 25-27, 2023, November 14, 2024, and January 29, 2025, to increase the number of available factfinders. LETC also offered virtual trainings. Additionally, fact-finding training was available through the Talent Management System, and the facility provided local training opportunities. As a result of these trainings, VA Southern Nevada Healthcare System currently has approximately over 100 staff trained in fact-finding.

Recommendation 3

The VA Southern Nevada Healthcare System Director ensures that clinical service chiefs take action timely when aware of patient safety concerns.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System's Director will ensure that clinical service chiefs act in a timely fashion when aware of patient safety concerns. The Chief of Staff will send a memorandum to all clinical service chiefs reinforcing that clinical service chiefs act when aware of patient safety concerns. VA Southern Nevada remains committed to timely reporting and action on all patient safety concerns identified.

VA Southern Nevada Healthcare System tracks actions of patient safety concerns through Joint Patient Safety Reporting (JPSR). Daily reports showing pending JPSR follow-up/actions, with the number of days open, are sent via email to leaders. JPSRs are tracked until closure to ensure appropriate actions are taken.

Recommendation 4

The VA Southern Nevada Healthcare System Director reviews the information outlined in this report, determines the need to initiate the state licensing board reporting process, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System reviewed the information outlined in this report and determined the need to initiate the state licensing board reporting process and will act as appropriate following the guidelines outlined in VHA Directive 1100.18, Reporting and Responding to State Licensing Boards.

Recommendation 5

The VA Southern Nevada Healthcare System Director requires clinical service chiefs and credentialing and privileging managers to receive education on the completion of provider exit review forms and that, when supervisory staff contact credentialing and privileging staff for initiation of the state licensing board reporting process, a process is in place to ensure the message is clear and received.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System's Director required clinical service chiefs and credentialing and privileging managers to receive education on completing provider exit review forms and that when supervisory staff contact credentialing and privileging staff for initiation of the state licensing board reporting process, a process is in place to ensure the message is clear and received.

The Credentialing Manager will provide education on the requirements to appropriately and accurately complete the exit review forms at the Medical Executive Committee and the Credentials Committee meetings. Additionally, the Credentialing Manager will create a process for staff so that the message provided to supervisory staff regarding the state board reporting process is clear and received.

Recommendation 6

The VA Southern Nevada Healthcare System Director ensures that clinical service chiefs and staff are educated on the need and process for submitting Joint Patient Safety Reporting reports upon awareness of patient safety events in accordance with facility policy.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System's Director will ensure that clinical service chiefs and staff are educated on the need and process for submitting JPSRs upon awareness of patient safety events in accordance with facility policy.

This topic will also be presented at an upcoming monthly Safety Forum and at a biannual medical staff meeting. JPSR information will be placed in the Daily Message sent to all users, and additional JPSR resources are available on the facility intranet SharePoint. A reference card on JPSR reporting will be created and distributed to clinical service chiefs for posting in clinical areas.

Recommendation 7

The VA Southern Nevada Healthcare System Director educates the Chief of Staff on the need to complete management reviews when warranted, ensures that a review occurs of the dental hygienist's care of Patient C, and ensures disclosure is provided if warranted.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System's Director educated the Chief of Staff on the need to complete management reviews when warranted, ensured that a review occurs of the dental hygienist's care of Patient C, and ensured disclosure is provided if warranted. The Quality Safety Value (QSV) Executive and Credentials Manager will meet with the Chief of Staff to review the management review process as outlined in the Provider Competency and Clinical Care Concerns dated January 2018. When any circumstances arise that indicate a need for management reviews, the Service Chief, Chief of Staff, Credentialing Manager, and QSV Executive, as needed, will collaborate to determine next steps.

Risk Management thoroughly reviewed Patient C's care after being notified of this case in November 2023. VA Southern Nevada Healthcare System will conduct further review of Patient C's dental cleaning and complete an institutional disclosure if warranted.

Recommendation 8

The VA Southern Nevada Healthcare System Director makes certain that the Chief of Staff utilizes high reliability organization principles and establishes a process for the communication of pervasive concerns regarding a provider's care.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

VA Southern Nevada Healthcare System's Director will ensure that the Chief of Staff utilizes high reliability organization principles and establishes a process for the communication of pervasive concerns regarding a provider's care. Since OIG's visit, the Chief of Staff regularly attends and participates in patient safety and high reliability organization educational activities including daily safety huddles, leadership rounds, and safety forums.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Valerie Lumm, MHL, BSN, Director Debbie Davis, JD Kevin Hosey, MBA, LCSW Deanna Lane, MSN, RN Patrice Marcarelli, MD James McMahon, MPT, AT
Other Contributors	Honor Carolina, LCSW Limin X. Clegg, PhD Sheyla Desir, MSN, RN Christopher D. Hoffman, LCSW, MBA Barbara Mallory-Sampat, JD, MSN Angelea McBride, BSN, RN Daphney Morris, MSN, RN Natalie Sadow, MBA Erika Terrazas, MS

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