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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens

Healthcare Inspection | **24-01092-228** | **September 30, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection in January 2024, and conducted two unannounced site visits February 21–22, 2024, and April 8–10, 2024, to determine whether staff, including leaders, followed required procedures related to suspected elder abuse of a community living center (CLC) resident at the St. Albans VA Medical Center (facility) in Queens, part of VA New York Harbor Healthcare System (system).[1] The scope of the inspection did not include a determination of whether the abuse occurred.

In late August 2023, VA Police at the system notified the OIG Office of Investigations that the resident had bruises and alleged being assaulted. A report of contact revealed a nursing assistant (nursing assistant 2) witnessed another nursing assistant (nursing assistant 1) grabbing the resident's wrist, stepping on the resident's feet, and threatening the resident.[2] Nursing assistant 1 admitted to VA Police grabbing the resident's wrist to prevent being hit but denied "stepping on or kicking [the resident's] feet or ankles," and when asked about verbally threatening the resident, nursing assistant 1 stated that it was "possible." The OIG Office of Investigations conducted an investigation and presented the case to the United States Attorney's Office, who declined the case. The OIG Office of Investigations referred the case to the OIG Office of Healthcare Inspections, who initiated the inspection in January 2024.

The OIG determined that leaders and staff failed to follow procedures to report the suspected abuse, ensure the resident's safety, and conduct a thorough investigation of the incident. In response to allegations of resident abuse, CLC leaders and staff are required to

- report all alleged violations of abuse immediately "in accordance with State law through established procedures";
- "have evidence that all alleged violations are thoroughly investigated";

[1] Elder abuse is defined as "any abuse or neglect of persons age 60 or older by a caregiver or another person in a relationship involving an expectation of trust." Veterans Health Administration (VHA) Directive 1199(2), *Reporting Cases of Abuse and Neglect*, November 28, 2017, amended March 17, 2023. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, September 3, 2024, which specifies elder abuse as "any physical, sexual, or psychological abuse, financial exploitation, or neglect of persons age 60 or older by a caregiver or another person in a relationship involving an expectation of trust."; A CLC is a VA nursing home. VA Benefits and Health Care, Geriatrics and Extended Care, Community Living Centers (VA Nursing Homes), accessed August 26, 2024, https://www.va.gov/geriatrics/pages/va_community_living_centers.asp; A resident is a patient who resides in a CLC. "Rights and Responsibilities of VA Patients and Residents of Community Living Centers," Veterans Health Administration, accessed February 1, 2024, https://www.va.gov/health/rights/patientrights.asp; The OIG uses the terms *patient* and *resident* interchangeably throughout the report.

[2] VA Form 119, "Report of Contact," September 1997. A report of contact is a written document to record brief statements of interactions and communications with patients, patient information, contact details, and type of contact.

- "prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress"; and
- "report the results of investigations to the administrator" or a designated representative and to appropriate state authorities, "within 5 working days of the incident."[3]

New York public health law states, any administrator, health care provider, registered nurse, licensed practical nurse, and licensed social worker, shall immediately report suspected abuse of a person receiving care or services in a residential health care facility "by telephone, and in writing within 48 hours," to the Commissioner of the New York State Department of Health.[4] The Veterans Health Administration (VHA) requires, "that all covered professionals, while acting in the scope of their VA employment, are required to adhere to Federal and state laws which govern the reporting of suspected cases of abuse and neglect," and to promptly document information regarding the abuse in the patient's electronic health record (EHR).[5] System policy requires nursing staff to assess "the patient for elder abuse/neglect, including the extent of the patient's injuries if physical symptoms are present," complete a "history of the abuse," facilitate treatment, and notify the "physician and social worker."[6] When "a harmful or potentially harmful" incident has occurred to a patient during routine care, the patient's provider shares clinically significant facts about the incident in "a forthright and empathetic" discussion with the patient or patient's family.[7]

The OIG found that nursing assistant 2 failed to immediately notify a supervisor of the alleged abuse, not mentioning the incident until three days later. Nursing assistant 2 told the OIG the reason for not immediately reporting the alleged abuse was being "scared," but then decided to report after seeing the resident in pain and the injuries to the resident's feet. After becoming aware of the suspected abuse, nursing staff did not report the suspected abuse to the unit social

[3] 42 C.F.R. § 483.12, *Freedom from Abuse, Neglect, and Exploitation*, October 4, 2016.

[4] New York Public Health Law, Section 2803-D 1-3, accessed March 14, 2025, https://newyork.public.law/laws/n.y._public_health_law_section_2803-d.

[5] VHA Directive 1199(2). This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1199. VHA Directive 1199 states that, "all covered professionals, while acting in the scope of their employment conducting any VHA-authorized health care activities, report suspected cases of abuse and neglect to the appropriate authorities as set for in [VHA Directive 1199]" (which retained the requirement to adhere to federal and state laws for reporting elder abuse) and has same or similar language regarding requirements for prompt documentation.

[6] System Policy 11-22, *Elder Abuse Identification, Management and Reporting*, August 2015. The policy was in effect during the incident and was replaced with System Policy 11-22, *Elder Abuse Identification, Management and Reporting*, April 2024. The policies have the same requirements for the issues identified in this report. System Policy 11-88 *Patient Abuse*, July 2021. If nurse managers need to take immediate action, they must consult with the ADPCS, Human Resources, and the Union.

[7] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

worker. The nurse manager told the OIG that the unit social worker was not directly notified but was sure the unit social worker knew of the incident through documentation in the resident's EHR and interdisciplinary meetings.

The OIG found no evidence that the Associate Director for Patient Care Services (ADPCS) and nurse manager alerted VA Police of the resident's injuries or complaint of abuse. VA Police learned of the suspected abuse from the resident's family member who filed a complaint after learning of the incident. The nurse manager told the OIG that the report of the suspected abuse occurred late in the afternoon and did not notify VA Police due to being focused on completing other tasks required for the incident.

Furthermore, a nurse practitioner failed to inform the resident's family of bruises. When asked why the family was not notified, the nurse practitioner stated, "I probably got distracted." The nurse practitioner also told the OIG that a family member must be informed of concerns of resident abuse but was unsure of their own responsibility to provide a clinical disclosure due to not having experience with concerns of abuse previously. Although the nurse practitioner documented evaluating the resident's right wrist injury two days after the incident, the nurse practitioner failed to document a complete physical exam and failed to consider whether the injuries were related to suspected abuse.

Leaders did not make any of the required reports to the New York State Department of Health. The chief of social work, who told the OIG that VA staff are not required to report the suspected abuse to state authorities, misunderstood the requirement. The OIG interviewed staff who described a culture in the CLC of silence, in which staff generally do not report, or underreport, patient safety incidents due to fear of reprisal from coworkers or the administrative burden. For example, nursing assistant 2 shared several repercussions received from coworkers after reporting nursing assistant 1.

The nurse manager failed to take immediate action to protect the resident's safety. The nurse manager told the OIG of being instructed on a Friday afternoon to remove nursing assistant 1 from the resident's care but waited until the following business day (three days) to obtain a system-required letter from human resources authorizing work assignment changes.

Over a five-month period, nursing leaders conducted two factfinding investigations into the alleged abuse, neither of which were thorough nor led to accurate conclusions.[8] The ADPCS told the OIG that the first factfinding, which had been initiated upon learning of the alleged abuse in late August 2023 and completed six days later, was inadequate, sharing that there was not "a complete sense of what happened and what should have happened." The ADPCS reported

[8] VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021. The handbook states that a factfinding is "a less formal administrative investigation" with the purpose of 'ascertaining the magnitude of a problem; gathering and analyzing evidence; identifying and interviewing witnesses; summarizing and recording witness statements."

tasking another factfinder to conduct a second factfinding. The second factfinding results were inconclusive as to whether nursing assistant 1 physically assaulted the resident. The OIG found that the second factfinding was completed approximately five months after the alleged abuse, exceeding a 14-day completion requirement, and did not include essential information from the VA Police report, which documented nursing assistant 1 admitted grabbing the resident by the wrist to prevent being hit by the resident. System policy requires that when an allegation of physical abuse is reported, a preliminary factfinding will be conducted and completed in 14 days to determine whether there is any suspicion of abuse and, if so, identify "root causes and system modifications that will reduce the likelihood of future such occurrences."[9] The OIG opined that an accurate conclusion would have indicated the allegation of patient abuse was plausible and, since nursing assistant 1 did not admit patient abuse to the factfinding investigator, system leaders would have been required to conduct an administrative investigation board (AIB). Unless allegations of patient abuse are found to be clearly false, or the employee admits to abuse, system policy requires facility leaders to convene an AIB.[10]

The OIG found additional reporting deficiencies related to other incidents of suspected resident abuse, and that not all CLC staff had received mandatory VHA Prevention and Management of Disruptive Behavior (PMDB) training. The OIG reviewed system patient safety incident reports from 2023 through early 2024 related to 12 incidents of CLC residents with allegations of abuse, and corresponding investigative information. The OIG found reporting deficiencies to VA Police, social work staff, and the residents' families. The OIG interviewed 21 CLC residents to determine whether there may have been other unreported incidents of patient abuse. None of the interviewed residents reported an unresolved or active concern of abuse.

The OIG reviewed PMDB training documentation of selected staff from early fall 2022 through mid-spring 2024 and found that 5 of 23 staff had not received the required annual training. Moreover, the OIG identified system documentation, dated approximately one week after nursing assistant 1's altercation with the resident, alerting nurse managers regarding staff "we believe have not taken this class [PMDB training on verbal de-escalation of residents' disruptive behavior and personal safety skills]," and attached a list of 154 staff names, which included nursing assistant 1.

During review of the resident's EHR, the OIG identified documentation deficiencies, which was identified as a finding during a previous OIG inspection at the system.[11] For example, although a registered nurse documented in the EHR that nursing assistant 2 reported the resident had bruises

[9] System Policy 11-88; The policy states that the "intent to abuse is not a requirement for [suspected] patient abuse. The patient's perception of how he/she was treated is an essential component of the determination as to whether a patient was abused."

[10] System Policy 11-88.

[11] VA OIG, *Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens*, Report No. 20-02968-170, June 22, 2021.

on both feet, nursing assistant 2 did not document the bruising in the resident's EHR. In another example, a physical therapist documented identical notes for three consecutive physical therapy sessions with the resident. The substandard documentation posed challenges and hindered system staff, VA Police, and the OIG during investigations and reviews.

Additionally, the OIG identified deficiencies in VHA and system abuse policies. Federal law requires that facility leaders "develop and implement written policies and procedures that prohibit and prevent abuse," which must include, but is not limited to, training, prevention, investigation, and reporting.[12] VHA and system policies did not include all required components.[13]

The OIG made one recommendation to the Under Secretary for Health to ensure VHA elder abuse policy addresses compliance with state and federal regulations.[14]

The OIG made six recommendations to the System Director related to provision of medical and psychosocial health care for residents who report abuse, completion of factfinding investigations, compliance with reporting requirements of suspected abuse, PMDB education, EHR documentation, and policy and procedures updates.

VA Comments and OIG Response

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion.[15] For this report, VHA provided the OIG comments during the draft phase. The OIG reviewed the comments and made changes to the report for clarification, but no changes were made to OIG findings.

The Acting Under Secretary for Health concurred in principle with recommendation 6. The Veterans Integrated Service Network and System Directors concurred with the recommendations

[12] 42 C.F.R § 483.12.

[13] VHA Directive 1199(2). This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1199. The policies contain the same or similar language regarding state abuse reporting laws; System Policy 11-22; System Policy 11-88.

[14] The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

[15] VA OIG GM Directive 308*, Comments to Draft Reports*, April 10, 2014, amended April 24, 2019.

and provided acceptable action plans (see appendixes A, 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

ADPCS	Associate Director for Patient Care Services
AIB	administrative investigation board
CLC	community living center
EHR	electronic health record
OIG	Office of Inspector General
PMDB	prevention and management of disruptive behavior
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection in January 2024, and conducted two unannounced site visits February 21–22, 2024, and April 8–10, 2024, to determine whether staff, including leaders, followed required procedures related to suspected elder abuse of a community living center (CLC) resident at the St. Albans VA Medical Center (facility) in Queens, part of VA New York Harbor Healthcare System (system).[1] The scope of the inspection did not include a determination of whether the abuse occurred.

Background

The system, part of Veterans Integrated Service Network (VISN) 2, consists of medical centers in Manhattan and Brooklyn, the facility, and two community-based outpatient clinics and two mobile clinics.[2] The system has a complexity level of 1b.[3] The facility has 142 CLC beds.

Freedom from Abuse

Abuse can take many forms, including psychological abuse (verbal threats, humiliation, harassment), physical abuse, sexual abuse, financial abuse, and neglect.[4] According to Centers for Medicare and Medicaid Services, "physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking." "Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time." Injuries, such as bruises, "that are non-accidental or unexplained," including "those found in unusual locations such as the head, neck, lateral locations on the arms, or posterior torso and

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[1] Elder abuse is defined as "any abuse or neglect of persons age 60 or older by a caregiver or another person in a relationship involving an expectation of trust." Veterans Health Administration (VHA) Directive 1199(2), *Reporting Cases of Abuse and Neglect*, November 28, 2017, amended March 17, 2023. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1199, *Reporting Cases of Abuse and Neglect*, September 3, 2024, which specifies elder abuse as "any physical, sexual, or psychological abuse, financial exploitation, or neglect of persons age 60 or older by a caregiver or another person in a relationship involving an expectation of trust."; A CLC is a VA nursing home. "VA Benefits and Health Care, Geriatrics and Extended Care," Community Living Centers (VA Nursing Homes), accessed August 26, 2024, https://www.va.gov/geriatrics/pages/va_community_living_centers.asp; A resident is a patient who resides in a CLC. "Rights and Responsibilities of VA Patients and Residents of Community Living Centers," Veterans Health Administration, accessed February 1, 2024, https://www.va.gov/health/rights/patientrights.asp; The OIG uses the terms *patient* and *resident* interchangeably throughout the report.

[2] "About VA New York Harbor Healthcare System," VA New York Harbor Health Care, accessed June 16, 2025, https://www.va.gov/new-york-harbor-health-care/about-us/.

[3] VHA Office of Productivity, Efficiency, and Staffing, "VHA Facility Complexity Model," October 1, 2023. VHA facilities are classified at levels (from most complex to least complex) 1a, 1b, 1c, 2, or 3.

[4] Julian Hirt et.al., "Staff-to-resident abuse in nursing homes: a scoping review," *BMC Geriatrics*, no. 22 (July 6, 2022): 563, https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-022-03243-9.

trunk, or bruises in shapes" (for example, finger imprints) are examples that could indicate abuse.[5]

CLC staff-resident relationships "are characterized by imbalances of power" as residents depend "on staff to satisfy their needs." Additionally, people with dementia, which may represent a majority of CLC residents, are particularly vulnerable to abuse due to their limited ability to recognize and report abuse.[6]

Under federal regulations adopted by the Veterans Health Administration (VHA), CLC residents have "the right to be free from abuse."[7] These regulations do not permit facility employees to engage in "verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion" of residents.[8]

In response to allegations of resident abuse, these regulations require leaders and staff at long-term care facilities to

- report all alleged violations of abuse immediately "in accordance with State law through established procedures";
- "have evidence that all alleged violations are thoroughly investigated";
- "prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress"; and

[5] VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023. To assess CLC compliance with federal regulations, processes for surveying long-term care facilities are outlined in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP specific to requirements for United States nursing homes. VHA voluntarily adheres to standards set by the US Department of Health and Human Services for the operation of long-term care facilities receiving Medicare and Medicaid funds in providing care for veterans in CLCs. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008, was replaced by VHA Directive 1142 and were in place consecutively during the events noted in this report. The handbook required adherence to The Joint Commission standards but not those set by the US Department of Health and Human Services. The directive was subsequently replaced by VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024. CMS State Operations Manual, accessed June 4, 2024, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.

[6] Julian Hirt et.al., "Staff-to-resident abuse in nursing homes: a scoping review."

[7] 42 C.F.R § 483.12, *Freedom from Abuse, Neglect, and Exploitation*, October 4, 2016. 42 C.F.R § 483.5, *Definitions*, July 13, 2017. "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish …. *Willful* [emphasis in original text], as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." In its CLC policy, VHA adopted the US Department of Health and Human Services' regulations governing long-term care facilities. VHA Directive 1142(1), § 4b.

[8] 42 C.F.R § 483.12.

- "report the results of investigations to the administrator" or a designated representative and to appropriate state authorities, "within 5 working days of the incident."[9]

VHA policy states, "that all covered professionals, while acting in the scope of their VA employment, are required to adhere to Federal and state laws which govern the reporting of suspected cases of abuse and neglect," including timely reporting suspected abuse to state agencies and promptly documenting information regarding the abuse in the patient's electronic health record (EHR).[10]

Prior OIG Report

A June 2021 OIG report substantiated that improper feeding by a registered nurse contributed to the death of a patient at the facility's CLC. The OIG found that staff entered inaccurate EHR documentation and did not submit an incident report. The OIG determined that system leaders did not complete a comprehensive review of the event or an institutional disclosure. The OIG made seven recommendations related to nursing competencies and training, feeding documentation, review of the patient's care, committee oversight, incident reports, and institutional disclosure, that have been closed.[11]

OIG Concerns

On August 28, 2023, system VA Police notified the OIG Office of Investigations that the resident had bruises and alleged being assaulted. The nurse manager told VA Police that there was a witness to possible abuse of the resident and requested the witness write a report of contact.[12] According to the report of contact, on the day of the incident (day 1) a nursing assistant (nursing assistant 1), as witnessed by another nursing assistant (nursing assistant 2), grabbed the resident's wrist, stepped on the resident's feet, and threatened the resident. Nursing assistant 1 admitted to VA Police grabbing the resident's wrist to prevent being hit by the

[9] 42 C.F.R § 483.12. Immediately is "not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury."

[10] VHA Directive 1199(2). This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1199. VHA Directive 1199 states that, "all covered professionals, while acting in the scope of their employment conducting any VHA-authorized health care activities, report suspected cases of abuse and neglect to the appropriate authorities as set forth in [VHA Directive 1199]" and has same or similar language regarding requirements for prompt documentation.

[11] VA OIG, *Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens*, Report No. 20-02968-170, June 22, 2021.

[12] VA Form 119, "Report of Contact," September 1997. A report of contact is a written document to record brief statements of interactions and communications with patients, patient information, contact details, and type of contact.

resident but denied "stepping on or kicking [the resident's] feet or ankles," and when asked about verbally threatening the resident, nursing assistant 1 stated that it was "possible."

The OIG Office of Investigations conducted an investigation and presented the case to the United States Attorney's Office, which declined the case. Subsequently, on November 3, 2023, the OIG Office of Investigations referred the case to the OIG Office of Healthcare Inspections. The OIG Office of Healthcare Inspections initiated the inspection on January 23, 2024, to

- determine whether system staff, including leaders, followed required procedures upon knowledge of suspected resident abuse; and
- evaluate system leaders' response to CLC resident safety concerns.

Scope and Methodology

The OIG conducted two unannounced site visits February 21–22, 2024, and April 8–10, 2024.

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 arises from 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.

Resident Event Summary

The resident was 81 years old with multiple neurological and psychiatric diagnoses, including dementia, which contributed to the need for long-term care in the CLC for approximately 12 years. Facility staff typically described the resident as cooperative and happy, but occasionally stubborn, defiant, or aggressive. Over the years, the resident had intermittent musculoskeletal complaints, prompting physical and radiographic evaluations, including x-rays of the upper and lower extremities, usually without evidence of acute injury. Nursing staff performed skin "reinspection/reassessment," including in mid-summer 2023, where the resident's skin was reported as "intact." The resident was not known by CLC staff to have bumps, bruises, or skin issues. Family members reported visiting the resident regularly.

Summary of the VA Police Investigation

Through interviews, VA Police learned that between days 2 and 4, one or more CLC staff were aware of bruising to the resident's wrist and feet. Two days later, nursing assistant 2 reported the incident of alleged abuse to a nurse manager; however, VA Police noted that they were "never notified … of this incident."

According to the VA Police investigation, on day 6, a family member of the resident filed a complaint that the resident alleged being "assaulted two nights ago and had bruises on [the resident's] body."[13] Nursing assistant 2 reported witnessing the incident of alleged abuse that occurred on day 1, in which the resident tried to hit nursing assistant 1, who then grabbed the resident's wrist, stepped on the resident's feet, and verbally threatened to beat the resident. Nursing assistant 1 denied assaulting the resident but admitted to grabbing the resident's wrist to prevent being hit and possibly cursing at and threatening the resident. Nursing assistant 1 asserted that the resident "kept pushing [the] wheelchair toward [nursing assistant 1]" and speculated that this "might be how [the resident's] ankles were bruised."

Both nursing assistants 1 and 2 reported that another nursing assistant (nursing assistant 3) was a witness to the incident, however, nursing assistant 3 denied to VA Police hearing or seeing any interactions between nursing assistant 1 and the resident.

VA Police concluded the investigation in a follow-up report in late fall 2023 stating that, "… poor record-keeping practices ... The absence of comprehensive documentation and a prevailing culture of dishonesty and attempts to conceal the incident among employees" significantly hindered the criminal investigation.

[13] According to the VA Police report, the resident reported being hit by two females.

Timeline of Related Events

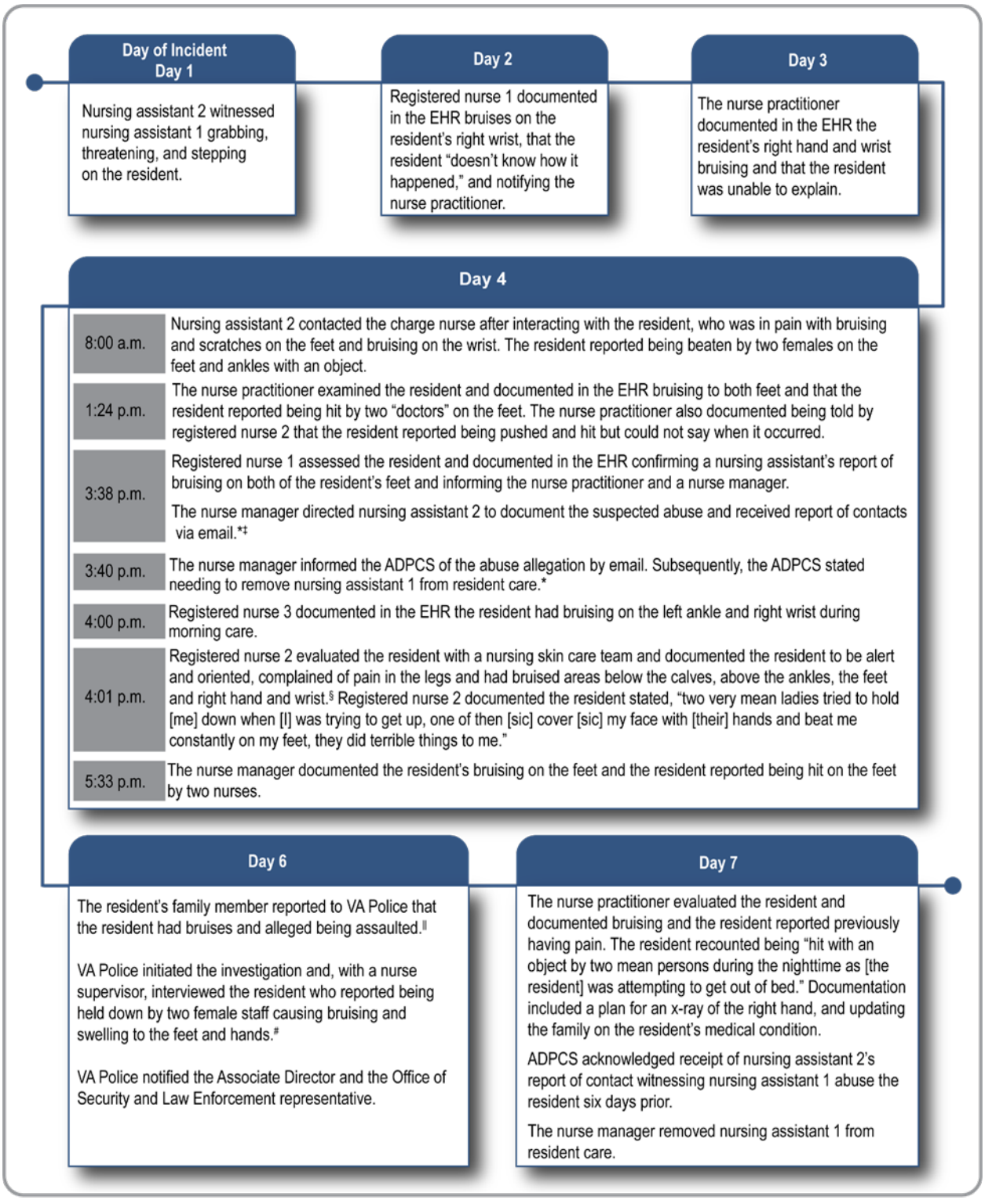

Figure 1. *Timeline of Events.*

Source: The OIG compiled data obtained from the resident's EHR, system and VA Police documents, interviews, and email correspondence.
[*]These events occurred at an undetermined later time or date.
[‡]The OIG did not independently review the content of these reports of contact.
[§]The nursing skin care team included registered nurse 1, registered nurse 2, registered nurse 3, and nursing assistant 2.
[‖]The resident's family member reported being initially informed by nursing assistants that the resident had hand and leg bruises, and the resident told the family member that a lady hit the resident with a shoe.
#The nurse supervisor contacted the nurse manager, which prompted an evaluation by the nurse practitioner.

Inspection Results

1. Failures to Follow Suspected Resident Abuse Procedures

The OIG determined that leaders and staff failed to report suspected abuse of the resident to a supervisor, the unit social worker, VA Police, the resident's family, and New York State authorities, as required. Additionally, nursing leaders and staff did not ensure the resident's safety and thoroughly investigate the suspected abuse. Interviews with system staff revealed a culture within the CLC of underreporting concerns through established processes.

This case involves "elder abuse," which triggers application of VHA policy requiring compliance with federal and state laws, which govern the reporting of suspected cases of abuse and neglect.[14]

Failures to Report

According to system policy, an allegation of patient abuse will be immediately documented on a report of contact. "The employee who witnesses, or who is the first to become aware of the incident" initiates the report of contact and informs their supervisor.[15] In cases where elder abuse has occurred or is suspected, system policies require nursing staff to assess "the patient for elder abuse/neglect, including the extent of the patient's injuries if physical symptoms are present," complete a "history of the abuse," facilitate treatment, and notify the "physician and social worker."[16] System policy also states that the social worker "conducts a thorough psychosocial assessment of the patient;" assists with "treatment, referral, reporting and documentation of

[14] VHA 1199(2). The directive states that "while acting within the scope of their VA employment," selected VHA employees, including nurses, health care practitioners, and social workers, "are required to adhere to Federal and state ... laws which govern the reporting of suspected cases of abuse and neglect." VHA Directive 1199 rescinded VHA Directive 1199(2) but retained the requirement to adhere to federal and state laws for reporting elder abuse.

[15] System Policy 11-88, *Patient Abuse*, July 2021.

[16] System Policy 11-22, *Elder Abuse Identification, Management and Reporting*, August 2015. The policy was in effect during the incident and was replaced with System Policy 11-22, *Elder Abuse Identification, Management and Reporting*, April 2024. The policies have the same requirements for the issues identified in this report. System Policy 11-88. If nurse managers need to take immediate action, they must consult with the ADPCS, Human Resources, and the Union.

abuse," and recommends intervention options.[17] Nursing leaders evaluate the need for immediate action, such as moving the employee involved in the incident "to another unit or a non-patient care area."[18] System policy details that allegations of patient abuse "should be documented in the Progress Notes and include what occurred, the results of the evaluation and any necessary treatment."[19]

VHA policy requires that "actual or possible violations of criminal laws … must be reported by VHA management officials to the VA Police with responsibility for the VHA facility in question."[20] When "a harmful or potentially harmful" incident has occurred to a patient during routine care, the patient's provider shares clinically significant facts about the incident in "a forthright and empathetic" discussion with the patient or patient's family.[21] Clinical disclosures serve "to maintain trust between patients and VA health care professionals" and are initiated "as soon as reasonably possible and generally within 24 hours of occurrence."[22]

Federal and New York State laws require that all alleged violations involving resident abuse be reported immediately.[23] New York public health law states any administrator, health care provider, registered nurse and licensed practical nurse, and licensed social worker shall immediately report suspected abuse of a person receiving care or services in a residential health care facility "by telephone, and in writing within 48 hours" to the Commissioner of the New York State Department of Health.[24] System policy requires that "suspected elder abuse/neglect in a health care facility should be reported to the NYS [New York State] Department of Health … [within] (24 hours)."[25] In addition, Federal law mandates that investigation results be

[17] System Policy 11-22.

[18] System Policy 11-88.

[19] System Policy 11-88.

[20] VHA Directive 5019.02, *Harassment, Sexual Assaults, and Other Defined Public Safety Incidents in Veterans Health Administration*, September 12, 2022, amended October 13, 2022.

[21] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[22] VHA Directive 1004.08. The policy requires a practitioner who had "primary responsibility for the resident during the current episode of care" to complete the clinical disclosure "relating to events where the harm is more than minor."

[23] 42 C.F.R § 483.12. Immediately is "not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury,"' New York Public Health Law, Section 2803-D 1-3, accessed March 14, 2025, https://newyork.public.law/laws/n.y._public_health_law_section_2803-d.

[24] New York Public Health Law, Section 2803-D 1-3.

[25] System Policy 11-22. VHA Directive 1199(2). The policy states that VA medical facilities work with their Privacy Officer and Office of Chief Counsel in the District "to determine if a particular case of suspected abuse or neglect of a child or adult is one that is subject to mandatory state reporting requirements and if so whether VA has legal authority to disclose the pertinent information to the state." VHA Directive 1199(2) was rescinded and replaced by VHA Directive 1199. The policies contain the same or similar language regarding working with their privacy officer or office of chief counsel.

reported to the administrator or designee and to appropriate state authorities "within 5 working days of the incident."[26]

Failure to Immediately Report to a Supervisor

The OIG found that nursing assistant 2 witnessed the alleged abuse of the resident on day 1 but failed to immediately report the incident to a supervisor or document the suspected abuse.

During interviews and in the VA Police report, the OIG found that three days after witnessing the altercation, nursing assistant 2 reported the alleged abuse to the nurse manager. That same day, the nurse manager directed nursing assistant 2 to document the incident in a report of contact. Nursing assistant 2 submitted the report of contact on day 7, three days later. Nursing assistant 2 told the OIG the reason for not immediately reporting the alleged abuse was being "scared," but then decided to report after seeing the resident in pain and the injuries to the resident's feet. Nursing assistant 2 recalled the nurse manager saying that reporting the incident was the right thing to do but also warned of potential staff backlash. Nursing assistant 2 also expressed, in an early fall 2023 interview with an OIG investigator and VA Police, that the culture among staff is to not say anything against each other, and shared several repercussions received from coworkers after reporting the alleged abuse, including

- threatened they should "never snitch on each other,"
- accused of ruining nursing assistant 1's life,
- treated "very cold" from staff, and
- theft of personal property.

The OIG concluded that nursing assistant 2 delayed reporting the suspected abuse to the nurse manager for three days and failed to document the incident in a report of contact for six days. These delays prevented the nurse manager from initiating a series of required time-sensitive actions related to protecting the resident's safety and reporting and investigating the alleged abuse.

[26] 42 C.F.R § 483.12. The Commissioner has jurisdiction to investigate elder abuse and, if sufficient credible evidence substantiates the allegations, to refer the case to law enforcement, the Nurse Aide Registry, and to state licensing boards; New York State Department of Health, "How to Use the Nurse Aide Registry," accessed November 14, 2024, https://www.health.ny.gov/health_care/consumer_information/nurse_aide_registry/using_the_nurse_aide_registry.htm. The web page states that the New York State Nurse Aide Registry is required for all nurse aides (or nursing assistants), including reports of any nurse aide "who has been convicted of or has a documented finding of resident abuse" or mistreatment.

Failure to Notify the Unit Social Worker

The OIG found that nursing staff failed to notify the unit social worker of the resident's injuries and allegations of abuse.

The nurse manager told the OIG that the unit social worker was not directly notified but was sure the unit social worker knew of the incident through documentation in the resident's EHR and interdisciplinary meetings. In an OIG interview in Spring 2024 (approximately eight months after the incident), the unit social worker reported being unaware of the suspected abuse, despite interacting with the resident "maybe a couple of times a week."

The OIG concluded that nursing staff failed to notify the unit social worker of the suspected patient abuse. Although facility policy does not specify how nursing staff are to notify the social worker, the OIG would have expected the unit social worker to have known about the suspected abuse through routine duties on the unit, such as interactions with the resident and review of the resident's EHR, which contained multiple entries of the resident's allegations of abuse and injuries, or informal and formal unit-based interdisciplinary discussions.[27] Nursing staff's failure to notify the unit social worker of the suspected abuse and lack of engagement by the unit social worker, whether intentionally or unintentionally, prevented the resident from receiving social work services such as a psychosocial assessment; interventions; and assistance with treatment, referral, reporting, and documentation of the abuse.

Failure to Notify VA Police

The OIG found no evidence that the Associate Director for Patient Care Services (ADPCS) and nurse manager, who became aware of the suspected abuse, alerted VA Police of the resident's injuries or complaint of abuse. VA Police learned of the suspected abuse from the resident's family member who filed a complaint on day 6.

When interviewed by the OIG, the ADPCS initially could not recall actions taken after being informed by the nurse manager of the suspected abuse on day 4 but stated an expectation that the nurse manager would contact VA Police. The nurse manager told the OIG that the report of the suspected abuse occurred late in the afternoon, and the nurse manager did not notify VA Police due to being focused on completing other tasks required for the incident.

The OIG concluded that despite knowledge of the resident's injuries and complaint of abuse on day 4, the nurse manager and the ADPCS failed to notify VA Police of the suspected abuse.

Failure to Inform the Resident's Family

The OIG found that the nurse practitioner, as the resident's provider, failed to provide a clinical disclosure to inform the resident's family of changes in the resident's condition, despite

[27] System Policy 11-22.

observing the resident's wrist bruises on day 2, and awareness of the resident's feet bruises and allegation of abuse reported on day 4.

When interviewed by the OIG, the nurse practitioner reported not knowing the wrist bruise was an injury on day 2, citing no trauma to the area. However, two days later, the nurse practitioner was made aware of the allegations of abuse reported by registered nurse 2 and assessed the bruises on the resident's feet but did not notify the family. When asked why the family was not notified, the nurse practitioner stated, "I probably got distracted." The nurse practitioner also told the OIG that a family member must be informed of concerns of resident abuse but was unsure of their own responsibility to provide a clinical disclosure due to not having experience with concerns of abuse previously. The resident's family member told the OIG that on day 6, on the way to visit the resident, nursing assistants informed the family member of the resident's injuries and allegation of abuse.

The nurse manager told the OIG that the nurse practitioner is responsible for notifying the family of the patient's bruises but believed this did not happen. The ADPCS reported an expectation for a member of the resident's care team to notify the family regarding the investigation.

The OIG concluded the nurse practitioner failed to provide clinical disclosure to the resident's family about any of the resident's injuries and alleged abuse. These failures can erode the family's trust in the system and deny the family an opportunity to provide timely support to the resident in the aftermath of the incident.

Related Concern: Inadequate Assessment of the Resident

The OIG determined, although the nurse practitioner documented the resident's right wrist injury on day 3, the nurse practitioner documented an incomplete physical exam and failed to consider whether the injuries were related to suspected abuse.

System policy requires a provider, such as a nurse practitioner, to conduct "a complete history and physical examination," and order "laboratory, x-ray, and other diagnostic studies in order to confirm or rule out suspicions of injury due to abuse."[28]

On day 3, after being informed of bruising on the resident's wrist, the nurse practitioner assessed the resident and confirmed "[bruising] to right radial [wrist] area," that there is "no reported trauma to [the] area," the resident was "unable [to] tell if [there was] any trauma to area," and there were "no futher (*sic*) [bruising] to [resident's] skin."[29] However, the nurse practitioner did not document in the EHR

- bruising in the shape of fingers, which was observed by nursing assistant 2 the previous day;

[28] System Policy 11-22.

[29] The nurse practitioner completed documentation on day 3 for an evaluation that occurred on an earlier date.

- puncture marks on the right palm, as identified by VA Police on day 7; and
- bruising to the resident's feet and ankles, as documented on day 4 by nursing staff.

When the OIG asked about actions taken, the nurse practitioner revealed having only examined the patient's right hand and wrist.

The following day, after being informed by staff that the resident had bruising to bilateral feet, the nurse practitioner reevaluated the resident and documented the resident's allegation of lying in bed, trying to get up, and "someone pushed [the resident] in [the] face"; and being hit on the feet, but could not say when the alleged abuse occurred. The nurse practitioner documented that the resident had multiple bruises on the feet and was observed the previous day to have bruising to the right wrist. The nurse practitioner further stated the resident has a history of dementia, so is "not [a] very reliable historian." The plan was to hold further aspirin administration, a blood thinning medication.

In an interview on day 7, VA Police asked about the possible cause of the bruising and the nurse practitioner stated the resident "has been on aspirin for a long time." VA Police further asked "if [the resident's] right hand/wrist and feet bruising resulted from [the resident's] aspirin use or an assault," the nurse practitioner "could not give a definitive answer and did not want to speculate."[30]

The OIG concluded the nurse practitioner documented an incomplete physical exam of the resident on day 3, which may have delayed the identification of additional injuries that were identified by staff the following day. The nurse practitioner also failed to consider whether the injuries indicated possible abuse. The nurse practitioner's knowledge of the wrist bruises, regardless of identifying the additional bruises, coupled with the inability to explain how they happened, qualified the bruises as injuries of unknown source.[31] Thus, the OIG would have expected the nurse practitioner to take required timely and robust actions to "confirm or rule out suspicions of injury due to abuse," consistent with quality care and policy related to abuse. [32]

[30] The OIG noted that the nurse practitioner placed a request for a psychology consult on day 8, stating the "reason for evaluation" as the resident's allegations of abuse. A psychologist completed the consultation nine days later, and concluded that, "based on the [resident's] lack of ability or willingness to engage in meaningful interaction or conversation," the resident was "a poor candidate for psychological services at this time."

[31] CMS State Operations Manual. The manual classifies injuries as 'injuries of unknown source' when "the source of the injury was not observed by any person; **and** [emphasis in original text] the source of the injury could not be explained by the resident; **and** [emphasis in original text] the injury is suspicious because of the extent of the injury or location of the injury … or the number of injuries observed at one particular point in time or the incidence of injuries over time.

[32] System Policy 11-22.

Failure to Report Suspected Elder Abuse to the State Authority

The OIG found that leaders did not make the required reports of suspected abuse, nor report investigation results, to the New York State Department of Health.[33]

The OIG found that leaders were unaware of the requirements to report suspected abuse to the state authority immediately by telephone, followed by a written report within 48 hours, and report investigation results within five days.[34] The acting nursing site manager reported being unaware of the reporting requirements. The chief of social work told the OIG that VA staff are not required to report patient abuse based on the facility's federal status. However, under federal regulations, allegations of abuse must be reported to state authorities, in accordance with state law.[35]

The OIG concluded leaders misunderstood the requirement and failed to make any required suspected abuse reports to New York State, which prevented the Commissioner of the New York State Department of Health from completing jurisdictional obligations such as investigating suspected abuse and, if warranted, referring the case to law enforcement, the Nurse Aide Registry, and state licensing boards. Although not voiced as a reason for the failures, system policies did not include most of the required state reporting procedures.

A Culture of Silence

The OIG learned through interviews a culture of silence existed in the CLC in which staff generally did not report, or underreported, patient safety incidents citing time-consuming administrative burdens that would result from reporting.

A VA Police leader shared in an interview that "a lot of stuff that does go on … doesn't get reported," and that staff have

> "created such a bond that it's a very hush-hush on anything on the wards … I've had numerous conversations with the President of the Union … because we've had numerous incidents ... [staff] that were just refusing to cooperate, in any type of investigation," recalling having had difficulty obtaining even the staff's name and date of birth.

When interviewed by the OIG, a nursing assistant expressed a culture in which staff have a mentality of "I don't see anything, and I don't hear anything."[36] Additionally, a nursing staff member shared that staff underreport because of the administrative burden of entering the

[33] 42 C.F.R § 483.12; New York Public Health Law, Section 2803-D 1-3.

[34] System Policy 11-22; 42 C.F.R § 483.12.

[35] 42 C.F.R § 483.12.

[36] The OIG identified an example of this when nursing assistant 3 told the VA Police of having no knowledge of the incident at lunchtime with the resident, which contradicted the sworn statements of nursing assistant 1 and nursing assistant 2 that nursing assistant 3 was present at the time.

information, such as in a report of contact, and concern with being involved in subsequent investigations. A nurse manager also reported believing reporting incidents to be administratively burdensome. Another nurse manager told the OIG that the CLC culture of underreporting is the "biggest problem" because staff do not want to say or document anything and fear reprisal.

Failure to Immediately Ensure Resident Safety

The OIG determined that nursing assistant 2's failure to immediately report the suspected abuse that occurred on day 1 inherently contributed to the failure to ensure the resident's safety. Additionally, the OIG found that the nurse manager, when notified, failed to take immediate action to protect the resident's safety.

Federal law requires staff to "prevent further potential abuse … or mistreatment while the investigation is in progress."[37] For reports of suspected abuse, staff must intervene "to eliminate the abuse."[38]

Nursing assistant 2's failure to immediately report the suspected abuse resulted in potential safety concerns for the resident as it prevented supervisors, VA Police, and staff from intervening to protect the resident. In addition, the nurse manager failed to ensure all residents' safety by delaying the removal of nursing assistant 1 from patient care. The nurse manager emailed the ADPCS regarding the suspected abuse on the afternoon of day 4. From interviews and email exchanges, the OIG found the ADPCS directed the nurse manager to remove nursing assistant 1 from the resident's care. However, the nurse manager admitted the removal was delayed for three days, because it was outside of business hours and required a letter from human resources authorizing the change in work assignment. Nursing assistant 1 reported to VA Police interacting with the resident on day 5, speaking with the resident on day 6, and documented in the resident's EHR caring for the resident on day 7.

The OIG concluded nursing assistant 2's three-day delay in reporting suspected abuse and the nurse manager's three-day delay in removing nursing assistant 1 from patient care, resulted in an unmitigated physical, emotional, and mental threat to the resident; jeopardized the well-being of residents; and delayed the preservation of relevant information for nearly one week.

Lack of Thorough Investigation of Suspected Abuse of the Resident

The OIG determined that nursing leaders conducted two factfinding investigations into the alleged abuse; however, neither factfinding 1 nor factfinding 2 were thorough, which led to

[37] 42 C.F.R § 483.12.

[38] System Policy 11-88.

inaccurate conclusions. Additionally, factfinding 2 was completed approximately five months after the alleged abuse, exceeding the 14-day completion requirement.

System policy requires that, when an allegation of physical abuse is reported, a preliminary factfinding (factfinding) will be conducted and completed within 14 days to determine whether there is any suspicion of abuse and, if so, identify "root causes and system modifications that will reduce the likelihood of future such occurrences."[39] Unless allegations of patient abuse are found to be clearly false, or the employee admits to abuse, system policy requires facility leaders to conduct an administrative investigation board (AIB).[40]

Six days after starting to investigate the allegation, the nurse manager submitted a summary of factfinding 1 to the ADPCS. The ADPCS told the OIG that factfinding 1 was inadequate, sharing that there was not "a complete sense of what happened and what should have happened."[41] Subsequently, the ADPCS reported tasking another investigator to conduct factfinding 2. Factfinding 2 was initiated in late fall 2023 and completed early 2024, approximately five months after the alleged abuse incident. When interviewed by the OIG, the ADPCS was unable to state the time frame for completing a factfinding. However, the OIG discovered the performance improvement manager sent a reminder email to the nurse manager and the ADPCS on day 7 that the factfinding was required to "be completed in 15 days."

The final report for factfinding 2 was inconclusive as to whether nursing assistant 1 physically assaulted the resident based on information obtained such as

- records showed that nursing assistant 1 was not assigned to the resident,
- records showed that nursing assistant 1 did not return to the CLC from an assignment to assist with a patient's travel until seven minutes after residents' lunch was served, and
- nursing assistant 1 denied physical contact with the resident.

However, the OIG determined this information was inconsistent with sworn statements nursing assistant 1 gave to VA Police. Specifically, nursing assistant 1 admitted to VA Police assisting

[39] System Policy 11-88. The "intent to abuse is not a requirement for [suspected] patient abuse. The patient's perception of how he/she was treated is an essential component of the determination as to whether a patient was abused." VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021. The handbook states that a factfinding is "a less formal administrative investigation" with the purpose of "ascertaining the magnitude of a problem; gathering and analyzing evidence; identifying and interviewing witnesses; summarizing and recording witness statements."

[40] System Policy 11-88.

[41] The OIG reviewed factfinding 1 and found that it did not contain investigation findings but rather a timeline of events from day 2 through day 9 (for example, when staff became aware of the resident's injuries), that largely were not pertinent to whether the abuse occurred. The OIG found that system leaders completed a third factfinding, specific to the nurse manager's response to the suspected abuse, from mid-fall 2023 to late fall 2023 (approximately 43 days).

the resident at lunchtime after returning to the CLC.[42] Additionally, the factfinding 2 investigator did not consider essential information from the VA Police report, which conflicts with the statement that nursing assistant 1 did not have physical contact with the resident. Specifically, the VA Police report documented nursing assistant 1 admitted grabbing the resident by the wrist to prevent being hit by the resident.

The OIG has concerns related to the facility's factfinding investigation process. According to VA policy, an authorization letter is required to provide the factfinding investigator guidance on the focus of the investigation and a blueprint for the review, which may include details such as the issues to be investigated and evidence already gathered.[43] The System Director informed the OIG that the ADPCS chartered the factfindings without charge memos. An authorization letter would have likely provided the factfinding investigator with formal written direction and necessary guidance on how to conduct a thorough investigation. A human resources specialist shared additional concerns related to the accuracy and thoroughness of the factfindings and stated that proper training on how to conduct factfinding investigations was warranted.

Based on the lack of thoroughness and the omission of essential VA Police information in factfinding 2, the OIG determined that factfinding 2's conclusion was inaccurate. The OIG opined that an accurate conclusion would have indicated the allegation of patient abuse was plausible and, since nursing assistant 1 did not admit to patient abuse, system leaders would have been required to conduct an AIB. The OIG shared concerns related to the system's factfindings and lack of thorough review of the suspected abuse with the System Director in March 2024. In response, the System Director initiated an AIB to review the allegations and provided the results of the AIB in June 2024.[44] The AIB found a preponderance of evidence to support that nursing assistant 1's behavior was resident abuse.

2. Inadequate Response to Additional CLC Resident Safety Concerns

The OIG found additional reporting deficiencies related to other incidents of suspected resident abuse as well as the failures by leaders to provide adequate Prevention and Management of Disruptive Behavior (PMDB) training to CLC staff.

The OIG reviewed system patient safety incident reports related to 12 incidents of abuse allegations for 11 CLC residents from mid-2022 through late 2023, and the corresponding

[42] The factfinding investigator concluded that nursing assistant 1 returned to work seven minutes past lunch time and admitted that possible verbal abuse occurred. The OIG verified, through review of a timecard, that nursing assistant 1 worked on the date of the incident.

[43] VA Handbook 0700.

[44] VA Handbook 0700. The handbook states that an AIB is a "type of administrative investigation … for collecting and analyzing evidence, ascertaining facts and documenting complete and accurate information," and "requires the most documentation and has substantial procedural requirements."

investigative information.[45] In a review of patient safety reports and EHR documentation, the OIG found the following reporting deficiencies:

- VA Police were not notified in 3 of the 12 incidents.[46]
- Social work staff were not notified in 6 of the 12 incidents.
- Residents' families were not notified in 10 of the 12 incidents.

The OIG interviewed 21 CLC residents to determine whether there may have been other unreported incidents of patient abuse. None of the interviewed residents reported an unresolved or active concern of abuse.

The OIG concluded nursing leaders and staff failed to notify VA Police, social work staff, and families of residents involved in suspected abuse incidents, which precluded those with a need to know from taking further action in advocacy of the residents.

Insufficient Staff Training in the Prevention and Management of Disruptive Behavior

The OIG found that leaders did not provide all CLC staff with mandatory PMDB training.

VHA requires all employees in designated clinical areas to have PMDB training annually.[47] PMDB training includes physical safety skill instruction that is particularly important in situations as discussed in this report, when staff encounter or need to deflect potentially aggressive behavior from patients.[48]

The OIG reviewed PMDB training documentation of selected staff from early fall 2022 through mid-spring 2024, and found that 5 of the 23 staff had not received the required training. Specifically, three staff had no evidence of annual PMDB training prior to the incident with the resident.

In addition, an internal system review conducted by patient safety staff identified 39 reported events from early fall 2022 through mid-summer 2023, "as physical and verbal assaults … by residents toward other residents, and residents towards staff." Patient safety staff documented

[45] Eleven incidents were patient safety incident reports provided by system staff, and one incident was identified in an OIG interview. For one resident identified in a patient safety incident report, the EHR could not be reviewed.

[46] When the OIG requested information regarding patient abuse allegations, the VA Police reported knowledge of two of the incidents, as of March 2024, for the past year.

[47] A nurse manager told the OIG that the PMDB training is an annual requirement for CLC staff. The Chief of Patient Service Education confirmed the unit nursing staff's PMDB training.

[48] VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2022. The directive states that the PMDB program uses the concept of "universal precautions for violence" and is "the only curriculum approved for mandatory training of all VHA personnel in concepts of workplace violence prevention."

"the absence of an established and consistent PMDB Training program for the CLC staff *contributed* [emphasis in original text] to the staff not having the appropriate skills necessary to help deescalate aggressive behaviors" and "may have led to the assaultive behavior events." According to the internal review report dated September 25, 2023, "most of the CLC staff" were not trained on verbal de-escalation of residents' disruptive behavior and personal safety skills.

Moreover, the OIG discovered an email correspondence on day 7 to system nurse managers, the ADPCS, and the performance improvement manager regarding staff "we believe have not taken this class [PMDB training on verbal de-escalation of residents' disruptive behavior and personal safety skills]," and attached a list of 154 staff names, which included nursing assistant 1.

The OIG concluded that system leaders failed to provide adequate PMDB training to staff, which may have contributed to the escalation of the physical altercation between nursing assistant 1 and the resident.

3. Related Concerns: Deficiencies in EHR Documentation and Omissions in Patient Abuse Policies

Deficiencies in EHR Documentation

The OIG identified deficiencies in the resident's EHR documentation by nursing assistant 2 and a facility physical therapist. VHA requires clinical staff to adhere to EHR documentation timeliness, accuracy, and completion.[49] Specifically, VHA requires CLC nursing documentation to "contain high quality, comprehensive and concise resident-centered information."[50] System policy specifies that for allegations of patient abuse "the event should be documented in the Progress Notes and include what occurred, the results of the evaluation and any necessary treatment."[51]

The OIG found registered nurse 1 documented that nursing assistant 2 reported the resident had bruises on both feet on day 4. However, the OIG did not find that nursing assistant 2 documented the bruising in the resident's EHR. Moreover, nursing assistant 2 documented activities of daily living notes in the resident's EHR on four days, from day 1 through day 5; however, the OIG

[49] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021, amended December 11, 2023. The policies contain the same or similar language related to clinical staff adherence to EHR documentation.

[50] VHA Directive 1142; VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013. VHA Handbook 1142.03 was rescinded and replaced with VHA Directive 1142 and provides similar expectations regarding documentation.

[51] System Policy 11-88.

found that nursing assistant 2 did not document the alleged abuse witnessed on day 1, related resident complaints, or the resident's injuries in the EHR.[52]

Further, a physical therapy EHR note the day after the suspected abuse was identical to the EHR notes documented from physical therapy sessions that took place two and five days earlier. Specifically, a 40-minute physical therapy session was documented in the EHR on day 2 describing work with the resident's ankles and legs, as well as the resident being "supervised" on step machines and walking; however, the physical therapy note did not document any bruising, physical limitations of the feet/ankles, or complaints of pain. Repeated documentation of the resident's "better affect," that the resident "willingly participated" in ankle exercises, and the resident's reported "0/10 pain" are difficult for the OIG to reconcile with the physical assault on the resident and the resulting injuries to the feet witnessed the previous day. When the OIG asked about the identical notes, the physical therapist affirmed the accuracy of the notes.

The OIG concluded that nursing assistant 2 omitted pertinent information and the physical therapist used verbatim notes from one session to another. Deficient EHR documentation by staff is a repeat finding at the system.[53] Incomplete and inaccurate medical record documentation can lead to incomplete or incorrect patient diagnoses and treatment decisions and compromises patient safety and care quality. Moreover, specific to this case, the system's substandard documentation posed challenges and hindered system staff, VA Police, and the OIG during reviews and investigations.

Omissions in Abuse-Related Policies

The OIG determined that VHA and system abuse policies do not include all components required by federal law. Federal law requires that facility leaders "develop and implement written policies and procedures that prohibit and prevent abuse," which must include, but is not limited to, training, prevention, investigation, and reporting.[54]

The OIG reviewed VHA's abuse policy and found that it does not fully address the elements required by law related to prevention.[55]

The OIG reviewed the system's two patient abuse-related policies, one on patient abuse and the other on elder abuse management and reporting, and found that the policies do not

[52] Centers for Medicare & Medicaid Services, 2008 appendix B (1), accessed January 3, 2025, https://www.cms.gov/research-statistics-data-and-systems/research/mcbs/downloads/2008_appendix_b.pdf. "Activities of daily living are activities related to personal care," such as "bathing or showering, dressing, getting in and out of bed or chair, walking, using the toilet, and eating."

[53] VA OIG, *Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens*.

[54] 42 C.F.R § 483.12.

[55] VHA Directive 1199(2). This directive was in place during the time of the events discussed in this report. VHA Directive 1199(2) was rescinded and replaced by VHA Directive 1199.

- address abuse prevention;
- include specific procedures that outline reporting requirements to the New York State Department of Health, and a report of investigation results to the administrator" or a designated representative and to appropriate state authorities, within five days; or
- include procedures for reporting suspected abuse to VA Police.[56]

While on-site in April 2024, the OIG team shared concerns related to the limitations of the system's patient abuse policies with the ADPCS, who said that the policies would be reviewed.

The OIG concluded that VHA and system policies do not address or include required components, which more likely than not would assist staff in the prevention and reporting of suspected patient and elder abuse. The lack of comprehensive and clear policies with requirements, as set forth by law, may have contributed to failures of staff and leaders to identify, review, and report the resident's suspected abuse as required.

Conclusion

Leaders and staff failed to report suspected abuse of a CLC resident to a supervisor, the unit social worker, VA Police, the resident's family, and New York State authorities, as required. In cases of abuse, staff are required to immediately report suspected abuse to state agencies, notify a supervisor, VA Police, ensure patient safety, and thoroughly investigate.

Specifically, nursing assistant 2 witnessed the alleged abuse of the resident but failed to immediately report the incident to a supervisor or document the suspected abuse. These delays prevented the nurse manager from initiating a series of required time-sensitive actions related to protecting the resident's safety and reporting and investigating the alleged abuse. The OIG also found that nursing staff failed to notify the unit social worker of the resident's injuries and allegations of abuse. Failure to notify the unit social worker of the suspected abuse and lack of engagement by the unit social worker, whether intentionally or unintentionally, prevented the resident from receiving social work services such as a psychosocial assessment, interventions, and assistance with treatment, referral, reporting, and documentation of the abuse.

The nurse manager and the ADPCS, who became aware of the suspected abuse, failed to notify VA Police of the resident's injuries or complaint of abuse. The nurse practitioner also failed to inform the resident's family of changes in the resident's condition, despite awareness of the resident's feet bruises and allegation of abuse. These failures can erode the family's trust in the

[56] System Policy 11-22; System Policy 11-88; New York Public Health Law, Section 2803-D 1-3; 42 C.F.R. § 483.12.

system and deny the family an opportunity to provide timely support to the resident in the aftermath of the incident.

The nurse practitioner documented an incomplete physical exam and failed to consider whether the injuries were related to suspected abuse, which may have delayed the identification of additional injuries that were identified by staff the following day. Leaders did not make the required reports of suspected abuse nor report investigation results to the New York State Department of Health, which prevented investigation of the suspected abuse and, if warranted, referral to law enforcement, the Nurse Aide Registry, and state licensing boards.

The OIG learned that a culture of silence existed in the CLC in which staff generally did not report, or underreported, patient safety incidents citing time-consuming administrative burdens that would result from reporting. A nursing assistant also expressed that the culture among staff is to not see or hear anything.

Additionally, the nurse manager did not take immediate action to ensure the resident's safety and nursing leaders did not thoroughly investigate the suspected abuse. Nursing assistant 2's failure to immediately report the suspected abuse and the nurse manager's failure to take immediate action when notified contributed to the failure to ensure the resident's safety and resulted in an unmitigated physical, emotional, and mental threat to the resident, jeopardized the well-being of all residents, and delayed the preservation of relevant information.

Nursing leaders conducted two factfinding investigations into the alleged abuse that led to inaccurate conclusions, and the second factfinding was delayed. The OIG has concerns related to the facility's factfinding investigation process; had leaders properly conducted factfinding 2, the conclusion would have indicated that the allegation of patient abuse was plausible and, more likely than not, would have triggered system leaders to conduct an AIB.

Nursing leaders and staff inadequately responded to other incidents of suspected resident abuse and, in some incidents, did not notify VA Police, a social worker, or family. System leaders failed to provide adequate PMDB training to staff, which may have contributed to the escalation of the physical altercation between nursing assistant 1 and the resident. During the inspection, the OIG also identified deficiencies in the resident's EHR documentation by nursing assistant 2 and a facility physical therapist, and with VHA and system policies related to patient abuse that did not include all required components.

Recommendations 1–7

1. The VA New York Harbor Healthcare System Director reviews facility processes to ensure medical and psychosocial health care for residents who report abuse, and staff are educated on the requirements.

2. The VA New York Harbor Healthcare System Director ensures that community living center nursing leaders and factfinding investigators complete factfindings in accordance with Veterans Health Administration policy.

3. The VA New York Harbor Healthcare System Director reviews responses to other incidents of suspected abuse and ensures actions are completed for resolution, including notifications.

4. The VA New York Harbor Healthcare System Director ensures community living center staff are compliant with Veterans Health Administration Prevention and Management of Disruptive Behavior Program education and training requirements.

5. The VA New York Harbor Healthcare System Director ensures community living center nursing and clinical staffs' electronic health records documentation meets requirements for timeliness, accuracy, and completion, and takes action as needed.

6. The Under Secretary for Health ensures that VHA abuse policy addresses compliance with federal statutes and regulations, including 42 C.F.R. § 483.12, and outlines suspected elder abuse processes to notify leaders, interdisciplinary care team members, VA Police, patients' families or designees, and state regulatory agencies; and identifies roles and responsibilities of reviewing officials for investigative reviews.[57]

7. The VA New York Harbor Healthcare System Director ensures system abuse policies include required elements to comply with Veterans Health Administration, state, and federal regulations, including 42 C.F.R. § 483.12; and clearly outlines processes for leaders and staff when responding to suspected abuse related to reporting (for example, to interdisciplinary care team members, VA Police, family or designee, and state regulatory agencies); and conducting factfinding investigations.

[57] The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: July 10, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens

To: Director, Office of Healthcare Inspections (54HL04)

1. Thank you for the opportunity to review and comment on OIG's draft report on Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens. The Veterans Health Administration (VHA) concurs in principle with Recommendation 6 made to the Under Secretary for Health and concurs with recommendations 1-5 and 7 made to the VA New York Harbor Healthcare System Director. An action plan is provided in the attachment.

2. VHA values OIG's assistance to ensure that all stakeholders are aligned around VHA's vision that all Veterans will have access to the highest quality care.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

Steven Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on July 10, 2025.]

Office of the Under Secretary for Health Response

Recommendation 6

The Under Secretary for Health ensures that VHA abuse policy addresses compliance with federal statutes and regulations, including 42 C.F.R. § 483.12, and outlines suspected elder abuse processes to notify leaders, interdisciplinary care team members, VA Police, patients' families or designees, and state regulatory agencies; and identifies roles and responsibilities of reviewing officials for investigative reviews.

Concur in Principle

Target date for completion: October 2025

Under Secretary for Health Comments

Ensuring the safety of vulnerable people and effectively reporting any suspected cases of abuse and neglect is a critical function of VHA. In general, VHA agrees that national policy should be in alignment with applicable statute and regulation and concurs in principle with this recommendation. While VHA recognizes OIG's request to align its policy with regulation, including 42 C.F.R. § 483.12, VHA does not agree that 42 CFR 483.12 is applicable to any VA long-term care facility. The language in 42 CFR 483.12(b)(5) refers to accordance with section 1150B of the Social Security Act. Section 1150B of the Act applies to long-term care facilities receiving at least $10,000 of Federal funds under Chapter 7 – Social Security, which excludes any VA long term-care facility.

VHA published an update to its national policy, VHA Directive 1199, Reporting Cases of Abuse and Neglect, on September 3, 2024. This policy update occurred after the Office of Inspector General (OIG) investigation was conducted. The development of VHA Directive 1199 was completed through significant collaboration with frontline clinicians, National Program Offices, VA General Counsel, and regulatory specialists. It is VHA policy that all covered professionals, while acting in the scope of their employment conducting any VHA-authorized health care activities, report suspected cases of abuse and neglect to the appropriate authorities. VHA Directive 1199 outlines that all VHA employees and trainees have a duty to report suspected cases of abuse and neglect, at minimum, to their supervisor. If the situation requires additional reporting, the supervisor assists and supports the employee/trainee through the process. VHA supervisors who are not covered professionals themselves must forward the report to a VA covered professional as soon as possible, as defined in VHA Directive 1199. VHA policy outlines specific responsibilities for all levels of the health care system, from Central Office to the individual employee and provides instruction to engage the Offices of the Chief Counsel in the Districts as needed. To ensure implementation of this directive, VA medical facilities are also required to develop and maintain standard operating procedures.

VHA appreciates OIG's review of this critical issue and commits to reviewing VHA Directive 1199 in the context of applicable Federal and state laws governing reporting of suspected child and elder abuse. This review will be performed collaboratively with VA regulatory specialists, VA Office of General Counsel, and the VHA Care Management and Social Work Services program office, as well as other subject matter experts. VHA will make edits to VHA Directive 1199, if applicable, to ensure effective implementation of this directive.

OIG Comments

The OIG agrees that VA community living centers (CLCs) do not meet the definition of a long-term care (LTC) facility under the Social Security Act (SSA), since they do not receive federal funding as defined by that statute.[58] However, as a matter of policy, VHA voluntarily adopted the survey process of the Centers for Medicare & Medicaid Services (CMS) for LTC facilities to determine whether CLCs are in compliance with federal laws regulating nursing homes.[59] The CMS survey process incorporates 42 C.F.R., part 483, which addresses a variety of issues governing elder abuse, including prevention of elder abuse, investigation of allegations of elder abuse, and the requirement to report elder abuse consistent with federal and state reporting statutes.[60] In its discussions with OIG regarding recommendation 6 in this report, VHA has not denied these facts.

Although VHA updated its policy on reporting elder abuse after this inspection by publishing VHA Directive 1199, VHA did not rescind Section 4b of VHA Directive 1142(1), or expressly state that VA-covered professionals providing care to residents in CLCs are no longer subject to the CMS survey process, or the provisions of 42 C.F.R., part 483.[61]

On the contrary, VHA acknowledges that its updated policy still requires covered VA professionals, acting in the scope of their employment conducting VHA-authorized healthcare activities, to report suspected elder abuse to appropriate authorities. The updated policy explains that appendix A provides background for determining whether federal and state laws governing the reporting of elder abuse apply to VA-covered professionals.

In appendix A, VHA notes that state reporting laws generally pertain to abuse suffered by vulnerable populations (including the elderly) and require a certain cadre of professionals (including CLC healthcare and social service providers), who reasonably suspect elder abuse, to report that information, as soon as possible, to the appropriate local or state law enforcement agency tasked with responsibility for the advocacy, protection, or health of such individuals. VHA further notes that states cannot compel VA providers acting in the scope of their

[58] 42 U.S.C. §§ 3002 (32) and (34).

[59] VHA Directive 1142(1).

[60] 42 C.F.R § 483.12.

[61] VHA Directive 1199(2); VHA Directive 1199; VHA Directive 1142(1).

employment to comply with a state law that conflicts with federal law or impedes federal operations, and that any disclosure of patient information to state authorities must comply with federal and state privacy and confidentiality laws. Nowhere does the updated policy state that VA providers are no longer required to comply with federal and state laws requiring the reporting of elder abuse. Rather, the updated policy specifically directs facilities to consult with the Office of Chief Counsel in their districts to determine whether the state where the VA facility is located has a law requiring the reporting of elder abuse and whether there is an exemption for VA providers.

VHA conceded in discussions with OIG that the Elder Justice Act (EJA) codified at 42 U.S.C. §§ 1397j through 1397m-5 is the appropriate statute to follow in its updated elder abuse policy, but rejected OIG's contention that the updated policy must also comply with 42 C.F.R. 483.12.[62] VHA's position is internally inconsistent, since the EJA and 42 C.F.R., part 483 are integrally related. The EJA amended the Social Security Act (SSA), Title XI, Part A, by adding section 1150B, requiring the reporting of crimes (including elder abuse) occurring in federally funded LTCs to appropriate federal and state law enforcement authorities. Pursuant to its rulemaking authority under the SSA, the Secretary of Health and Human Services issued 42 C.F.R. 483.12 to provide guidance to federally funded LTCs for reporting crimes of elder abuse to appropriate federal and state law enforcement and other officials. It would be incongruous for VHA to apply the EJA in its updated policy, but not its implementing regulations.

It has always been VHA's policy that CLCs must comply with federal and state statutes for reporting elder abuse to state authorities.[63] If VHA wants to change this policy it should do so explicitly, not by an opaque reference to the EJA that is contradicted by the remaining language of the updated policy, including the explicit direction in Appendix A for medical facilities to consult with the Office of Chief Counsel in their districts to determine how to comply with such federal and state reporting laws.

As it stands, VHA has two contradictory policies regarding the reporting requirements for elder abuse occurring in CLCs, which require clarification, consistent with OIG's recommendation 6.[64]

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

[62] 42 U.S.C. §§ 1397j–1397 m-5.

[63] VHA Directive 2012-022, *Reporting Cases of Abuse and Neglect*, September 4, 2012; VHA Directive 1199(2).

[64] VHA Directive 1199; VHA Directive 1142(1).

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 16, 2025

From: Director, New York/New Jersey Department of Veterans Affairs (VA) Health Care Network (10N2)

Subj: OIG Draft Report—Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens (VIEWS # 13239004)

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL04)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the report findings and recommendations of OIG draft report—Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, contact the Veterans Integrated Service Network Quality Management Officer.

(*Original signed by:*)

Joan E. McInerney, MD, MBA, MA, FACEP
Network Director, VISN 2

[OIG comment: The OIG received the above memorandum from VHA on July 10, 2025.]

Appendix C: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 16, 2025

From: Director, Department of Veterans Affairs (VA) Healthcare NY Harbor Healthcare System (630)

Subj: VA OIG Draft Report—Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens (VIEWS # 13239004)

To: Director, New York/New Jersey VA Health Care Network (10N2)

1. We appreciate the opportunity to review and comment on the OIG draft report—Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens. VA Healthcare NY Harbor Healthcare System concurs with the recommendations and will take corrective action.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Performance Improvement Manager.

(*Original signed by*:)

Timothy Graham
Director

[OIG comment: The OIG received the above memorandum from VHA on July 10, 2025.]

System Director Response

Recommendation 1

The VA New York Harbor Healthcare System Director reviews facility processes to ensure medical and psychosocial health care for residents who report abuse, and staff are educated on the requirements.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

A full review of current policies and practices has been completed. A revised policy is being prepared that addresses the requirements for timely reporting of observed or suspected patient/resident abuse to both facility leadership and police, state, and federal authorities. This policy also details the actions required to protect patient/resident safety and initiate personnel actions related to incidents of alleged abuse. This policy, once finalized, will be processed through the facility governance structure for formal approval. It will then be disseminated through the Designated Learning Office (DLO) to all staff members throughout the St. Albans campus. Targeted education and auditing of the process will commence upon final approval of the revised policy. The Clinical Executive Board (CEB) is chaired by the Chief of Staff (COS). The CEB reports monthly to the Executive Council (EC), which is chaired by the Medical Center Director (MCD).

Compliance will be monitored with a target of 90%, which will be tracked by the DLO and reported monthly to the CEB.

Recommendation 2

The VA New York Harbor Healthcare System Director ensures that community living center nursing leaders and factfinding investigators complete factfindings in accordance with Veterans Health Administration policy.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

A fact-finding standard operating procedure (SOP) in accordance with VHA policy is being written by the Compliance Officer at the request of the MCD. Once the SOP is finalized, it will be reviewed and approved by the CEB, which is chaired by the COS, and the EC, which is chaired by the MCD.

A SharePoint was established for all documentation related to fact-findings. The SharePoint will be reviewed weekly at the MCD's huddle with the Pentad. The weekly review will include a review of the timeliness of charge memos, final reports, and follow-up reports and actions. Final fact-finding reports will be reviewed for thoroughness and completeness by the convening authority. It is the responsibility of the convening authority to ensure that the concurrence memo is also timely, and that follow-up reports and actions are submitted as per the concurrence memo. A tracking tool will be developed to monitor monthly timeliness for each step of the fact-finding process. The MCD will review the data monthly at the fact-finding huddle. The weekly review and auditing will begin in July 2025.

Compliance will be defined as 90% compliance for 6 months as per the tracking tool. The MCD will meet with the convening authority for an action plan when compliance is below 90%.

Recommendation 3

The VA New York Harbor Healthcare System Director reviews responses to other incidents of suspected abuse and ensures actions are completed for resolution, including notifications.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The Reporting Patient Abuse and Protecting Veteran and Staff SOP was revised to include notification requirements. The Joint Patient Safety Report (JPSR) will be reported at the daily Enterprise morning report to ensure all appropriate notifications to all required Services.

The weekly review, using SharePoint, will include a review of the timeliness of charge memos, final reports, and follow-up reports and actions. Final reports will be reviewed for thoroughness and completeness by the convening authority. It is the responsibility of the convening authority to ensure that the concurrence memo is also timely, and that follow-up reports and actions are submitted as per the concurrence memo. The MCD will review the data weekly at the fact-finding huddle. The weekly review and auditing will begin in July 2025.

Compliance will be defined as 90% compliance for 6 months as per the tracking tool. The MCD will meet with the Convening authority for an action plan when compliance is below 90%.

Recommendation 4

The VA New York Harbor Healthcare System Director ensures community living center staff are compliant with Veterans Health Administration Prevention and Management of Disruptive Behavior Program education and training requirements

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

Weekly tracking, reporting, and executive review of employee compliance with Prevention and Management of Disruptive Behavior (PMDB) educational mandates at the Enterprise Operations Morning Report are already the standard at this facility. All areas with compliance less than 90% will be reviewed with the area manager and the respective Executive Senior Leader. Action plans will be required for areas not meeting this target and progress will be tracked until resolution. PMDB Compliance data, collected and reported by the DLO, will continue to be reported to the Executive Staff weekly at the Enterprise Operations Morning Report. The CEB is chaired by the COS. The CEB reports monthly to the EC, which is chaired by the MCD.

Compliance will be monitored with a target of 90% for 6 consecutive months. The MCD will meet with the Convening authority for an action plan with compliance less than 90%.

Recommendation 5

The VA New York Harbor Healthcare System Director ensures community living center nursing and clinical staffs' electronic health records documentation meets requirements for timeliness, accuracy, and completion, and takes action as needed.

_X _Concur

____Nonconcur

Target date for completion: March 2026

Director Comments

The Quality Management department will implement a monthly audit of medical record documentation for the Community Living Center (CLC). The audit will review medical record documentation for timeliness, accuracy, and completion per Joint Commission and VHA Directives. Twenty randomly selected medical records will be reviewed monthly. The results of the audit will be reported quarterly to the CLC Quality Assurance/Performance Improvement (QAPI) Committee. The QAPI Committee will report quarterly to the Quality Committee. The

QAPI Committee is chaired by the acting Associate COS/Extended Care. The Quality Committee reports to the EC, both of which are chaired by the MCD.

Compliance will be monitored with a target of 90% for 6 consecutive months. The MCD will meet with the Convening authority for an action plan when compliance is below 90%.

Recommendation 7

The VA New York Harbor Healthcare System Director ensures system abuse policies include required elements to comply with Veterans Health Administration, state, and federal regulations, including 42 C.F.R. § 483.12; and clearly outlines processes for leaders and staff when responding to suspected abuse related to reporting (for example, to interdisciplinary care team members, VA Police, family or designee, and state regulatory agencies); and conducting factfinding investigations.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The revised policy on Patient/Resident Abuse Reporting and Prevention includes notification and reporting requirements to VA Police and to State Department of Health authorities for all incidents of observed or suspected abuse. The JPSR will be reported at the Enterprise morning report and will serve as the tracking tool to ensure all appropriate notifications to all required Services. Monthly reports will be tracked by the CEB meeting until the target is met for 6 months. The CEB is chaired by the COS. The CEB reports monthly to the EC, which is chaired by the MCD.

Compliance will be monitored with a target of 90% for 6 months as per the tracking tool. The MCD will meet with the Convening authority for an action plan when compliance is below 90%.

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	Clarissa Reynolds, MBA, NHA, Director Erin Butler, LCSW Joseph Caiati, MD Andrew Waghorn, JD
Other Contributors	Shelby Assad, LCSW Sheyla Desir, MSN, RN Natalie Sadow, MBA Heather Shand Nancy Short, LCSW Erica Taylor, MSW, LICSW April Terenzi, BA, BS

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