US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA Western New York Healthcare System in Buffalo

Healthcare Inspection | **24-02930-175** | **July 31, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Western New York Health Care System (system) to review allegations regarding the clinical care of a resident at a system community living center (CLC) located in Batavia, New York.[1] The resident required emergency care at a community hospital and subsequently died after receiving hospice care at the Buffalo VA Medical Center (VAMC). The OIG substantiated that ongoing and cumulative deficiencies in care at the Batavia CLC may have contributed to a resident's (Resident A's) preventable decline in health, which necessitated palliative and end-of-life care. Further, the OIG reviewed and found similar deficiencies in care for a second resident and identified concerns regarding leaders' response to clinical care deficiencies, medical provider staffing, and nursing education.

Resident A Case Summary

Resident A was in their seventies with a history of dementia, anxiety, and diabetes.[2] In late winter 2024, Resident A was admitted to the Buffalo VAMC for increasing combativeness, agitation, and confusion. The resident's inpatient medications included periodic single doses of haloperidol for severe agitation, which were no longer required when Resident A was started on risperidone.[3] Resident A, with behavior controlled and normal laboratory studies, was discharged from the Buffalo VAMC to the Batavia CLC Maple unit for long-term care.

Upon admission to the CLC (day 1), the chief of geriatric service (chief geriatric physician) added haloperidol 2.5 milligram (mg) by injection every eight hours as needed for extreme agitation. A resident physician documented Resident A's baseline cognitive status as confused and a nurse noted Resident A needed extensive assistance with daily activities, including eating.

[1] "What is a Community Living Center?" VHA Geriatrics and Extended Care, accessed July 25, 2024, https://www.va.gov/geriatrics/pages/va_community_living_centers.asp; VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024. CLCs are VA residential care facilities for veterans who require nursing home level of care. Services provided to CLC-admitted veterans, or "residents," include assistance with daily maintenance, such as bathing or dressing; skilled nursing; rehabilitation; and palliative and hospice care. The Batavia CLC has three care units—Spruce, Maple, and Pine. The Pine unit is designated for dementia care; however, all units may serve residents with dementia.

[2] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[3] Haloperidol is an antipsychotic medication used to treat psychotic disorders and severe behavioral problems. National Institutes of Health, National Library of Medicine, *Medline Plus*, "Haloperidol," accessed December 10, 2024, https://medlineplus.gov/druginfo/meds/a682180.html. Risperidone is an antipsychotic medication used to treat mental illness, including behavioral issues such as aggression. National Institutes of Health, National Library of Medicine, *Medline Plus*, "Risperidone," accessed December 10, 2024, https://medlineplus.gov/druginfo/meds/a694015.html.

That evening, Resident A sustained a fall without injury and a nurse documented vital signs as normal with an elevated fingerstick blood sugar level at 137 milligrams per deciliter (mg/dl).[4]

On day 2, the chief geriatric physician doubled Resident A's haloperidol order and on day 3, doubled the resident's risperidone dose. On day 16, the chief geriatric physician ordered blood work to monitor Resident A's diabetes and electrolyte levels. Four days later, a nurse documented Resident A had a fingerstick blood sugar level completed, which was elevated at 349 mg/dl.

From days 1 through 23, Resident A received 21 doses of haloperidol. On the night of day 23, a registered nurse noted Resident A was lethargic, did not respond to voice, and had abnormal vital signs. A nurse obtained a fingerstick blood sugar level, which read ">600" mg/dl. After notification, a physician ordered transfer of Resident A to a community hospital for evaluation.

Resident A was evaluated in the emergency department of the community hospital and admitted to the intensive care unit with a diagnosis of hyperosmolar hyperglycemic state.[5] Resident A underwent multiple treatments at the community hospital with improvement in responsiveness but not cognition. On day 36, Resident A was transferred to the Buffalo VAMC for hospice care and died two days later.

Inspection Results

The OIG substantiated deficiencies in care, including (1) physician and nursing staff management of Resident A's dementia and diabetes, and (2) nursing documentation of medication administration and nutritional intake.

The OIG further identified deficiencies in provider staffing and nurse education that increased risk to patient safety and may have contributed to Resident A's functional decline.

Dementia Care

The Veterans Health Administration (VHA) requires all medical facilities to provide a "full continuum of diagnostic, treatment, and supportive services" to veterans with dementia in collaboration with families and caregivers.[6] Researchers developed a dementia-specific intervention program, published in 2005, known as Staff Training in Assisted Living Residences

[4] The system's laboratory's reference range for normal fingerstick blood sugar is 70–115 mg/dl.

[5] Resident A's blood sugar result at the community hospital was 909 mg/dl. Hyperosmolar hyperglycemic state is a condition where blood sugar levels become very high and the body cannot use glucose or fat for energy. If left untreated, it can "lead to life-threatening dehydration and coma." Mayo Clinic, "Hyperglycemia in diabetes," accessed July 29, 2024, https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631.

[6] VHA Directive 1140.12, *Dementia System of Care*, October 18, 2019.

(STAR).[7] In 2010, VHA adapted the STAR program into a collaborative and interdisciplinary clinical intervention program known as STAR-VA, to decrease the frequency and severity of behaviors, such as agitation.[8]

When a resident exhibits disruptive behavior, nursing staff must enter a STAR-VA note in the electronic health record (EHR), which is used to develop a team-based intervention plan.[9] Further, if a resident exhibits physically disruptive behaviors, antipsychotic medications may be used; however, nursing staff must attempt non-pharmacological approaches and document the specific behaviors exhibited.[10] Additionally, nurses are required to notify the provider of a resident's refusals of prescribed medication as well as document in the EHR, "why [the medication] was not administered and the name of the provider contacted."[11]

The OIG found no evidence of STAR-VA notes in the EHR, despite nursing staff's recollection of disruptive behaviors and the administration of haloperidol 21 times over Resident A's 23-day stay. Further, specific behaviors necessitating administration of haloperidol were only documented approximately 24 percent of the time and only one attempt to re-direct Resident A prior to administration was noted in the EHR. A system corrective action plan from late summer 2024 outlined the need to reeducate all staff on STAR-VA behavioral notes.

Before starting antipsychotic medications and upon placing orders, medical providers must evaluate residents to determine the medical necessity and document clinical rationale.[12] However, the OIG found the chief geriatric physician failed to document assessments and reassessments of Resident A when placing orders for antipsychotic medication.

Upon admission to the CLC, a medical provider was unable to complete a full physical exam as Resident A "was confused and extremely agitated." However, a provider did not complete the

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[7] Linda Teri et al., "STAR: A Dementia-Specific Training Program for Staff in Assisted Living Residences," *The Gerontologist*, 45, no. 5 (October 2005): 686-693, https://doi.org/10.1093/geront/45.5.686.

[8] Linda Teri et al., "STAR: A Dementia-Specific Training Program for Staff in Assisted Living Residences," *The Gerontologist* 45, no. 5 (October 2005): 686–693, www.doi.org/10.1093/geront/45.5.686; Michele J. Karel et al., "Effectiveness of Expanded Implementation of STAR-VA for Managing Dementia-Related Behaviors Among Veterans," *The Gerontologist* 56, no. 1 (July 16, 2015): 126–134, www.doi.org/10.1093/geront/gnv068; VA, "STAR-VA Intervention for Managing Challenging Behaviors in VA Community Living Center Residents with Dementia: Manual for STAR-VA Behavioral Coordinators and Nurse Champions," accessed September 11, 2024, https://dvagov.sharepoint.com/sites/vhastar-va/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhastar%2Dva%2FShared%20Documents%2FSTAR%2DVA%20Manual%202017c%2Epdf&parent=%2Fsites%2Fvhastar%2Dva%2FShared%20Documents. (This site is not publicly accessible.)

[9] System Policy 111-53, *Behavioral Health Consult in Community Living Center (CLC),* April 4, 2022.

[10] System Policy 119-32, *Use of Psychotropic (Neuroleptic) Medications in Community Living Centers*, January 6, 2023. A psychotropic is "… any drug that affects brain activities associated with mental processes and behavior" including antipsychotic, antidepressant, and anti-anxiety medications." 42 C.F.R. § 483.45 (2024).

[11] System Policy 118-03, *Administration of Medications and IV Fluids using BCMA*, March 1, 2023.

[12] Clinical rationale includes "the benefit of the medication to the resident" and indications of improvement to the resident's distress. System Policy 119-32.

medical assessment at any time during the following 22 days of admission and did not document clinical rationale for continued use of haloperidol. The chief geriatric physician reported "hav[ing] inadvertently omitted any documentation."

Deficiencies in Diabetes Care and Monitoring

Resident A was prescribed diabetes medication to control blood sugar and reduce the risk of diabetes-related complications. Missing doses of diabetes medication can lead to serious and life-threatening complications if left untreated, and monitoring nutritional intake of older adults with diabetes is critical as irregular appetite and intake can increase the risk of abnormal blood sugar levels.[13]

The OIG found CLC nursing staff failed to document and communicate the majority of Resident A's refusals of medication. Nursing staff also failed to document 29 percent of Resident A's meal intake—notably, in the four days prior to Resident A's clinical deterioration, the EHR reflected limited documentation and a significant decrease in meal intake. Additionally, the OIG found the chief geriatric physician ordered a basic metabolic panel, which included a serum blood sugar measurement, for Resident A on CLC day 18 but failed to ensure completion of the order. The medical support assistant was not notified of the order as expected and there was no mechanism to identify missed orders.

On CLC day 20, a licensed practical nurse performed a fingerstick blood sugar level on Resident A, but the nurse did not report the elevated result (349 mg/dL) to a supervising nurse, and the nursing supervisor, who was later informed of the result by the resident's family member, did not assess the resident or notify the provider. The nursing supervisor told the OIG of "assuming" that follow-up care, such as additional fingersticks and insulin, was ordered. Additionally, the chief geriatric physician received an EHR alert with the result the following morning but took no further action to address the elevated blood sugar level.

OIG-Identified Issues in the Care of Resident B

The OIG received an additional complaint related to the care of another CLC resident, Resident B. The complaint alleged that following a period of no nutritional intake for five days, there was no intervention documented in Resident B's EHR until the sixth day. System leaders performed a clinical review of Resident B's care for a 36-day period, as requested by the OIG, and noted a lack of documented notification and communication to escalate issues that seemingly

[13] "Diabetic ketoacidosis is a serious complication of diabetes" and if left untreated, "can lead to loss of consciousness and … death." Mayo Clinic, "Diabetic Ketoacidosis," accessed July 24, 2024, https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551. Medha N. Munshi et al., "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association," *Diabetes Care* 39, no. 2 (January 11, 2016): 308-318, https://doi.org/10.2337/dc15-2512.

delayed care, lack of documented assessments upon changes in the resident's condition, and that the chief geriatric physician did not consistently document clinical assessments before or following transfers to higher levels of care.

The OIG reviewed Resident B's EHR for the same 36-day period and found similar issues. Additionally, the OIG determined that nursing staff failed to consistently document and notify the provider of held medications and the chief geriatric physician did not place transfer orders, from the CLC to the emergency department, as required.[14]

Leaders' Response

VHA expects organizational leaders to "promote the delivery of highly reliable, high-quality and safe patient care" and encourages staff to report patient safety adverse events through the Joint Patient Safety Reporting system—the "primary mechanism" to identify, investigate, and analyze healthcare system vulnerabilities.[15]

CLC Leaders' Response

The OIG found that nursing leaders and staff failed to enter a patient safety report when Resident A's elevated fingerstick blood sugar result on CLC day 20 was not reported to a supervising nurse and clinical follow-up did not occur as required.

Approximately one week after the fingerstick, nursing leaders were notified, via an email, of Resident A's fingerstick elevated blood sugar level and that the licensed practical nurse did not report results to a supervising nurse. When asked about consideration of a patient safety report, the unit nurse manager said, "I don't know why it didn't occur to me. It would have been a good idea." The OIG learned the chief geriatric physician and CLC medical director also did not enter patient safety reports or escalate the care concerns, despite awareness of the resident's outcomes following transfer from the CLC to the community emergency department.

System Leaders' Response

Once aware of care concerns at the CLC, system leaders identified the need for and conducted an institutional disclosure; temporarily removed the chief geriatric physician from providing care; and initiated clinical and administrative investigations.[16]

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[14] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024.

[15] VHA Directive 1050.01 (1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[16] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. When a "harmful or potentially harmful adverse event has occurred during the patient's care," VHA requires disclosure to the patient or their personal representative. An institutional disclosure includes an expression of apology and notification of legal options.

The OIG learned that the interim Chief of Staff (COS) became aware of the care issues at the Batavia CLC upon assuming the acting role in mid-August 2024.[17] The chief geriatric physician was suspended from clinical care in late summer and, shortly after, an institutional disclosure was conducted. Following clinical care reviews and an administrative investigation, in late 2024, the interim COS initiated a focused professional practice evaluation (FPPE) for cause.[18] Per the FPPE for cause, the chief geriatric physician would return to clinical care and receive weekly performance reviews.

Additional Concerns Identified by the OIG

The OIG identified an additional concern with CLC medical provider staffing and determined that staffing was inadequate to support the clinical and administrative needs of the Batavia CLCs.

The CLC medical director told the OIG of identifying the need for five full-time providers at the Batavia and Buffalo CLC sites; however, there are only three providers.[19] The chief of quality told the OIG that CLC staff reported concerns about the chief geriatric physician's responsiveness but attributed the concerns to provider staffing and did not report them to executive leaders, believing there was nothing that could be done. The interim COS, CLC medical director, and chief of quality also told the OIG that recruiting is difficult due to the rural location of Batavia; in response, the interim chief geriatric physician described a plan to expand recruitment.

The OIG further identified ineffective nursing education and training organization, due to unclear roles and responsibilities and a perceived lack of support from the nurse education department, and a lack of required dementia care training, which the OIG determined contributed to care deficiencies.

During an interview, the associate chief of nursing service for geriatrics explained sharing the responsibility to identify training needs with the unit nurse managers and the clinical nurse expert; however, the OIG learned from interviewed CLC nursing leaders that this responsibility was not clearly defined.[20] CLC nursing staff also expressed a lack of support from the nurse education department; upon review of nursing staff training for 2024, the OIG found only 2 of

[17] Effective August 18, 2024, the VISN 2 Network Director designated an interim system executive director and chief of staff. The executive director and chief of staff were in the interim positions for the duration of this inspection.

[18] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024; VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. An FPPE for cause is an evaluation of a provider's performance "to determine if any action should be taken."

[19] VHA does not have a required staffing methodology for CLC medical providers but a full-time equivalent calculator from the VHA Office of Geriatrics and Extended Care may be used to determine the number of recommended providers—the CLC medical director told the OIG of using this calculator.

[20] CLC nursing leaders include the clinical nurse expert, Maple unit nurse manager, and a nurse supervisor.

the 11 training topics related to the issues identified in the care of Residents A and B. Additionally, not all Maple unit nursing staff completed required STAR-VA training, and the system did not have a dementia education plan as required.[21] The interim system executive director reported "[a]n education plan is being developed."

The OIG made 10 recommendations to the System Director related to completion of behavioral notes and rounds, antipsychotic medication administration, nursing documentation, fingerstick blood sugar testing, laboratory processes, reporting of patient safety events, nursing oversight, FPPE for cause, medical provider staffing, and nursing education.

VA Comments and OIG Response

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

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Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
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[21] The VA medical system director is responsible for "[e]nsuring that the [system] has a dementia education plan for addressing all … training on the care of [residents] with dementia." VHA Directive 1140.12.

Contents

Abbreviations

ACNS	associate chief of nursing service
ADLs	activities of daily living
CLC	community living center
CNE	clinical nurse expert
EHR	electronic health record
FPPE	focused professional practice evaluation
GEC	Geriatrics & Extended Care
HRO	high reliability organization
JPSR	Joint Patient Safety Reporting
LPN	licensed practical nurse
MSA	medical support assistant
OIG	Office of Inspector General
QAPI	quality assurance performance improvement
STAR	Staff Training in Assisted Living Residences
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Western New York Health Care System (system) to review allegations regarding the clinical care of a resident at a system community living center (CLC) located in Batavia, New York. The resident required emergency care at a community hospital and subsequently died after being transferred to the Buffalo VA Medical Center (VAMC) for hospice care. The OIG further reviewed the care provided to a second resident in the CLC, as well as additional concerns regarding leaders' response to clinical care.

Background

The system is part of Veterans Integrated Service Network (VISN) 2 and is designated as a level 1b high complexity facility.[1] The system includes the Buffalo and Batavia VAMCs and nine outpatient clinics in Western New York and provides comprehensive care, including primary and specialty services. The Buffalo VAMC includes inpatient care and one CLC unit primarily for short stay and hospice care.[2] The Batavia VAMC operates three CLC units, including one designated to care for residents with dementia (dementia care unit).[3] Per the associate chief of nursing service (ACNS) for geriatrics, each CLC unit has a separate nurse manager but shares nurse supervisors and providers. From October 1, 2022, through September 30, 2023, the system served 54,761 patients.

VHA Geriatric and Extended Care

The Veterans Health Administration (VHA) Office of Geriatrics & Extended Care (GEC) is responsible for policy and oversight related to the provision of service to veterans in VA facilities, as well as community and home-based care settings.[4] Further, the office promotes the

[1] VHA Office of Productivity, Efficiency, & Staffing, "Fact Sheet Facility Complexity Model," January 28, 2021. The Facility Complexity Model "rates facilities as 1a, 1b, 1c, 2, or 3, with facilities rating 1a being the most complex and those rated 3 the least complex." A level 1b facility is considered high complexity with "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs."

[2] In an interview, the CLC Medical Director confirmed one CLC unit as primarily for short stay and hospice care.

[3] The Batavia VAMC is located approximately 36 miles east of the Buffalo VAMC. The three Batavia CLC units are named Spruce, Maple, and Pine. In an interview, a unit nurse manager reported the Pine unit is designated for dementia care; however, other units may also serve residents with dementia. Dementia is a group of symptoms of cognitive decline "including disturbances in memory, language, spatial abilities, impulse control, judgment, or other areas of cognitive ability severe enough to interfere with social or occupational functioning." VHA Geriatrics and Extended Care, "Implementation Guidelines for Veterans Health Administration Dementia System of Care (VHA DSOC)," October 24, 2019.

[4] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Facilities*, March 24, 2022.

"advancement of geriatrics and long-term care through research, education, and evaluation of new clinical models."[5]

CLCs are VA residential care facilities for veterans who require nursing home level of care and assistance with activities of daily living (ADLs), such as bathing or dressing; skilled nursing services; rehabilitation; medical; and palliative and hospice care.[6] Intended outcomes for residents in CLC care include "… restoring residents to the highest practicable level of well-being, maximizing function and independence, preventing declines in health and providing comfort at the end of life."[7] Resident stays may be short-term (such as for rehabilitation, or to provide respite for caregivers) or for extended periods of time, for dementia or other long-term conditions.[8]

Dementia System of Care

VHA requires "that all VA medical facilities provide comprehensive, coordinated, person-centered care for Veterans with dementia and their caregivers," supported by VHA's dementia system of care.[9] VHA's dementia system of care includes clinical care "… designed to provide the full continuum of diagnostic, treatment, and supportive services."[10] VHA guidance for implementation of the dementia system of care includes the interdisciplinary care team as a key element of dementia care to "[manage] the multiple medical, physical, functional, psychological, and social effects of dementia through coordinated efforts to enhance quality of life."[11] CLC teams collaborate to provide clinical care for cognitive disorders, such as dementia, and address behavioral symptoms "… through a balance of Veteran-centered behavioral, environmental and pharmacological interventions."[12] VHA requires CLC interdisciplinary teams to include a

[5] "Geriatrics and Extended Care Program," VA Patient Care Services, accessed January 21, 2025, https://www.patientcare.va.gov/geriatrics.asp#:~:text=The%20Office%20of%20Geriatrics%20and%20Extended%20Care%20advances,the%20advancement%20of%20geriatrics%20and%20long-term%20care%20thr.

[6] "What is a Community Living Center?" VHA Geriatrics and Extended Care, accessed July 25, 2024, https://www.va.gov/geriatrics/pages/va_community_living_centers.asp. VHA refers to veterans admitted to CLCs as "residents." ADLs "are specific personal care activities or tasks required for daily maintenance or sustenance," including eating. VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.

[7] VHA Directive 1142(1).

[8] "What is a Community Living Center?" VHA Geriatrics and Extended Care.

[9] VHA Directive 1140.12, *Dementia System of Care*, October 18, 2019.

[10] VHA Directive 1140.12.

[11] VHA Geriatrics and Extended Care, "Implementation Guidelines for Veterans Health Administration Dementia System of Care (VHA DSOC)."

[12] VHA Directive 1140.11; VHA Geriatrics and Extended Care, "Implementation Guidelines for Veterans Health Administration Dementia System of Care (VHA DSOC)."

psychologist, and requires mental health providers to "be available and part of the overall interdisciplinary care team to help address challenging dementia-related behaviors."[13]

Dementia Care—Medication Management

Pharmacological interventions for dementia may involve the administration of psychotropic drugs—"… any drug that affects brain activities associated with mental processes and behavior" including antipsychotic, antidepressant, and anti-anxiety medications.[14] The American Geriatrics Society Beers Criteria recommends avoiding use of antipsychotic medications in patients 65 years old and above, noting a "… greater rate of cognitive decline and mortality in people with dementia."[15]

Providers use antipsychotic medications for patients with dementia who exhibit behavioral issues including agitation, restlessness, and anxiety, but the use of these medications should be monitored and subject to regular risk-benefit analyses, as well as "balanced against their serious side effects."[16] Side effects may occur, especially when antipsychotic medications are combined with multiple other medications, referred to as polypharmacy. Polypharmacy in the geriatric population may increase risks for falls, cognitive impairment, and functional decline.[17]

System policy states, "Psychotropic/neuroleptic medications will not be prescribed unnecessarily" and "[n]on-pharmacological interventions will be attempted to accommodate the resident's behavior throughout the treatment course," such as STAR-VA.[18]

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[13] VHA Directive 1142(1).

[14] 42 C.F.R. § 483.45 (2024).

[15] "The [American Geriatrics Society] Beers Criteria is an explicit list of [potentially inappropriate medications] that are typically best avoided by older adults in most circumstances or under specific situations, such as in certain diseases or conditions." 2023 American Geriatrics Society Beers Criteria Update Expert Panel, "American Geriatrics Society 2023 updated AGS Beers Criteria for potentially inappropriate medication use in older adults," *Journal of the American Geriatrics Society*, 71 (March 29, 2023): 2052-2081, https://doi.org/10.1111/jgs.18372.

[16] Jason Jalil, Pargol Nazarian, and Hans F. von Walter, "Polypharmacy in Treatment of Behavioral Issues in Dementia—Use of Atypical Antipsychotics," *Clinics in Geriatric Medicine* 38, no. 4 (November 11, 2022): 641-652, https://doi.org/10.1016/j.cger.2022.05.006.

[17] Jalil, Nazarian, and von Walter, "Polypharmacy in Treatment of Behavioral Issues in Dementia—Use of Atypical Antipsychotics."

[18] System Policy 119-32, *Use of Psychotropic (Neuroleptic) Medications in Community Living Centers*, January 6, 2023; VA, "STAR-VA Intervention for Managing Challenging Behaviors in VA Community Living Center Residents with Dementia: Manual for STAR-VA Behavioral Coordinators and Nurse Champions," accessed September 11, 2024, https://dvagov.sharepoint.com/sites/vhastar-va/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhastar%2Dva%2FShared%20Documents%2FSTAR%2DVA%20Manual%202017c%2Epdf&parent=%2Fsites%2Fvhastar%2Dva%2FShared%20Documents. (This site is not publicly accessible.); System Policy 111-53, *Behavioral Health Consult in Community Living Center (CLC),* April 4, 2022.

Prior OIG Reports

In September 2024, the OIG published a report, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo.* The OIG substantiated delays in scheduling community care consults and, contrary to high reliability organization (HRO) principles and values, leaders failed to resolve the delays.[19] The report also found a failure to complete an institutional disclosure following an identified delay in a patient's treatment.[20] The OIG made four recommendations, including one recommendation related to institutional disclosure, which is closed—three recommendations remain open.[21]

Allegations and Related Concerns

On June 20, 2024, the OIG received allegations related to the care of Resident A at the Batavia CLC. The complainant alleged that the resident received inadequate care while in the CLC, specifically related to dementia care, diabetes care, and monitoring of nutritional intake and blood sugar levels.[22]

The complainant further reported nursing staff failed to monitor the resident, who was transferred to a community hospital with a critically elevated blood sugar reading and died approximately two weeks later following admission to the Buffalo VAMC for "hospice end of life care."[23] The complainant, the designated healthcare decision-maker, also reported being unaware that Resident A received haloperidol (an antipsychotic medication) during the CLC admission.[24]

In late August 2024, the OIG received an anonymous complaint related to the care of an additional Batavia CLC resident, Resident B. The complaint alleged that following a period of no nutritional intake for five days, there was no intervention documented in Resident B's electronic

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[19] VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, Report No. 23-03679-262, September 27, 2024.

[20] VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*.

[21] VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*.

[22] The complainant is a family member of Resident A, who was also the resident's primary caretaker and healthcare proxy. A healthcare proxy is an appointment of "someone you trust to make health decisions for you if you are unable to do so." National Institutes of Health, National Library of Medicine, *MedlinePlus*, "Advance Directives," accessed January 22, 2025, https://medlineplus.gov/advancedirectives.html.

[23] For the purposes of this report, "critically elevated" refers to a blood glucose reading more than four times above the system laboratory's upper limit of normal reference range.

[24] Haloperidol, with the brand name Haldol, is an antipsychotic medication used to treat psychotic disorders and severe behavioral problems. National Institutes of Health, National Library of Medicine, *Medline Plus*, "Haloperidol," accessed December 10, 2024, https://medlineplus.gov/druginfo/meds/a682180.html.

health record (EHR) until the sixth day.[25] The OIG reviewed the allegations and the resident's EHR and sent a request for clinical review to the system on September 5, 2024. Due to the concerns related to Resident B's assessment and delays in response to changes in the resident's condition, the OIG included review of the additional complaint, and the system's response, in this inspection.

Scope and Methodology

The OIG initiated the inspection on July 15, 2024, and conducted an on-site visit September 24–26, 2024. The OIG conducted additional interviews through January 8, 2025. The OIG interviewed the complainant, system executive leaders, current GEC service leaders, a quality management leader and staff member, and pharmacy staff.[26] The OIG also interviewed CLC nursing leaders, managers, supervisors, and staff.[27]

The OIG reviewed relevant VHA directives, handbooks, and guidelines. The OIG also reviewed system policies and procedures related to medication management, laboratory testing and results notification, and CLC and dementia-related care. The OIG examined nurse training records, and relevant EHRs of residents A and B.[28]

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

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.

[25] Although Resident B was a long-term CLC resident, the allegation of delayed care focused on a discrete episode of care when the resident was sent to the emergency room for a higher level of care.

[26] In August 2024, the system executive director and chief of staff were detailed to other positions. Andy Paden and Tyler Pacos, "Director, Chief of Staff at Buffalo VA Medical Center removed from positions," *WGRZ*, August 20, 2024, https://www.wgrz.com/article/news/local/wny-va-director-chief-of-staff-fired/71-0196c50b-b8df-470e-9bee-6e7a395ba01b. Effective August 18, 2024, the VISN 2 Network Director designated an interim system executive director and chief of staff. The executive director and chief of staff were in the interim positions for the duration of this inspection.

[27] The OIG learned the CLC units use nurse supervisors as liaisons between nursing staff and medical providers and each unit has one nurse manager with supervision responsibilities for all unit nursing staff. Nurse supervisors and unit nurse managers report to the ACNS for geriatrics, who then reports to the associate director for patient care services.

[28] The OIG reviewed Resident A's EHR for CLC days 1–23, as well as for the inpatient care prior to and following the CLC stay, and for Resident B for a 36-day period prior to and following the resident's transfer to a higher level of care. The team reviewed community care medical records where available in the resident's EHR.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Resident A Case Summary

Resident A was in their seventies with a history of dementia, hemorrhagic stroke, seizures, anxiety, diabetes, and dysphagia (difficulty swallowing).[29] In late winter 2024, Resident A was admitted to the Buffalo VAMC for increasing combativeness, agitation, and confusion. To assist with Resident A's medication management, physicians obtained a psychiatry consult. Changes to Resident A's medications included adding sertraline for anxiety and periodic single doses of haloperidol for severe agitation until Resident A was started on risperidone, after which time Resident A no longer required haloperidol.[30] A nurse administered Resident A's last haloperidol dose nine days prior to hospital discharge. The attending physician noted at discharge that Resident A's "behaviors remained well controlled on current med[ication] regimen." Additionally, three days prior to hospital discharge, Resident A's laboratory studies showed normal blood sugar, kidney function, and electrolyte levels.

Resident A was discharged from the Buffalo VAMC to the Batavia CLC Maple unit for long-term care. At discharge, a clinical pharmacist completed a pharmacy discharge medication reconciliation note showing all Resident A's current medications and doses. The pharmacist did not include haloperidol in the discharge medication list.

Upon admission to the Batavia CLC (day 1), the chief of geriatric service (chief geriatric physician) ordered continuation of Resident A's hospital medications and added haloperidol 2.5 milligram (mg) by injection every 8 hours as needed for extreme agitation. The chief geriatric physician also ordered routine blood pressure and oxygenation checks every 8 hours and then 66 hours later, changed these checks to weekly. In the history and physical EHR note, co-signed by the chief geriatric physician, a resident physician documented Resident A's

[29] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[30] Sertraline is a medication, with the brand name of Zoloft, that is used to treat conditions including depression, anxiety, and post-traumatic stress disorder by increasing serotonin, a hormone which regulates mood. Cleveland Clinic, "Sertraline Tablets," accessed December 12, 2024, https://my.clevelandclinic.org/health/drugs/20089-sertraline-tablets; Risperidone is an antipsychotic medication used to treat mental illness, including mood disorders and behavioral issues such as aggression. National Institutes of Health, National Library of Medicine, *Medline Plus*, "Risperidone," accessed December 10, 2024, https://medlineplus.gov/druginfo/meds/a694015.html.

baseline cognitive status as confused with a recent increase in episodes of worsening confusion. In the CLC admission nursing assessment, a nurse noted Resident A needed extensive assistance with ADLs, supervision during eating, and use of a wheelchair. The nurse also recorded Resident A's admission vital signs. A pharmacist completed a pharmacy admission review note documenting Resident A was at risk for polypharmacy with 16 medications and the addition of haloperidol with risperidone. That evening a nurse documented Resident A sustained a fall without injury after which Resident A's vital signs were normal, and a fingerstick blood sugar level was slightly elevated at 137 milligrams per deciliter (mg/dl).[31] The nurse notified the chief geriatric physician and Resident A's family about the fall. About an hour and a half later, Resident A received a 2.5 mg haloperidol injection documented by the nurse as for "agitation."

On day 2, a nurse recorded Resident A's third vital sign assessment approximately 15 hours after the last assessment. The chief geriatric physician doubled Resident A's haloperidol order to 5 mg as needed for extreme agitation, and Resident A received two haloperidol doses that day. Additionally, a pharmacist completed a post-fall medication review and recommended monitoring Resident A due to the current medication combination and addition of as-needed haloperidol.

On day 3, the chief geriatric physician doubled Resident A's risperidone dose to twice a day. On day 5, a clinical dietitian completed a nutrition assessment for Resident A and added a nutrition supplement due to Resident A's variable food intake at meals.

On day 15, the chief geriatric physician reordered Resident A's haloperidol medication. The next day, the chief geriatric physician ordered blood work for completion on day 18 to monitor Resident A's diabetes, blood sugar, and electrolyte levels.

In the morning of day 20, a nurse documented Resident A was confused and unable to respond or grasp concepts. Later that afternoon, Resident A had a finger stick blood sugar level completed, which was elevated at 349 mg/dl; however, the EHR did not contain documentation of intervention provided in response to the elevated blood sugar level. About three hours later, a nursing assistant entered an EHR note stating Resident A completed 75 percent of dinner. On the morning of day 21, another nursing assistant described Resident A's ADLs as extensive assistance or total dependence.

From days 1 through 23, Resident A received 21 doses of haloperidol. On day 23, a nurse documented Resident A developed weight loss due to difficulty with self-feeding, and occupational therapy recommended a restorative eating and swallowing program. That evening, a registered nurse documented Resident A slept through breakfast and lunch but did eat dinner with sips of water. Late that night, Resident A was noted by a registered nurse to be lethargic and not responding to voice; Resident A's vital signs were obtained, which revealed a fast heart rate,

[31] The system's laboratory's reference range for normal fingerstick blood sugar is 70–115 mg/dl.

rapid breathing, a slightly elevated but non-febrile temperature, and normal blood pressure. Additionally, a nurse completed a finger stick blood sugar level with an elevated reading of ">600" mg/dl. A nurse notified a physician, and the physician ordered transfer of Resident A to a community hospital for evaluation. Resident A's family was also notified.

At the community hospital, Resident A was evaluated in the emergency department and admitted to the intensive care unit for an elevated sodium level, elevated blood sugar requiring an insulin infusion, and a diagnosis of hyperosmolar hyperglycemic state.[32] Resident A underwent multiple treatments at the community hospital with improvement in responsiveness but no improvement in cognition. On day 36, Resident A's family chose comfort care for Resident A and the resident was transferred to the Buffalo VAMC for hospice care. Resident A died two days later.

Inspection Results

The OIG substantiated deficiencies in care at the Batavia CLC contributed to Resident A's death. Deficiencies included (1) physician and nursing staff management of Resident A's dementia and diabetes, and (2) nursing documentation of medication administration and nutritional intake. These ongoing and cumulative deficiencies, as a result of CLC nursing staff and the chief geriatric physician failures, may have contributed to Resident A's preventable decline in health, resulting in irreparable clinical injury that necessitated palliative and end-of-life care.

The OIG further identified deficiencies in provider staffing and nurse education that increased the risk of patient safety events and may have contributed to Resident A's functional decline.

1. Deficiencies in Care Contributed to Resident A's Death

The OIG found deficiencies in (1) completion of a full medical assessment; (2) dementia care, including the administration of antipsychotic medications; and (3) diabetes care and monitoring, including CLC staff's response to Resident A's elevated blood sugar on CLC day 20.

Initial Medical Assessment Documentation

The OIG found that the chief geriatric physician failed to ensure a complete history and physical examination of Resident A upon admission or during the resident's CLC stay, as required. System policy requires providers to complete a medical assessment within 72 hours of a resident's admission to the CLC, including a history and physical examination and identification

[32] Resident A's blood sugar result at the community hospital was 909 mg/dl. Mayo Clinic, "Hyperglycemia in diabetes," accessed July 29, 2024, https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631. Hyperosmolar hyperglycemic state is a condition where blood sugar levels become very high and the body cannot use either glucose or fat for energy and, when left untreated, can "lead to life-threatening dehydration and coma."

and prioritization of problems.[33] Resident physicians may conduct medical assessments as long as the care provided is directed and supervised by a physician (supervising provider) who is privileged to provide care at that VA medical facility.[34] The supervising provider must indicate supervision in the EHR, such as documenting review of and concurrence with the resident physician's assessment via a cosignature or addendum.[35]

On CLC day 1, a resident physician conducted a history and physical examination of Resident A. The resident physician entered the exam note into the EHR within the first 72 hours of admission as required, noting Resident A was admitted to the CLC for agitation and confusion, and had received a psychiatry assessment and administration of risperidone with as-needed haloperidol while hospitalized at the Buffalo VAMC. However, the resident physician was unable to complete a physical exam or further assessments, stating it was "not feasible at this point as the patient was confused and extremely agitated." The resident physician identified the following treatment plans and corresponding problems

- continued administration of risperidone and as-needed haloperidol for agitation and dementia,
- maximization of non-pharmacological approaches to treat agitation for deconditioning, and
- continued administration of metformin for diabetes.

The same day, the chief geriatric physician wrote an addendum to the resident physician's note, documenting review of and concurrence with the plan of care for Resident A. However, the OIG found no evidence in the EHR that a provider completed the missing elements of the medical assessment at any time during the following 22 days of admission. When asked why the history and physical examination was not completed at a later date, the chief geriatric physician stated, "[W]e can complete the hands-on portion … at a future time when the [resident] is calmer. I am quite sure that I examined the [resident] at a future time but may have inadvertently omitted any documentation."

The OIG determined the chief geriatric physician's failure to ensure a full history and physical examination for Resident A led to missed opportunities to prioritize and further identify Resident

[33] System Policy 111-21, *Interdisciplinary Care Management on the Community Living Centers (CLC),* November 1, 2019; System Policy 11-72, *Assessment and Reassessment of Patients*, July 1, 2023.

[34] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024. "A resident is an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, chiropractors, or podiatrists, and who participates in patient care under the direction of supervising practitioners."; VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019; VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. "Clinical privileging is defined as the process by which a VA facility authorizes a [licensed provider] to independently (i.e., without supervision or restriction) provide healthcare services on a facility-specific basis."

[35] VHA Directive 1400.01.

A's care needs. A documented complete history and physical examination would have better informed all clinical staff, including nursing, about care priorities and established the resident's baseline status. The OIG opines the information would have supported timely and comprehensive interventions that may have mitigated the resident's functional decline and need for a higher level of care.

Dementia Care Documentation

The OIG found deficiencies with dementia care for Resident A. Specifically, nursing staff failed to (1) use required notes to document the resident's behaviors or conduct behavioral rounds as required; (2) document the resident's behaviors necessitating the administration of antipsychotic medication; and (3) notify the chief geriatric physician when the resident refused scheduled risperidone, which was prescribed for agitation.[36]

Additionally, the chief geriatric physician failed to document assessments and reassessments of Resident A when placing orders for antipsychotic medication, as system policy requires.[37]

Nursing Failures

Documenting Resident Behaviors and Conducting Behavioral Rounds

Researchers developed a dementia-specific intervention program, published in 2005, known as Staff Training in Assisted Living Residences (STAR), to teach "… direct care staff how to identify the factors within the environment and within their own interactions with residents that can be altered to … reduce resident affective and behavioral distress."[38] In 2010, VHA adapted the STAR program into an interdisciplinary clinical intervention for CLC residents, known as STAR-VA.[39] The STAR-VA program "is a collaborative, interdisciplinary intervention …" of CLC staff members who develop and implement behavioral intervention plans, that have "… repeatedly demonstrated … significant decreases in the frequency and severity of target behaviors, …" such as agitation.[40]

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[36] System Policy 111-53.

[37] System Policy 119-32.

[38] Linda Teri et al., "STAR: A Dementia-Specific Training Program for Staff in Assisted Living Residences," *The Gerontologist*, 45, no. 5 (October 2005): 686-693, https://doi.org/10.1093/geront/45.5.686.

[39] Michele J. Karel et al., "Effectiveness of Expanded Implementation of STAR-VA for Managing Dementia-Related Behaviors Among Veterans," *The Gerontologist* 56, no. 1 (July 16, 2015): 126-134, https://doi.org/10.1093/geront/gnv068.

[40] VA, "STAR-VA Intervention for Managing Challenging Behaviors in VA Community Living Center Residents with Dementia: Manual for STAR-VA Behavioral Coordinators and Nurse Champions."; Agitation refers to a state of annoyance, emotional turmoil, or intense unease. It can vary from mild to severe, occur quickly or gradually, may be short-lived or prolonged, and "is a common part of dementia."; Cleveland Clinic, "Agitation," accessed December 3, 2024, https://my.clevelandclinic.org/health/symptoms/agitation.

System policy requires nursing staff to enter a STAR-VA note in the EHR "for those [residents] who exhibit a distress and/or disruptive behavior incident." The CLC clinical psychologist must review all STAR-VA notes and attend "regularly scheduled" behavioral rounds, as well as work with the clinical team to develop a team-based intervention plan that addresses the resident's behaviors. An interdisciplinary team conducts behavioral rounds to discuss behaviors that occur weekly or more often, and related safety concerns.[41]

In interviews, nursing staff described concerns for the resident and staff's physical safety regarding Resident A's behaviors, including attempting to hit and bite staff; however, the OIG found nursing staff did not document any STAR-VA notes during the resident's admission. When the OIG asked about the use of STAR-VA notes, a nursing assistant stated that it was less likely for residents on the Maple unit to have behaviors requiring a STAR-VA note, in comparison to the Pine unit. The OIG reviewed a system CLC corrective action plan from late summer 2024, which documented the need to reeducate staff on STAR-VA behavioral notes to address deficiencies with dementia care.[42]

The CLC medical director and the CLC psychologist told the OIG of being surprised that Resident A's EHR did not contain STAR-VA notes. The CLC medical director explained,

> I always look for the STAR behavior notes because that is how we communicate any behavior symptoms … it asks the nursing staff to document what was the behavior, what was going on at the time, what interventions were tried, if any, what [as-needed] medications were given, and what was the result of giving that [as-needed] medication or the results of their non-pharmacologic interventions.

The CLC psychologist noted, "I was just surprised that [Resident A] was even having those experiences [be]cause to the best of my knowledge, I didn't even know that [Resident A] was struggling." The CLC psychologist further explained that while STAR-VA notes were used more consistently on the dementia unit, use was less on the other units, and the CLC had been "reinvigorating" use of the notes since June 2024.

The OIG found that CLC staff did not conduct behavioral rounds to discuss Resident A's behaviors. The nurse manager of the dementia unit told the OIG that behavioral rounds are used to discuss how to manage challenging behaviors for individual residents, including non-pharmacological interventions and response to medications, and behavioral rounds were more consistent on Pine unit but only recently started for the other two Batavia CLC units. The CLC medical director told the OIG that behavioral rounds, reinitiated for the Spruce and Maple units

[41] System Policy 111-53.

[42] VHA Directive 1142(1). The action plan was in response to an Interim Quality Oversight Survey that is an internal process used by system leaders to assess CLC unannounced survey readiness.

in mid-September 2024, were not occurring because "there hadn't been quite as many behaviors."

Documentation of Resident A's Behaviors

System policy states that residents with dementia may receive psychotropic medications when staff have documented the frequency of physical behaviors such as biting, kicking, or scratching. If as-needed psychotropic medications, such as antipsychotic medications, are used to address challenging behaviors, nursing staff must attempt non-pharmacological approaches, and document the specific behaviors that support the administration of the medication.[43] Non-pharmacological interventions include "behavioral management techniques; engagement in pleasant activities; and environmental interventions," such as "addressing lighting, noise, [and] temperature."[44]

The OIG found that nursing staff administered haloperidol 21 times over Resident A's 23 day stay on the CLC. Although the OIG found that nursing staff documented in the medication administration system that haloperidol was given for "agitation," specific behaviors necessitating administration were only documented in the EHR for 5 of the 21 administrations (approximately 24 percent).[45] Further, nursing staff only documented one attempt to re-direct Resident A with a non-pharmacological intervention prior to administering haloperidol.

Notification of the Chief Geriatric Physician Regarding Medication Refusals

System policy requires that nurses notify the provider "for all medications not administered" and "[t]he administering nurse will write a note in [the EHR] to identify what medication was held/not given, why it was not administered and the name of the provider contacted."[46]

While receiving inpatient care at the Buffalo VAMC (prior to transfer to the Batavia CLC), an inpatient resident physician prescribed risperidone to manage Resident A's agitation. An inpatient physician later documented that risperidone "proved successful in limiting behavioral outbursts and combativeness," and Resident A no longer required haloperidol.

The OIG reviewed medication administration records and found that Resident A refused 6 of 43 scheduled risperidone administrations during the CLC stay; however, the OIG found that nursing staff only documented notifying the chief geriatric physician for one of the six refusals.

The OIG determined that nursing staff's failure to document Resident A's behaviors in STAR-VA notes and conduct behavioral rounds, as required, limited awareness of other

[43] System Policy 119-32.

[44] VHA Geriatrics and Extended Care, "Implementation Guidelines for Veterans Health Administration Dementia System of Care (VHA DSOC)."

[45] The OIG found that only one nursing note described specific physical behaviors. Most often, specific behaviors were described as yelling or screaming.

[46] System Policy 118-03, *Administration of Medications and IV Fluids using BCMA*, March 1, 2023.

interdisciplinary CLC staff to create care plans that may have included non-pharmacological interventions to manage behaviors. The OIG is concerned that nursing staff failures to consistently document specific behaviors necessitating haloperidol, as well as communicate the resident's refusals of risperidone, limited the chief geriatric physician's ability to evaluate the need for and effectiveness of the medications.

Physician Failures

System policy requires medical providers to evaluate residents and determine the medical necessity of starting psychotropic medications, including antipsychotic medications.[47] Orders for as-needed antipsychotic medication, such as haloperidol, are limited to 14 days; however, a new order can be placed if the medical provider "[d]irectly examines and assess [*sic*] the resident" and documents clinical rationale.[48] Additionally, VHA suggests medical providers "document a risk-benefit discussion, including risk of increased mortality … with the Veteran or caregiver before initiating pharmacological treatment of dementia-related behavioral symptoms and upon follow-up to re-assess medication efficacy."[49]

Prior to CLC admission, a psychiatry resident examined Resident A while inpatient at the Buffalo VAMC and recommended consideration of "low dose [haloperidol] for danagerous [*sic*] behaviors if agitated." During Resident A's CLC admission, the chief geriatric physician prescribed haloperidol for "extreme agitation" as follows

- on CLC day 1, 2.5 mg every eight hours as needed, after the resident physician documented, in a history and physical EHR note, that while inpatient Resident A "required multiple repeated doses of [as-needed] haldolol [*sic*] for agitation … after which [the resident] seems to have improved …;"
- on CLC day 2, 5 mg every eight hours as needed, doubling the dose from the previous day; and
- on CLC day 15, 5 mg every eight hours as needed—a new order to continue pharmacological treatment of Resident A's dementia-related behaviors.

The OIG found the chief geriatric physician failed to document clinical rationale for as-needed haloperidol upon admission and when doubling the dose the next day, on CLC day 2. The chief geriatric physician also failed to conduct an examination and assessment or document clinical rationale, of Resident A when placing a new order for haloperidol on CLC day 15, as required.[50]

[47] System Policy 119-32.

[48] Clinical rationale includes "the benefit of the medication to the resident" and indications of improvement to the resident's distress. System Policy 119-32.

[49] VHA Geriatrics and Extended Care, "Implementation Guidelines for Veterans Health Administration Dementia System of Care (VHA DSOC)."

[50] System Policy 119-32.

When the OIG asked why the haloperidol dose doubled from CLC day 1, on CLC day 2, the chief geriatric physician could not recall, stating,

- "I typically go by what they're discharged on,"
- "I don't typically use two and a half [2.5 mg]," and
- "If it warrants it … we try the lowest dose, but we'll go higher."

However, in review of Resident A's EHR and contrary to the chief geriatric physician's response, the OIG found that the resident was not prescribed haloperidol upon discharge from the Buffalo VAMC. In fact, Resident A only received haloperidol six times, for a total of 5 mg during the 19-day hospitalization.[51]

Additionally, when asked whether a resident is reexamined for continuation (beyond 14 days) of as-needed haloperidol, the chief geriatric physician told the OIG, "No, not necessary. Not … routinely unless there's an issue that came up." The OIG found the chief geriatric physician's response did not align with system policy, which requires examination and reassessment of the resident in addition to a new order to continue as-needed antipsychotic medication beyond 14 days.[52]

The chief geriatric physician told the OIG of the importance of STAR-VA notes to alert the provider of resident behavior, and to monitor the doses of haloperidol, explaining "... I can read about it and I can know what's going on, and I can watch the doses. Control things." However, as noted previously, Resident A's EHR contained no STAR-VA notes and the OIG found no evidence that the chief geriatric physician monitored nursing staff's administration of haloperidol during the resident's stay. The chief geriatric physician told the OIG of reviewing Resident A's haloperidol administration with the unit nurse manager after the resident's transfer to the community hospital and attributed the resident's lethargy to a "brewing infection," not haloperidol.[53]

The OIG also identified concerns regarding the chief geriatric physician's communication with Resident A's family member about the use of antipsychotic medications, as outlined in VHA guidance regarding risk-benefit discussions with the caregiver.[54] Resident A's family member told the OIG of having discussions regarding the use of antipsychotic medications with the medical provider at the Buffalo VAMC during the resident's inpatient admission, but did not recall similar discussions with the chief geriatric physician during the resident's CLC stay.

[51] Resident A's EHR indicates the highest dose of haloperidol administered while inpatient at the Buffalo VAMC was 1 mg and the last dose was eight days before the resident transferred to the CLC.

[52] System Policy 119-32.

[53] The OIG found no evidence that Resident A was diagnosed with an infection following transfer for the hyperglycemic event.

[54] VHA Geriatrics and Extended Care, "Implementation Guidelines for Veterans Health Administration Dementia System of Care (VHA DSOC)."

Further, when asked if aware that Resident A received haloperidol at the Batavia CLC, the family member stated, "No, but I noticed that [the resident] was more sleepier when I would go to visit [them]."

The chief geriatric physician told the OIG that upon Resident A's admission to the CLC, Resident A's family member asked for assistance to control the resident's agitation and reported haloperidol had been used in the past. However, the OIG could not find evidence of discussions regarding the use of antipsychotic medications prior to or after the meeting with CLC staff to review the resident's care plan, on CLC day 16.

While the OIG is unable determine if there was a conversation about haloperidol with Resident A's family member during admission, the OIG found that Resident A's family member did not have a clear understanding of the medication plan for Resident A. The OIG is concerned that in the absence of EHR documentation, including assessments, clinical rationale (with the benefit of and response to pharmacological intervention), and a risk-benefit discussion with Resident A's family, the chief geriatric physician may not have considered clinical risk factors regarding the use of antipsychotic medications.

Deficiencies in Diabetes Care and Monitoring

The OIG found deficiencies in the management of Resident A's diabetes likely contributed to Resident A's decline. Specifically,

- CLC nursing staff failed to document and communicate clinical factors, such as missed medications and poor nutritional intake to the provider;
- the chief geriatric physician failed to manage Resident A's diabetes and ensure completion of laboratory orders; and
- CLC nursing staff and the chief geriatric physician failed to clinically respond to an abnormal fingerstick blood sugar measurement.

Nursing Failures

Documentation and Communication of Missed Medications

System policy requires an administering nurse to notify a provider when a resident refuses a medication. The nurse must also document, in the EHR, the resident's refusal and notification to the provider.[55] While the system policy does not specify how a provider must be notified, the

[55] System Policy 118-03.

OIG considered notes which documented the name of the provider contacted, or added the provider as an additional signer, as documenting notification to the provider.[56]

Resident A was prescribed metformin for treatment of type 2 diabetes, which helps control blood sugar by increasing insulin sensitivity and decreasing the amount of glucose absorbed from food and produced in the body. These actions reduce the risk of serious diabetes-related complications such as heart disease, stroke, and kidney damage.[57] Missing doses of medications used to lower blood sugar, such as metformin, can lead to serious complications such as diabetic ketoacidosis and hyperosmolar hyperglycemic state that can be life-threatening if left untreated.[58]

The OIG reviewed medication administration records and found that nursing staff documented that Resident A refused 11 of 45 scheduled metformin administrations during the CLC stay. The OIG also found that nursing staff only documented 5 of the 11 metformin refusals in the EHR and notified providers three times—the chief geriatric physician twice and the CLC medical director once—by adding one of the CLC physicians as an additional signer.

Monitoring of Nutritional Intake

System policy requires nursing assistants to document "data, observations, care ... and [ADLs] provided on assigned patients," which includes eating and meal intakes, and report those observations to the supervising registered nurse.[59] Monitoring nutritional intake is critical for older adults with diabetes, especially those with cognitive impairment, as irregular appetite and nutrition intake can increase the risk of low and high blood sugars, which can lead to life-threatening complications.[60]

The OIG reviewed Resident A's EHR for documentation of meal intake throughout the resident's CLC stay. The OIG found nursing staff failed to consistently document Resident A's meal intakes in the EHR and notify a nursing supervisor or the resident's provider when meal intake decreased. Notably, in the four days prior to Resident A's clinical deterioration requiring transfer to a higher level of care, the EHR reflected limited documentation and a significant

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[56] "'Additional signer' is a communication tool used to alert a clinician about information pertaining to the patient." The additional signer function "is designed to allow providers to call attention to specific documents and for the recipient to acknowledge receipt of the information." VHA, *Health Information Management Health Record Documentation Program Guide Version 1.2*, September 29, 2023.

[57] National Institutes of Health, National Library of Medicine, *Medline Plus*, "Metformin," accessed December 3, 2024, https://medlineplus.gov/druginfo/meds/a696005.html.

[58] "Diabetic ketoacidosis is a serious complication of diabetes" that occurs when the body begins to break down fat leading to a buildup of acids in the bloodstream. If left untreated, "diabetic ketoacidosis can lead to loss of consciousness and … death." Mayo Clinic, "Diabetic Ketoacidosis," accessed July 24, 2024, https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551.

[59] System Policy 118-34, *Nursing Documentation in the Patient Care Medical Record*, March 1, 2022.

[60] Medha N. Munshi et al., "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association," *Diabetes Care* 39, no. 2 (January 11, 2016): 308-318, https://doi.org/10.2337/dc15-2512.

decrease in meal intake. The OIG found that nursing staff failed to document meal intakes for 19 of 66 meals (29 percent) during the CLC stay (see table 1.)

Table 1: Resident A's CLC Documented Meal Intakes

CLC day*	Breakfast	Lunch	Dinner
2	50%	50%	25%
3	No documentation	No documentation	75%
4	No documentation	No documentation	75%
5	100%	100%	75%
6	0%	25%	100%
7	50%	50%	50%
8	No documentation	No documentation	No documentation
9	No documentation	No documentation	No documentation
10	No documentation	No documentation	100%
11	No documentation	100%	100%
12	100%	0%	0%
13	100%	50%	75%
14	100%	50%	25%
15	100%	100%	100%
16	100%	100%	75%
17	100%	75%	75%
18	25%	50%	50%
19	100%	75%	75%
20	No documentation	No documentation	75%
21	No documentation	No documentation	No documentation
22	25%	0%	No documentation
23	0%	0%	75%‡

Source: OIG review of Resident A's electronic health record documentation.
**CLC day 1 is not included as Resident A arrived late in the evening, after the majority of meals were served.*
‡Of note, a nursing assistant documented a conflicting dinner consumption of 0 percent approximately 40 minutes before the entry of 75 percent.

For CLC day 20, when the fingerstick showed an elevated blood sugar reading, and day 21, nursing staff did not document the resident's intake for five of the six meals. On CLC days 22 and 23, nursing staff documented four of the resident's six meal intakes as 0–25 percent, a notable decrease from the intakes documented through CLC day 19. However, the OIG reviewed the EHR and found no evidence that nursing staff notified a supervisor or provider of the significant change in the resident's intake until CLC day 23, when a charge nurse documented that the resident slept through breakfast and lunch and added the CLC medical director as an additional signer. Later that night, a different nurse notified a nursing supervisor that the resident was "lethargic and not responding … normally."

During an interview, the nursing assistant assigned to care for Resident A on CLC day 20 could not explain why meal documentation was missing. The unit nurse manager and associate director for patient care services told the OIG of expecting nursing staff to document meal intakes for every meal, for every resident. Nursing assistants who spoke with the OIG also acknowledged the expectation to document all meals in daily ADL notes. One nursing supervisor noted surprise at the lack of documentation and that nursing staff "didn't alert anybody," given "such a drastic decline in [Resident A's] normal everyday behavior."

The OIG is concerned that nursing staff's failure to document and communicate medication refusals and changes in Resident A's meal intake may have limited recognition of a change in the resident's condition and consideration of clinical interventions, such as adjusting medications or monitoring blood sugar levels when the resident repeatedly refused metformin.

Physician Failures

System policy requires CLC staff "… to identify and act on risk factors to prevent functional decline in residents and to plan care that would delay any decline in residents' function. Residents are monitored and evaluated at regular intervals appropriate to their condition."[61]

For individuals residing in long-term care settings, such as the CLC, the American Diabetes Association recommends blood sugar monitoring "based on complexity of regimen and risk of hypoglycemia."[62] The American Diabetes Association also states "[a]lthough much attention is rightly focused on hypoglycemia, persistent hyperglycemia increases the risk of dehydration, electrolyte abnormalities …, and hyperglycemic hyperosmolar syndrome."[63] The American Diabetes Association does not specify a frequency in blood sugar monitoring; however, suggests increasing blood sugar monitoring when a resident has comorbidities of cognitive dysfunction (such as dementia) and presents with behavioral changes of "[r]efusal of medications" and "[i]rregular dietary intake or skipped meals."[64]

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[61] System Policy 111-21.

[62] Munshi et al., "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association."; "Hypoglycemia happens when the level of sugar (glucose) … drops below the range that is healthy for you … [It] requires immediate treatment by eating or drinking sugar/carbohydrates." "[I]t causes certain symptoms like shakiness and a faster heartbeat and can be life-threatening if it goes too low." Cleveland Clinic, "Hypoglycemia (Low Blood Sugar)," accessed on March 24, 2025, https://my.clevelandclinic.org/health/diseases/11647-hypoglycemia-low-blood-sugar.

[63] Munshi et al., "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association."; "Hyperglycemia happens when there's too much sugar (glucose) in your blood. It's also called high blood sugar." Symptoms of hyperglycemia include increased thirst and hunger, headache, and fatigue, and "[i]t's especially important to know the early signs … and to monitor your blood sugar regularly if you take … medications for diabetes." If hyperglycemia is acute (sudden and severe) or left untreated, it can be life-threatening. Cleveland Clinic, "Hyperglycemia (High Blood Sugar)," accessed March 25, 2025, https://my.clevelandclinic.org/health/diseases/9815-hyperglycemia-high-blood-sugar.

[64] Munshi et al., "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association."; VHA Directive 1140.12.

On CLC day 1, the resident physician documented, in the EHR, the plan to manage Resident A's diabetes as "Continue metformin," and the chief geriatric physician noted concurrence. Resident A refused metformin 11 times during admission and nursing staff communicated 3 of the 11 refusals to providers—twice to the chief geriatric physician and once to the CLC medical director. Additionally, a CLC pharmacist notified the chief geriatric physician of 2 of the 11 refusals of metformin. The OIG found the chief geriatric physician documented acknowledgment, in the EHR, approximately two days later but took no action to address refusals of metformin.

The OIG reviewed Resident A's EHR and found no evidence that the chief geriatric physician conducted ongoing blood sugar monitoring given the resident's presentation of risk factors such as behavioral changes, refusal of medications, and irregular dietary intake.

During an interview, the chief geriatric physician explained that the management of diabetes is dependent on a resident's diabetic history, such as the frequency of fingerstick blood sugar tests and the medications the resident takes. The chief geriatric physician stated some residents may need daily fingersticks and others, such as Resident A, may be controlled on metformin. The chief geriatric physician also stated, "[t]here was no apparent clinical evidence that the blood sugar reading would suddenly spike several weeks after admission."

The OIG acknowledges that the American Diabetes Association does not specify a frequency to monitor blood sugar for long-term care residents; however, the OIG found no evidence that the chief geriatric physician acted upon the risk factors Resident A displayed during admission, such as medication refusals and changes in behavior, as expected in diabetes management.

Completion of Laboratory Orders

VHA policy states that each ordering provider, or designee, is responsible for initiating appropriate clinical action and follow-up for any orders they place.[65]

In review of the EHR, the OIG found that the chief geriatric physician ordered a basic metabolic panel for Resident A, which included a serum blood sugar measurement, on CLC Day 16, to be completed by CLC Day 18.[66] The order was never completed, and the resident was transferred for emergency care with a critically elevated blood sugar level (over 900 mg/dL) on CLC day 23.

In an interview, when asked about the incomplete laboratory order, the chief geriatric physician told the OIG of not knowing why the order was incomplete and expressed that the process was

[65] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

[66] The laboratory orders had a "start date" of CLC day 18. In an interview with the Batavia primary care nurse manager, the OIG learned that the "start date" is the date the labs are to be drawn, unless otherwise indicated on the order.

"pretty foolproof." The Batavia primary care nurse manager, who manages laboratory draws for Batavia CLC residents, explained the steps to the OIG:[67]

- The ordering provider enters the laboratory orders in the EHR.
- The ordering provider enters the resident's name on a shared scheduling document and notifies the laboratory medical support assistant (MSA) of the request by telephone or through electronic messaging if the order is to be completed in less than two weeks.[68]
- The laboratory MSA schedules the appointment.[69]

The primary care nurse manager told the OIG that the MSA scheduler does not have visibility of laboratory orders entered for CLC residents and relies upon the provider to notify the MSA through a shared scheduling document, telephone, or electronic messaging, to schedule the laboratory draws. The primary care nurse manager explained that this process had been adopted in late 2023 to better predict the volume of laboratory draws needed.

While the chief geriatric physician and the primary care nurse manager had positive perceptions of the new process, the CLC medical director told the OIG of concerns with the additional steps involved, stating, "any extra step may cause misses and I have seen that for myself, a lab that I had recently ordered was missed because I didn't alert the MSA."

When the OIG asked the primary care nurse manager whether there had been any issues with missed laboratory orders since implementation of this process, the primary care manager responded, "I can't see missed labs … the feedback from the [CLC] providers is [it] is working out very well." However, during the interview, the primary care nurse manager reported that Resident A's incomplete metabolic panel, as learned from the OIG, was the first known instance of missed completion for laboratory orders. The primary care nurse manager told the OIG that upon reviewing the shared scheduling document and electronic messaging, the order placed on CLC day 16 for Resident A could not be found on either document.

When asked about gaps in the process that may have contributed to the failure to complete the laboratory order, the primary care nurse manager told the OIG the process relies on a manual step of entering the resident's name on the shared document to alert the next person in the process. Additionally, staff who conduct the laboratory draws cannot see incomplete CLC laboratory orders in the EHR without having the resident's name. Further, the primary care nurse

[67] The laboratory manager and the CLC medical director told the OIG of the primary care nurse manager's role in lab draws for CLC residents.

[68] The OIG learned that the scheduling document was accessible to CLC providers, some CLC nursing staff, primary nursing staff, and the scheduling MSA.

[69] The primary care nurse manager also explained that once the lab draw is scheduled, the resident goes to the laboratory area in primary care, or a primary care nursing staff member goes to the CLC, to obtain the blood specimen.

manager could not confirm if retrospective audits or reviews are conducted to ensure laboratory orders are completed.

The OIG found that the chief geriatric physician failed to ensure that the laboratory order was completed as ordered for Resident A. However, the OIG also found that the procedure for scheduling Batavia CLC residents relied on additional actions by the ordering provider, and there was no mechanism to identify missed orders. The OIG concluded that had the laboratory order been timely completed, the results may have led to earlier identification of Resident A's increasing blood sugar, and medical interventions prior to transfer to a community hospital for hyperglycemia that resulted in the resident's death. Additionally, the OIG is concerned that the Batavia CLC laboratory process could lead to delays or omissions in critical test results and presents risks to resident safety.

Response to Abnormal Fingerstick Blood Sugar Measurement

The OIG substantiated that CLC staff, including nursing staff and the chief geriatric physician, failed to take action on fingerstick blood sugar results, which delayed identification of a change in Resident A's condition.

Nursing Failures

The OIG found that nursing staff failed to respond to, or notify the chief geriatric physician of, Resident A's elevated fingerstick blood sugar result on CLC day 20.

System policy allows registered nurses to "obtain or direct another nursing staff member" to obtain a fingerstick blood sugar test when clinically indicated and states nursing staff must report the test result to the provider and document the result in the EHR.[70] Additionally, system policy requires licensed practical nurses (LPNs) to document, as well as report to their supervising registered nurse, observations and care provided to residents. Further, registered nurses must document assessment of a resident when there is a change in condition.[71]

In an interview, Resident A's family member described requesting an LPN to test the resident's blood sugar on CLC day 20 because the resident was "shaking" and "lethargic." The family member reported that the LPN asked the resident "are you cold?" and performed a fingerstick blood sugar test at the family's request.

[70] System Policy 113-09, *Fingerstick Glucose Testing Policy*, March 1, 2021.
[71] System Policy 118-34.

The OIG reviewed a glucometer record that indicated the LPN operated the device that registered a fingerstick blood sugar level elevated at 349 mg/dl.[72] In an interview, the LPN reported having no recollection of the fingerstick blood sugar measurement. The nursing supervisor and the unit nurse manager confirmed during interviews with the OIG that the LPN was the individual who obtained the fingerstick from Resident A on CLC day 20.

The OIG found the LPN did not document the following in the EHR

- the resident's symptoms or the family's concerns about the resident's condition,
- the elevated blood sugar measurement as taken, or
- report of the fingerstick blood sugar result to a nursing supervisor.

In an interview, the LPN could not recall or provide a reason for not reporting the result but expressed awareness of the requirement to notify a nursing supervisor and further noted sometimes forgetting to document actions taken.

Although the LPN did not directly notify a supervising nurse (either a registered nurse or nursing supervisor) of Resident A's fingerstick blood sugar measurement, the nursing supervisor told the OIG of becoming aware of the result when Resident A's family member called the evening of CLC day 20 and told the nursing supervisor that Resident A seemed lethargic during dinner and the fingerstick blood sugar measurement was higher than normal. The nursing supervisor recalled reviewing the EHR and reassured Resident A's family member that Resident A was still receiving metformin. Per the nursing supervisor, Resident A's family member called again, the following day, to check if there was any change. Following the call, the nursing supervisor recalled speaking to nursing staff, who reported "[Resident A] was very agitated this morning. [Resident A] got Haldol at 6:42 and [is] currently sleeping … but [they've] been doing fine."

Despite knowing about the fingerstick blood sugar measurement, and that Resident A's family member noted the elevated result as abnormal, the nursing supervisor did not assess the resident or notify the provider. The supervisor explained, "[n]obody's reported this, so obviously I'm assuming that it's a normal fingerstick; that this is a fingerstick that's scheduled to be done, and

[72] A glucometer is "an instrument for measuring the concentration of glucose [sugar] in the blood." *Merriam-Webster.com Dictionary*, "glucometer," accessed February 11, 2025, https://www.merriam-webster.com/dictionary/glucometer. The OIG reviewed the glucometer data and Resident A's EHR and noted while the LPN's name was not in the EHR, the glucometer data indicated the LPN as the operator and the date, time, and resultant blood sugar level matched that of Resident A's laboratory results. Resident A's fingerstick blood sugar result was 137 mg/dL on CLC day 1. Prior to the CLC admission, and while inpatient at the Buffalo VAMC, Resident A's blood sugar test results ranged from 112–144 mg/dL. The normal reference range for blood drawn sugar was 70–140mg/dl.

[Resident A] probably got … insulin." The supervisor added, "there was no indication that I would need to double check [the LPN] and second guess [the LPN]."[73]

Physician Failures

The OIG found that while nursing staff failed to notify the chief geriatric physician of Resident A's fingerstick blood sugar result on CLC day 20, the chief geriatric physician received a view alert with the result but took no further action and failed to address Resident A's elevated blood sugar.[74]

VHA requires providers to "[initiate] appropriate clinical action and follow-up …" and document clinical actions in the EHR when test results "require therapeutic intervention or action."[75]

In an interview, the chief geriatric physician explained, although being on call the day of and after the fingerstick blood sugar measurement (on CLC day 20), the result "never got to me." The chief geriatric physician told the OIG that a fingerstick blood sugar of 349 would be "significant" and require further assessment and possibly an order for insulin but stated "[the nursing staff] have to let me know." However, the OIG reviewed records provided by the system chief health informatics officer that showed the fingerstick result generated an automatic view alert to the chief geriatric physician through the EHR that same day. Records also showed that the chief geriatric physician "displayed" and "processed" the view alert the morning after the measurement was taken. Despite viewing the result, the chief geriatric physician did not document any follow-up to the abnormal result in Resident A's EHR.

When asked if the chief geriatric physician recalled an alert of the fingerstick blood sugar of 349 from CLC day 21, the chief stated, "I was not notified," and had nursing staff provided notification,

> I would have instructed the nursing supervisor to perform a full assessment of the veteran and notify me of the findings. After receiving the assessment, in this case, I would have ordered a one-time dose of regular insulin to cover the elevated [blood sugar]; I also would have ordered three-times-a-day finger sticks with regular insulin coverage to monitor [the resident's] [blood sugar] readings going forward.

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[73] The OIG reviewed Resident A's EHR and medication administration record and found no evidence that the resident was given insulin following the fingerstick blood sugar measurement. The resident did not have orders for sliding scale insulin. Sliding scale insulin refers to "a small amount of short-acting insulin … administered as needed based on the patient's current [blood sugar] readings." Charles Kodner, Laurie Anderson, and Katherine Pohlgeers, "Glucose Management in Hospitalized Patients," *American Family Physician* 96, no. 10 (November 15, 2017): 648-54.

[74] View alerts are EHR "notifications to providers about clinical information," such as an abnormal lab result. VHA, *Health Information Management Health Record Documentation Program Guide Version 1.2*; VA Computerized Patient Record System (CPRS) User Guide: GUI Version, May 2013.

[75] VHA Directive 1088.

When the OIG asked what actions should have been taken in response, the CLC medical director said that Resident A should have received follow-up fingerstick blood sugar testing for "at least for the next couple days," additional blood testing, and in-person assessment by a provider in the days immediately following the elevated fingerstick blood sugar.[76]

The OIG determined that both nursing staff and the chief geriatric physician failed to respond to Resident A's elevated fingerstick blood sugar result as expected. The OIG found nursing staff failed to document the fingerstick sugar test result and report it to a nursing supervisor; assess the resident; and alert a medical provider. Additionally, the chief geriatric physician failed to initiate clinical action and follow-up after viewing the fingerstick result alert. Given the change in Resident A's condition, earlier intervention may have prevented the resident's clinical decline and death.

2. OIG-Identified Issues in the Care of Resident B

In late August 2024, the OIG received an anonymous complaint related to the care of an additional resident, Resident B, who received care at the Batavia CLC. The complaint alleged that Resident B "… spent 5 full days with no intake and there was no follow-up nor intervention until [the 6th day]." On September 5, 2024, the OIG requested system leaders perform a clinical review of Resident B's care for a period during late summer 2024. System leaders provided the OIG a response on November 6, 2024, and documented a clinical review of care for Resident B for a 36-day period beginning in late summer 2024.

The OIG also conducted an independent clinical review for the same 36-day period. Based on the two reviews of care, the OIG substantiated there was a delayed response to changes in Resident B's clinical status. The OIG found clinical concerns, inconsistent with system policy, similar to those identified in the care provided to Resident A.[77] These concerns included (1) the failure of nursing staff to communicate changes in Resident B's clinical condition, and (2) the failure of the chief geriatric physician to document an examination and assessment in response to a change in the resident's condition.[78]

Resident B Case Summary

Resident B, in their eighties, had a medical history of dementia, dysphagia, and malnutrition, and lived in the Batavia CLC since late fall 2023.

[76] The CLC medical director noted that the fingerstick was performed on the weekend and a provider would be expected to conduct an assessment on the Monday following.

[77] The OIG is unable to determine that Resident B "spent 5 full days with no intake" as there was no documentation in the EHR, and the complainant was anonymous. The OIG instead focused on the 36-day period to better understand the course of clinical care.

[78] System Policy 118-34; System Policy 11-72; System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024.

In late summer 2024, CLC staff did not record Resident B's daily nutritional intake in the ADL notes for two days (day 2 and 3). Over the subsequent four days (days 4–7), CLC staff recorded Resident B consumed about five cups of a nutrition supplement, but only a 25 percent portion of one meal. On day 8, a CLC staff member documented Resident B ate no solid food over two meals and did not document the third meal or nutrition supplement intake. Additionally, that afternoon the chief geriatric physician signed a note in acknowledgment that a CLC nurse had held Resident B's blood pressure medication as Resident B had a blood pressure reading under the set parameters.

The next day (day 9), CLC staff documented notifying the chief geriatric physician that Resident B had minimal solid food intake over the last 5 days. In the morning of day 9, a CLC registered nurse wrote a nursing transfer note indicating Resident B was transferred to the Buffalo VA Emergency Department. An emergency department physician treated Resident B with intravenous fluids for dehydration and an antibiotic for a urinary tract infection. An emergency department nurse documented transfer of Resident B back to the Batavia CLC. Upon return to the Batavia CLC, a nursing assistant noted the patient did not eat dinner but consumed one cup of nutrition supplement.

From day 10 through day 26, CLC staff recorded variable food and liquid nutrition intake for Resident B. In the morning of day 27, a CLC registered nurse documented notifying the chief geriatric physician Resident B had no oral intake during the overnight shift. On day 27 about mid-day, CLC registered nurses noted Resident B was being transferred to the Buffalo VA Emergency Department for dehydration and low heart rate. After intravenous fluid treatment in the emergency department, Resident B was returned to the Batavia CLC. The next day, day 28, an internal medicine resident physician documented examination, evaluation, and care plan for Resident B after the emergency department visit, and the chief geriatric physician completed an addendum note concurring with the resident physician's examination and care plan.

During days 29 through 36, CLC staff again documented improved but variable solid food intake by Resident B, and the chief geriatric physician wrote no further EHR notes.

Results of System Care Reviews

System leaders reviewed the care of Resident B for the 36-day period beginning in late summer 2024, and noted

- "there was no consistent clinical assessment/intervention done [upon] any changes in [Resident B's] clinical status";
- "there was a lack of documented notification and communication to escalate issues, seemingly causing a delay in care"; and

- the chief geriatric physician did not consistently document clinical assessments before or following transfers to higher levels of care, such as the emergency department, which did not meet the "[s]tandard of [c]are."

The OIG reviewed Resident B's EHR for the same 36-day period of CLC care and found

- nursing staff did not document timely notification to a nurse supervisor or the provider regarding Resident B's decline in intake of meals and fluids;
- nursing staff failed to document and notify the provider of held medications, as required; and
- the chief geriatric physician failed to document assessment of Resident B when there was a significant change in the resident's condition.[79]

Nursing Failures

System policy requires

- nursing assistants to report observations about ADLs to the supervising registered nurse;
- LPNs to document, as well as report to the supervising nurse, observations and care provided to residents; and
- registered nurses to document assessment of a resident when there is a change in condition.[80]

The OIG reviewed meal and fluid intake documentation for Resident B from days 1–9 and found no evidence in the EHR that nursing staff notified a nursing supervisor or provider of the resident's low meal intake and reduced fluid intake until day 9.

Additionally, because Resident B was transferred to the emergency department on two occasions, for dehydration on day 9 and a low heart rate and dehydration on day 27, the OIG reviewed Resident B's EHR for evidence that nursing staff notified a medical provider when

[79] As noted above, system policy also requires that the nurse administering medication notify the medical provider of any held medications and document the name of the provider contacted in the EHR. System Policy 118-03. A medication may be held and not given if a resident is not allowed anything by mouth or if a provider sets a parameter for administration (for example, blood pressure).

[80] System Policy 118-34; Changes in condition for older residents can be physical, including changes in vital signs and weakness, or non-physical, such as changes in demeanor, appetite, agitation, sleeping, or complaints of pain. Agency for Healthcare Research and Quality (AHRQ), "Improving Patient Safety in Long-Term Care Facilities," *Module 1: Detecting Change in a Resident's Condition*, accessed January 27, 2025, https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod1.html.

medications were held for low blood pressure or low heart rate.[81] The OIG reviewed the resident's medication administration history, and identified medications with hold parameters related to blood pressure and heart rate and found the medications were held on 18 occasions; however, the OIG found no evidence in the EHR that nursing staff notified the medical provider on 13 of these occasions.[82]

Physician Failures

System bylaws and policy require that the medical provider completes and documents an examination and reassessment of the resident when there is a "significant change in the patient's condition or diagnosis."[83] Further, if a resident requires a higher level of care, the medical provider must place an order in the EHR "[w]hen [the resident] is transferred from one level of care to another level of care."[84]

Day 9 Transfer to Emergency Department

The OIG found no evidence that the chief geriatric physician performed an examination or clinical assessment upon Resident B's change in condition that required transfer to a higher level of care on day 9. The chief geriatric physician also did not place a transfer order in the EHR, as required, when the resident required transfer to the emergency department.[85] Further, upon the resident's return to the CLC the same day, after treatment for dehydration and a urinary tract infection in the emergency department, the chief geriatric physician failed to document an examination or clinical assessment.[86]

Day 27 Transfer to Emergency Department

The OIG noted a finding in the system review that the chief geriatric physician did not consistently document clinical assessments before or following transfers to higher levels of care.

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[81] Resident B's medication orders directed nursing staff to hold certain medications when systolic blood pressure was less than 100 mm Hg or the resident's heart rate was less than 50 beats per minute. "Blood pressure is determined by the amount of blood the heart pumps and the amount of resistance to blood flow in the arteries. A blood pressure reading has two numbers … systolic pressure … is the pressure in the arteries when the heart beats." "Blood pressure is measured in millimeters of mercury (mm Hg)." Low blood pressure can be a sign of dehydration. Mayo Clinic, "Low blood pressure (hypotension)," accessed January 17, 2025, https://www.mayoclinic.org/diseases-conditions/low-blood-pressure/symptoms-causes/syc-20355465.

[82] The OIG considered one "occasion" when medications held were scheduled for the same administration time or held for the same reason.

[83] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024; System Policy 11-72.

[84] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024.

[85] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024.

[86] Additionally, the OIG found that the chief geriatric physician did not document in Resident B's EHR through day 27 when the resident was again sent to the emergency department for dehydration.

However, the OIG did not find that the chief geriatric physician failed to assess the resident before transfer to, or upon return from, the emergency department on day 27. The OIG found the chief geriatric physician was in communication with nursing staff for approximately four hours on the morning of transfer regarding the resident's status, and nursing staff were monitoring the resident's condition. However, the OIG found the chief geriatric physician did not place an order for transfer to the emergency department in the EHR, as required.[87] The OIG found a resident physician documented an assessment of Resident B upon return to the CLC from the emergency department, and the chief geriatric physician added an addendum indicating concurrence, as VHA policy requires.[88]

The OIG determined that nursing staff's failure to document communication of changes in Resident B's condition may have limited the chief geriatric physician's awareness of the resident's condition, which required emergency care twice during the period of review. However, regarding the first transfer to a higher level of care on day 9, the chief geriatric physician was alerted to changes in Resident B's condition the day before but did not document an assessment prior to or following the transfer. The OIG is concerned that EHR documentation does not support that the chief geriatric physician provided medical assessment and attention to the resident's condition as required.

3. Leaders' Response

VHA expects organizational leaders to "promote the delivery of highly reliable, high-quality and safe patient care."[89] The OIG found that CLC leaders failed to uphold VHA HRO values. Specifically, CLC leaders failed to submit patient safety reports, provide oversight of nursing care, or consider disclosure upon awareness of adverse events in Resident A's care. However, system leaders identified the need for and conducted an institutional disclosure; temporarily removed the chief geriatric physician from providing care; and initiated clinical and administrative investigations once aware of concerns with Resident A's care.

[87] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024.

[88] VHA Directive 1400.01.

[89] VHA Directive 1050.01 (1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

CLC Leaders' Response

VHA policy "affirms its unwavering commitment to quality health care and patient safety for Veterans," which VHA's HRO framework has demonstrated since 2018.[90] VHA's HRO vision and goal includes leaders modeling "principle-based behaviors to demonstrate organization values and establish front-line culture."[91] The OIG found CLC leaders failed to adhere to the following VHA HRO principles

- "Sensitivity to Operations," expects leaders be "mindful of people, processes, and systems that impact patient care;"
- "Preoccupation with Failure," expects leaders to "[h]ave a laser-sharp focus on catching errors before they happen and predicting and eliminating risks before they cause harm;" and
- "Reluctance to Simplify," expects leaders "[g]et to the root causes of a problem rather than settling for simple explanations."[92]

To uphold HRO principles and to ensure high-quality and safe patient care, VHA encourages staff to report patient safety adverse events through the Joint Patient Safety Reporting (JPSR) system.[93] JPSR is the "primary mechanism" to identify health care system vulnerability and "[t]hese reports provide the foundation for investigating and analyzing root causes and to [*sic*] identifying the contributing factors which require action to prevent future events."[94]

Nursing Leaders and Staff Failed to Report Patient Safety Event

The OIG found that nursing leaders and staff failed to enter a patient safety report when Resident A's abnormal fingerstick blood sugar result on CLC day 20 was not reported to a supervising nurse, as required, and clinical follow-up did not occur. Further, nursing leaders did not provide sufficient oversight of nursing practice.

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[90] VHA Directive 1050.01 (1); "VHA's Journey to High Reliability is a long-term commitment to Veterans and our workforce to continuously improve and advance toward Zero Harm across VHA, drawing on lessons learned from other industries, other health systems and all areas of VHA." VA/VHA, *VHA High Reliability Organization (HRO) Reference Guide*, April 2023, VA/VHA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/Edit_View.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Reference%20Guide%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This site is not publicly accessible.) The guides contain the same or similar language regarding HRO framework and principles.

[91] VA/VHA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024.

[92] VA/VHA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024.

[93] VHA Directive 1050.01 (1).

[94] VHA Directive 1050.01 (1).

The OIG found no evidence of a patient safety report for Resident A regarding the unreported fingerstick blood sugar reading on CLC day 20. The nursing supervisor told the OIG of learning of the abnormal results several hours after the fingerstick on CLC day 20 from Resident A's family member. Approximately one week later, the nursing supervisor notified the unit nurse manager and the ACNS for geriatrics, via an email, of Resident A's fingerstick blood sugar level and that the LPN did not report results to a supervising nurse.[95]

When asked about consideration of a patient safety report, the unit nurse manager said, "I don't know why it didn't occur to me. It would have been a good idea."

The OIG would have expected that given Resident A's highly elevated blood sugar on CLC day 23 and transfer to a higher level of care, nursing leaders would have identified the failure of nursing staff to address the elevated sugar level on CLC day 20 and enter a patient safety report as an opportunity to identify factors leading to Resident A's further decline, and improve nursing performance, consistent with HRO principles.

CLC Nursing Leaders Failed to Provide Oversight of Nursing Practice

VHA holds the CLC nurse leader, such as the ACNS, responsible for "[e]nsuring that standards of nursing professional practice … and policy are implemented throughout the CLC."[96] Additionally, the CLC nurse leader must "promote learning experiences and improve performance of nursing personnel in CLCs."[97]

The OIG asked the unit nurse manager and the ACNS for geriatrics what actions were taken after learning of the events on CLC day 20 of Resident A's stay. The unit nurse manager recalled that the nursing supervisor informally counseled the LPN to notify a supervisor for fingerstick blood sugar results outside of a resident's normal range, and the concerns were addressed in nursing staff huddles.

The ACNS for geriatrics reported addressing the issue with the unit nurse manager, who indicated nursing staff would be provided with education on reporting significant changes in the condition of residents and expectations about "escalation protocol, including timeliness and proper documentation and whom to notify." The ACNS also confirmed

- "[c]ollaborat[ing] with nurse education department to provide 101 training with direct patient care staff," which staff completed on October 30, 2024; and
- completion of a standard operating procedure that requires "clinical staff" to report changes in a resident's condition to the nurse and a unit nurse manager or nursing

[95] The nursing supervisor was on duty as the supervisory nurse for CLC days 20 and 21 of Resident A's stay.

[96] VHA Directive 1142(1).

[97] VHA Directive 1142(1).

supervisor who then complete an assessment of the resident and report any concerns to the medical provider.[98]

To further explore how the ACNS for geriatrics promotes learning experiences and seeks improvement for CLC nursing care, the OIG asked the ACNS about quality reviews. The ACNS reported quality reviews are performed through the CLC quality assurance performance improvement (QAPI) committee. The committee, comprised of CLC leaders, such as the ACNS for geriatrics and the CLC medical director and CLC quality consultant, seeks to prevent adverse events and promote quality of care, patient safety, and zero harm.[99] In an interview, the ACNS for geriatrics expressed that Resident A's care was not addressed through this forum. Rather, huddles were used to discuss care concerns with the CLC team. The ACNS stated, "we do a good job at addressing those concerns when we are aware of it," and noted "documentation issues" were identified as missed opportunities in Resident A's care.[100]

Additionally, the "[QAPI] committee is charged with documenting both the QAPI process and systems-level changes," and meeting minutes should include elements such as the identification of quality concerns, the development of corrective action plans, and subsequent monitoring for effectiveness.[101] The OIG reviewed meeting minutes from October 2023 through October 2024 for evidence of nursing oversight and found that, although the committee identified quality concerns and created action plans in November 2023 for improving accuracy of ADL documentation and completion of STAR-VA notes through audits, there is no evidence of tracking data in the subsequent meetings. Without data, the OIG questions CLC leaders' ability to monitor and track efficacy of actions implemented through the QAPI committee.

The OIG determined CLC nursing leaders' failure to enter a patient safety report and provide expected oversight over CLC nursing practice and policy regarding the care of Resident A did not uphold HRO principles of sensitivity to operations or preoccupation with failure. Additionally, the OIG is concerned that current QAPI processes are failing to monitor and thereby improve nursing performance.

[98] The OIG learned from the ACNS for geriatrics that "101 training" outlined "the process of notification when the change in [a resident's] condition occurs," as well as signs and symptoms of hyper- and hypoglycemia. System Policy 118-36, *Escalation of Clinical Concerns in the CLC*, October 1, 2024.

[99] VHA Geriatrics and Extended Care, "CLC Quality Assurance Performance Improvement" (standard operating procedure), May 12, 2022.

[100] During interview, the unit nurse manager reported completing "spot audit[s]" of nursing documentation a couple of times a week; looking at monthly and weekly documentation with the "major focus [on] the ADL documentation making sure that it's done and that it's accurate."

[101] VHA Geriatrics and Extended Care, "CLC Quality Assurance Performance Improvement."

Physician Leaders Failed to Report Patient Safety Event

The OIG found that the chief geriatric physician and CLC medical director did not enter patient safety reports or consider disclosure of adverse care, despite awareness of the patient's outcomes following transfer from the CLC.

"It is VHA policy to disclose harmful or potentially harmful adverse events to patients or their personal representatives in order to maintain trust between patients and VA health care professionals, and to ensure uniform practice across all VA medical facilities."[102] Clinical disclosures, conducted by the resident's provider, inform the resident or resident's personal representative (who could be a family member) that a "harmful or potentially harmful adverse event has occurred during the patient's care" and are an "appropriate first step in a process" that may require a higher level disclosure, such as an institutional disclosure.[103] An institutional disclosure also includes an expression of apology and notification of legal options for further guidance and compensation.[104]

The OIG found no evidence of a patient safety report for Resident A regarding the unreported fingerstick blood sugar reading on CLC day 20. During interviews, the OIG learned that the chief geriatric physician and CLC medical director were aware of the patient's adverse outcome but neither considered escalating the care concerns. Specifically,

- the chief geriatric physician, aware of Resident A's transfer to a community hospital and diagnosis of diabetic ketoacidosis, reported to the OIG their belief that sepsis was the cause of the diagnosis; and
- the CLC medical director "informally" discussed concerns about Resident A's care with the unit nurse manager and the chief geriatric physician as well as listened to concerns raised by Resident A's family member; however, did not share these concerns with system leaders.[105]

The OIG determined that the failure of CLC leaders to report a patient safety event or consider clinical disclosure regarding CLC staff's failure to respond to the resident's elevated blood sugar measurement on CLC day 20, (1) precluded system staff from investigating and analyzing root causes to prevent future events, and (2) led to system leaders' delayed awareness for the need of an institutional disclosure.

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

[103] VHA Directive 1004.08.

[104] VHA Directive 1004.08.

[105] In an interview, the CLC medical director recalled one instance of concern regarding care provided by the chief geriatric physician but the CLC medical director "defer[red] to [the chief geriatric physician] judgment because [they] would have been seeing that [resident] far more often than me."

System Leaders' Response

The OIG found that, upon awareness of concerns regarding Resident A's care, system leaders

- conducted an institutional disclosure,
- temporarily removed the chief geriatric physician from the CLC to prevent further harm to residents, and
- initiated clinical and administrative investigations.

Institutional Disclosure

During interviews, the OIG learned that the system chief of Quality, Safety, and Value (chief of quality) and the Associate Director of Patient Care Services did not become aware of concerns regarding CLC care specific to Resident A until early August 2024. The interim chief of staff recalled discussions in late summer 2024 with the interim system executive director and the system chief of quality that resulted in the determination that the management of Resident A's diabetes required an institutional disclosure.[106] The chief of quality told the OIG of becoming aware of the concerns regarding the care provided to Resident A upon notification of inspection by the OIG in August 2024, and assigning a quality specialist to perform a review of care. The results identified deficiencies in diabetes care that were sufficient to warrant a disclosure. In fall 2024, the interim chief geriatric physician conducted an institutional disclosure with Resident A's family member, outlining that "[low sodium], hyperglycemia, and diabetic ketoacidosis were part of the complicated clinical scenario around the time of [Resident A's] death"; and there is an ongoing, internal investigation of the care provided.[107]

Summary Suspension of Clinical Privileges

A physician's clinical privileges "may be summarily suspended when the failure to take such action may result in an imminent danger to the health of any individual."[108] When a physician is placed on a summary suspension, the physician's practice is reviewed through a focused clinical care review, which "is typically completed within 30-calendar days" and reviewed by the Executive Committee of the Medical Staff (ECMS).[109] ECMS members may vote to take no

[106] Of note, the interim chief of staff began the role on August 18, 2024.

[107] Per the interim chief geriatric physician, the interim role was assumed in late summer 2024, when the chief geriatric physician was summarily suspended, and still functions as the medical director for the system's home-based primary care program.

[108] VHA Directive 1100.21(1).

[109] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024; VHA Directive 1100.21(1). A focused clinical care review is an objective and retrospective fact-finding process to assess the physician's practice. The Executive Committee of the Medical Staff, mostly compromised of "licensed physician members of the medical staff practicing in the VA medical facility," is a group responsible for "making specific recommendations directly to the organization's governing body for approval … and acting on reports and recommendations."

action, initiate a focused professional practice evaluation (FPPE) for cause, or revoke or reduce privileges.[110]

The interim chief of staff told the OIG that due to starting the role in mid-August, awareness of the issues were "all at once." Specifically, the OIG inspection, an unrelated administrative investigation, and the additional OIG concerns regarding Resident B led the interim chief of staff to have "concerns that difficulty with communication with [the chief geriatric physician] could be having an impact on patient care." The interim chief of staff described reporting these concerns to the interim system executive director and proposing to suspend the chief geriatric physician from clinical care.

In late summer 2024, the interim system executive director signed a letter summarily suspending the chief geriatric physician's clinical privileges until further notice and pending an investigation of clinical performance.

System leaders initiated and completed clinical care reviews (in late summer and early fall 2024) to address concerns with the CLC care provided to Residents A and B by the chief geriatric physician and found deficiencies similar to those identified in the OIG's reviews of care provided to Residents A and B. The OIG found one of the system leaders' actions included ensuring the completion of a focused clinical care review for Resident B, and this review was performed per VHA requirements.[111] In response to the focused clinical care review findings, the ECMS met in early fall 2024 to vote on privileging actions for the chief geriatric physician. The committee unanimously voted to renew the chief geriatric physician's privileges and initiate an FPPE for cause. In mid-fall 2024, the interim system executive director rescinded the summary suspension but stated the chief geriatric physician would not return to clinical care until an administrative investigation was completed.[112]

Administrative Investigation Board

When "significant incidents. . .and issues" occur, VHA conducts administrative investigations to collect and analyze evidence.[113] An Administrative Investigation Board is an administrative

[110] System, *Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA) VA Western New York Healthcare System*, May 9, 2024; VHA Directive 1100.21(1). An FPPE for cause is an evaluation of a provider's performance "to determine if any action should be taken on the [provider's] privileges after a clinical concern has been triggered and a [focused clinical care review] has been conducted."

[111] VHA Directive 1100.21(1); VHA policy designates "clinical reviews which address specific issues," such as focused clinical care reviews, "as confidential and privileged under 38 U.S.C. § 5705," and further details will not be discussed in this report. VHA Directive 1320, *Quality Management And Patient Safety Activities That Can Generate Confidential Records And Documents*, July 10, 2020.

[112] VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021.

[113] VA Directive 0700.

investigation to collect and analyze evidence, facts, and information on matters of interest to VA.[114]

The OIG found system leaders chartered an Administrative Investigation Board in mid-fall 2024, per VA requirements, to determine whether care provided by the chief geriatric physician to Residents A and B could be "considered or categorized as patient abuse or neglect by VHA standards."[115] The Administrative Investigation Board did not substantiate the allegations and recommended that system leaders "[r]eturn [the chief geriatric physician] to clinical care as soon as possible."

In late 2024, the interim chief of staff presented the FPPE for cause criteria to the chief geriatric physician, which the ECMS unanimously approved approximately one week earlier. Per the FPPE for cause, upon the chief geriatric physician's return to clinical care in four days, the interim chief of staff will conduct weekly reviews of the chief geriatric physician's

- documented resident evaluations before and after a change in condition requiring transfer to community care, and
- antipsychotic medication orders with "appropriate dosing, frequency, duration, and indication" and "documentation of behaviors and/or symptoms warranting the use."[116]

The OIG found that once aware of the concerns with Resident A's care through the OIG inspection, system leaders identified the need to evaluate the provision of care, remove the chief geriatric physician from care until further investigation, and conduct an institutional disclosure. The OIG determined that system leaders, once aware, addressed the concerns regarding the chief geriatric physician's care through administrative investigations and an FPPE for cause to evaluate for care deficiencies as expected.

4. Additional Concerns Identified by the OIG

The OIG identified an additional concern with CLC medical provider staffing and determined that staffing was inadequate to support the clinical and administrative needs of the Batavia CLCs.[117] The OIG further identified ineffective nursing education and training organization, due to unclear roles and responsibilities and a perceived lack of support from the nurse education

[114] VA Directive 0700.

[115] The interim chief of staff charged the Administrative Investigation Board in mid-fall 2024.

[116] The weekly reviews will be performed for the period of the FPPE for cause (late 2024 through early spring 2025).

[117] The OIG also reviewed CLC nurse staffing levels and found that staffing met or exceeded target levels during the period which encompassed the time of Resident A's clinical decline. The OIG reviewed the method used to calculate actual nursing hours provided per patient day but did not conduct an independent evaluation of the data provided by VHA used to calculate the nursing hours provided.

department. The OIG also found Maple unit nursing staff lacked required dementia care training.[118]

Concern with Medical Provider Staffing

While VHA does not have a required staffing methodology for CLC medical providers, the VHA Office of Geriatrics and Extended Care has published a full-time equivalent calculator to determine the number of recommended providers.[119] The calculator incorporates factors such as average daily resident census, the number of admissions, discharges, and transfers, and includes specific calculations for residents with dementia and those on hospice units, to predict the recommended provider full-time equivalents.

The CLC medical director told the OIG of using a GEC-recommended full-time equivalent calculator, and determining the need for a total 5.0 full-time equivalents between the Batavia and Buffalo CLC sites—4.1 for providers and an additional 0.9 for the CLC medical director role.[120] However, after a medical provider at the Batavia site retired in early 2024, and during the timeframe of admission for Residents A and B, the CLC provider full-time equivalents, which included the chief geriatric physician, CLC medical director, and a nurse practitioner, only totaled 3.0. The CLC medical director explained the concern with this staffing scenario:

> I think that when you are so short staffed on your clinical providers…that is a patient safety issue and unfortunately things like documentation and being as thorough, even missing a notification when you are covering too many patients than what is recommended, I think is potentially a problem.

The CLC medical director also reported the staffing shortage made it difficult to complete clinical and administrative duties, such as responding to patient care notifications and conducting clinical oversight. Due to these concerns, as well as risk to patient safety while providing simultaneous coverage to both Batavia and Buffalo CLC locations, the CLC medical director stepped down from the role of medical director in October 2024.

The chief of quality told the OIG that CLC staff expressed concerns about the chief geriatric physician's responsiveness, which the chief of quality attributed to CLC medical provider staffing. The chief of quality did not report the concerns to executive leaders, believing there was nothing that could be done.

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[118] The OIG specifically addressed unmet training needs for Maple unit nursing staff based on allegations related to Resident A's care; however, recommendations are system-based to ensure consistency of training throughout all system CLC units.

[119] Office of Geriatrics and Extended Care (GEC), "Standardization of Staffing in VA Community Living Centers (CLCs)," accessed October 16, 2024.

[120] The OIG reviewed the tool used to calculate the full-time equivalent needs but did not conduct an independent evaluation of the data provided by VHA used to calculate the recommended full-time equivalent.

During interviews, the OIG also learned of difficulties recruiting for the medical provider position, vacated in early 2024. The interim chief of staff, CLC medical director, and chief of quality told the OIG that difficulties were due to the rural location of Batavia. The interim chief of staff also told the OIG that two candidates had declined the position. In response to the recruiting difficulties, the interim chief geriatric physician described developing a plan to repost the position, expanding the announcement to nurse practitioners as well as physicians.

Inadequate medical provider staffing limits providers' time to ensure CLC residents receive expected medical care. As noted by the CLC medical director, increased patient care responsibility and limited time to accomplish administrative and oversight duties increases risk to patient safety.

Concerns with Nursing Education

VHA requires the CLC nurse leader "to promote learning experiences and improve performance of nursing personnel in CLCs."[121] To ensure "orientation, training, and competence" of all system employees, the education department facilitates initial orientation "with collaboration of Department Leads that present specific topics" and managers ensure staff receive subsequent, unit-specific orientation.[122]

During an interview, the ACNS for geriatrics explained sharing the responsibility to identify additional training needs with the unit nurse managers and the clinical nurse expert (CNE). Additionally, the ACNS reported recognizing areas for improvement regarding Resident A's care as well as "working with my educator" to identify and mitigate barriers.[123]

The OIG interviewed CLC nursing leaders and learned the responsibility for coordinating and providing education and training was not clearly defined.[124] During an interview, the CNE stated "education is… some part of the role, but I'm more of a supportive role from what I understand . . .but it's not a clearly defined role …"

The OIG reviewed a summary of nursing staff training, provided by the CNE, that outlined training occurred on 11 occasions from January–October 2024. However, only 2 of the 11 training topics related to the issues identified in the care of Residents A and B—required

[121] VHA Directive 1142(1).

[122] System Memorandum No. 05-22, *Employee Competence*, May 5, 2017. This policy was rescinded and replaced by System Policy 141-22, *Employee Orientation and Competency*, January 1, 2025. These policies contain similar language related to initial and unit-specific orientation, but the January 2025 version specified "collaboration of Department Leads" and that managers ensure staff receive unit-specific orientation while the May 2017 version did not. However, the OIG learned from the ACNS of geriatrics that, prior to the January 2025 policy version, the nursing education department and CLC nursing leaders all contributed to orientation material and CLC nurse managers (unit nurse managers) were responsible for providing unit-specific orientation.

[123] The ACNS for geriatrics noted needed improvements with documentation, as well as follow-up and prompt supervisor notification of blood sugar levels out of normal range.

[124] CLC nursing leaders include the CNE, Maple unit nurse manager, and a nurse supervisor.

documentation in the long-term care setting and the system's policy regarding fingerstick blood sugar tests. Further, training did not take place until the week the OIG was onsite and the CNE's records indicated not all Maple unit staff completed training:

- Only two of five LPNs and four of ten nursing assistants signed attendance for the training on required documentation in the long-term care setting; however, all registered nurses signed attendance.
- No regularly scheduled registered nurses signed attendance for training on the system's policy regarding fingerstick blood sugar tests.

During interviews, CLC nursing staff expressed a lack of presence and support at Batavia from the nurse education department

- "… [W]e're supposed to have education, I believe in this building, two times a week. I've seen them one time this year …" "But I think that's part of the problem being merged with Buffalo."
- "We need an education department here, is what we need here. That's my opinion …"
- "I have suggested developing our own nursing education in Batavia and unfortunately, to date, that hasn't occurred."

Dementia Care Related Education

The VA medical system director is responsible for "[e]nsuring that the [system] has a dementia education plan for addressing all [system] staff needs for education and training on the care of [residents] with dementia."[125]

During interviews, the OIG asked nursing staff what training was provided and what additional training was needed to provide care for residents with dementia. One registered nurse stated,

> I'll be honest, I do not recall an extensive training at all [during orientation] … I was actually quite amazed because we do have a lot of dementia patients on our floor as well as [the dementia unit] … I have brought this up to my manager before, that I feel people need a whole entire class on how to deal with dementia patients, because they do not know how to talk to dementia patients … and I feel … there's no education on that, none.

One registered nurse told the OIG of a lack of dementia-related training prior to working on the dementia unit and when asked what training would have been helpful, the nurse told the OIG "Dementia training, medication."[126] The nurse manager of the dementia unit also shared

[125] VHA Directive 1140.12.

[126] The registered nurse, assigned to the Maple unit, reported floating to the dementia unit due to staffing needs.

concerns about the lack of STAR-VA training for CLC staff. The nurse manager told the OIG, "I can tell that [staff on other units] don't have the same skills as the Pine [unit] staff."

Following a request for documents, the OIG learned that the system did not have a dementia education plan as required. In a memo, the interim system executive director acknowledged the system's lack of a dementia education plan and reported "[a]n education plan is being developed."

Although the system did not have a dementia education plan, the ACNS for geriatrics provided the OIG with a list of required training for all CLC nursing staff that included STAR-VA education as a requirement during CLC orientation (with the CLC psychologist) and annually thereafter.[127] In review of STAR-VA training records, the OIG found that not all Maple unit nursing staff had completed STAR-VA training. The following nursing staff did not complete STAR-VA education during orientation:

- Four of five registered nurses.
- Three of six LPNs.
- Two of nine nursing assistants.

Additionally, the following nursing staff did not complete annual, online, STAR-VA education in the last two years.

- Three of the five registered nurses.
- Five of the six LPNs.
- Five of the nine nursing assistants.[128]

Further, the OIG found two nursing assistants never completed annual, online, STAR-VA education.

In an interview, the CLC psychologist confirmed providing STAR-VA training during orientation but stated it was "hit or miss" and described challenges training staff during the COVID-19 pandemic as they were rapidly filling vacancies, and it was difficult to track.

The CLC psychologist also expressed uncertainty on who was currently responsible for monitoring which staff need STAR-VA orientation training, explaining that a nurse educator previously provided notification when new staff needed training. However, the nurse educator

[127] A nurse quality management specialist confirmed the CLC psychologist provides in-person STAR-VA education during CLC orientation and nursing staff complete subsequent annual training online.

[128] The OIG found only one LPN and one nursing assistant completed the required annual STAR-VA training within the last year (in 2024). Of note, the nurse who reported "prophylactic" haloperidol administration has no record of STAR-VA orientation training completion and last completed annual, online STAR-VA education in 2021.

told the OIG of continuing to notify the CLC psychologist of all new hires to the Batavia CLC, and that the process had not changed.

The OIG determined that the lack of clear roles and responsibilities regarding education and training coordination, as well as a perceived lack of support from the nurse education department, has resulted in unmet training needs for nursing staff at the Batavia CLC. Further, the lack of adequate education in caring for residents with dementia contributed to care deficiencies.

Conclusion

The OIG substantiated deficiencies in Resident A's care at the Batavia CLC, including physician and nursing staff management of Resident A's dementia and diabetes and nursing documentation of medication administration and nutritional intake, may have contributed to the resident's death. These ongoing and cumulative deficiencies may have contributed to a preventable decline in health, resulting in irreparable clinical injury that necessitated palliative and end-of-life care.

Specifically, the OIG determined the chief geriatric physician's failure to complete a full history and physical examination precluded timely and comprehensive interventions that may have mitigated the resident's functional decline. The lack of documentation regarding Resident A's behaviors limited interdisciplinary CLC staff in the creation of dementia care plans that included non-pharmacological behavior management or evaluation of the effectiveness of pharmacological treatment. The OIG found Resident A's family member did not have a clear understanding of the resident's medication plan and is concerned that the chief geriatric physician may not have considered clinical risk factors regarding the use of antipsychotic medications.

The OIG also found several deficiencies in the management of Resident A's diabetes, including nursing staff's failure to document and communicate medication refusals and changes in the resident's meal intake, which limited the chief geriatric physician's ability to consider clinical care adjustments. The chief geriatric physician did not act upon these risk factors and failed to ensure completion of laboratory orders that may have led to earlier identification of Resident A's increasing blood sugar and medical intervention prior to Resident A needing a higher level of care for hyperglycemia. The OIG determined that nursing staff and the chief geriatric physician failed to intervene upon awareness of Resident A's elevated blood sugar on CLC day 20 as expected.

The OIG determined that CLC leaders failed to uphold VHA HRO principles and values when CLC leaders failed to submit patient safety reports, provide oversight of nursing care, or consider disclosure upon awareness of the adverse event in Resident A's care, which precluded system staff from investigating and analyzing root causes to prevent future events and delayed the institutional disclosure.

Similar deficiencies in care occurred with another CLC resident, Resident B, as nursing staff failed to document communication of changes in condition that may have limited the chief geriatric physician's awareness to intervene prior to the resident's need for emergent care. The OIG also found that, on one occasion, the chief geriatric physician did not document an assessment of the resident prior to or following transfer to the emergency department and did not place transfer orders. However, once aware of CLC care deficiencies for Resident A and B, system leaders temporarily removed the chief geriatric physician from providing care and initiated clinical and administrative investigations.

The OIG further identified deficiencies in provider staffing and nurse education that increased the risk of patient safety events and may have contributed to Resident A's functional decline. The OIG found CLC medical provider staffing was inadequate to support the clinical and administrative needs of the Batavia CLCs, and ineffective nursing education and training organization resulted in unmet training needs for nursing staff at the Batavia CLC.

Recommendations 1–10

1. The VA Western New York Health Care System Executive Director ensures that community living center staff complete behavioral notes and conduct behavioral rounds, consistent with system policies regarding behavioral health and administration of antipsychotic medications, monitors for compliance, and takes action as indicated.

2. The VA Western New York Health Care System Executive Director evaluates community living center nursing staff compliance with system policies regarding the administration of medications, and nursing documentation related to medication refusals, medical provider notification, and residents' nutritional intake, and takes action as required.

3. The VA Western New York Health Care System Executive Director reviews the system policy regarding the use of antipsychotic medications in the community living center and considers aligning system policy with Veterans Health Administration's dementia system of care recommendation to document risk-benefit discussions for all residents receiving pharmacological interventions for dementia-related behaviors.

4. The VA Western New York Health Care System Executive Director makes certain community living center staff comply with the system policy on fingerstick blood sugar testing, including documenting results and notification to the resident's provider, and monitors compliance, taking action as indicated.

5. The VA Western New York Health Care System Executive Director reviews Batavia community living center laboratory processes and takes action as necessary to ensure timely completion of orders.

6. The VA Western New York Health Care System Executive Director ensures community living center staff enter joint patient safety reports and disclosures, as Veterans Health Administration guides and requires, and in support of high reliability organization principles, and monitors compliance.

7. The VA Western New York Health Care System Executive Director makes certain the community living center quality assurance performance improvement procedures adhere to Veterans Health Administration requirements, including the use of data to track effectiveness of quality assurance activities, and supports improvement in community living center nursing care.

8. The VA Western New York Health Care System Executive Director ensures completion of the chief geriatric physician's focused professional practice evaluation for cause per Veterans Health Administration requirements.

9. The VA Western New York Health Care System Executive Director evaluates community living center medical provider staffing to ensure staffing meets patient care needs and takes action as necessary, including continued recruitment to fill vacancies.

10. The VA Western New York Health Care System Executive Director ensures review of education plans, education needs assessments, and completion of a system dementia education plan as well as initial and ongoing Staff Training in Assisted Living Residences-VA training, as expected, for all community living center nursing staff, and takes action as indicated.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 12, 2025

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

Subj: VA OIG Draft Report—Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA Western New York Healthcare System in Buffalo

To: Director, Office of Healthcare Inspections (54HL07)
Executive Director, Office of Integrity and Compliance (10OIC)

1. 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 the OIG Draft Report—Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA Western New York Healthcare System in Buffalo.

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

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

(*Original signed by:*)

Joan E. McInerney, MD, MBA, MA, FACEP

[OIG comment: The OIG received the above memorandum from VHA on June 24, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 11, 2025

From: Director, VA Western New York Healthcare System, Buffalo, NY (528)

Subj: VA OIG Draft Report—Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA Western New York Healthcare System in Buffalo

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— Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA Western New York Healthcare System in Buffalo. VA Western New York 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 Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Harold B. Pharis
Interim Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on June 24, 2025.]

Facility Director Response

Recommendation 1

The VA Western New York Health Care System Executive Director ensures that community living center staff complete behavioral notes and conduct behavioral rounds, consistent with system policies regarding behavioral health and administration of antipsychotic medications, monitors for compliance, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

A local process for identification of Community Living Center (CLC) residents that are considered at risk, fragile, or complex, have emerging medical or behavioral concerns, or early warning signs of deterioration was initiated in October 2024 via local standard operating procedure (SOP) establishing an interdisciplinary Watchlist Huddle.

In October 2024, CLC Lodges in Batavia initiated interdisciplinary behavioral rounds. Residents with behavioral concerns are identified by the Watchlist Huddle or during Geriatric Psychiatry consultative calls, which also review antipsychotic medication use. Behavioral rounds are led weekly by the clinical psychologist, along with an interdisciplinary team, in accordance with the local SOP. Documentation of the rounds, including the intervention plan, are in the electronic medical record.

To demonstrate compliance, monitoring for the completion of rounding and documentation on identified Watchlist residents will be conducted monthly by lodge nurse managers and reported at the local CLC Quality Assurance Performance Improvement (QAPI) meeting. The Associate Chief Nursing Service (ACNS) of Geriatrics will report compliance updates to the Executive Director at the Quality and Patient Safety Committee until 90% compliance is met for six consecutive months.

Recommendation 2

The VA Western New York Health Care System Executive Director evaluates community living center nursing staff compliance with system policies regarding the administration of medications, and nursing documentation related to medication refusals, medical provider notification, and residents' nutritional intake, and takes action as required.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

Education was provided to the CLC nursing staff in October 2024 to reinforce facility policies and processes related to topics such as medication administration and documentation, including nutritional intake. Additional education was also provided via the Talent Management System in October 2024 on Documentation and Change in Patient Condition. An SOP, Escalation of Clinical Concerns in the CLC, was implemented in October 2024 and reviewed with staff by nurse managers.

To demonstrate compliance with system policies, patient chart reviews will be implemented. Identified issues will be discussed with staff and managers for correction and continuous process improvement. Review outcomes will be reported at the local CLC QAPI meeting by the Clinical Nurse Expert and CLC RN Quality Management Specialist. The ACNS of Geriatrics will report compliance updates to the Executive Director at the Quality and Patient Safety Committee until 90% compliance is met for 6 consecutive months.

Recommendation 3

The VA Western New York Health Care System Executive Director reviews the system policy regarding the use of antipsychotic medications in the community living center and considers aligning system policy with Veterans Health Administration's dementia system of care recommendation to document risk-benefit discussions for all residents receiving pharmacological interventions for dementia-related behaviors.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

To align with the VHA Dementia System of Care Directive, CLC clinicians will document a risk-benefit discussion, including risk of increased mortality from certain agents, for applicable residents before initiating pharmacological treatment of dementia-related behavioral symptoms and upon follow-up to re-assess medication efficacy.

To demonstrate compliance, patient chart reviews will be implemented and monitored for compliance. Review outcomes will be reported at the local CLC QAPI meeting by the CLC RN Quality Management Specialist. The ACNS of Geriatrics will report compliance updates to the Executive Director at the Quality and Patient Safety Committee until 90% compliance is met for 6 consecutive months.

Recommendation 4

The VA Western New York Health Care System Executive Director makes certain community living center staff comply with the system policy on fingerstick blood sugar testing, including documenting results and notification to the resident's provider, and monitors compliance, taking action as indicated.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

Education for the CLC Nursing staff on the facility policy and process for fingerstick glucose testing was completed. An SOP for Escalation of Clinical Concerns in the CLC was implemented in October 2024 and reviewed with staff by managers.

The Western New York VA Ancillary Test Coordinator conducts monthly reviews for local policy compliance with critical fingerstick blood glucose testing, including required confirmation testing, documentation, and timely notification to providers. Any issues found with compliance are reported to the nurse managers for action to be taken as indicated.

To demonstrate compliance, results will be reported at the local CLC QAPI meeting monthly for tracking and development of actions as indicated. The ACNS of Geriatrics will report compliance updates to the Executive Director at the Quality and Patient Safety Committee until 90% compliance is met for 6 consecutive months.

Recommendation 5

The VA Western New York Health Care System Executive Director reviews Batavia community living center laboratory processes and takes action as necessary to ensure timely completion of orders.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The Western New York VA Medical Center System Redesign Coordinator will facilitate a Lean Education Academic Network process review for Batavia CLC laboratory processes, identify gaps and waste, and assist with initiation of process change with an aim to ensure timely completion of orders. The Batavia Primary Care Nurse Manager is the process owner and

responsible for implementation of the identified solutions; the ACNS of Ambulatory Services will Champion the project.

To demonstrate compliance, the project and outcomes will be reported to the Executive leadership team in a Project Report Out meeting.

Recommendation 6

The VA Western New York Health Care System Executive Director ensures community living center staff enter joint patient safety reports and disclosures, as Veterans Health Administration guides and requires, and in support of high reliability organization principles, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: May 2025

Director Comments

The Western New York Patient Safety Manager (PSM), beginning in October 2024, increased presence on the Batavia CLC lodges to include being on site at the Batavia campus at least 1 day per week. While on site, the PSM rounds on the units providing support to nursing staff, including reminders for staff to enter Joint Patient Safety Reports (JPSR) for any patient safety concerns. In addition, the PSM performs any just in time training related to issues with entering JPSR. In May 2025, the PSM began sending monthly categorized JPSR data reports to the ACNS for Geriatrics and nurse managers. The PSM participates in the Interdisciplinary CLC daily morning huddle and ensures that any patient safety incidents discussed have been reported in JPSR. In support of High Reliability Organization (HRO) principles, the PSM conducts education on reporting patient safety concerns at new employee orientation, monthly at all staff HRO safety forums and quarterly at the Executive Committee for Nursing Services meeting. The PSM interfaces with risk management when identifying a report that may require a disclosure. The Risk Manager then performs the necessary reviews and coordinates disclosures, if indicated.

OIG Comments

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

Recommendation 7

The VA Western New York Health Care System Executive Director makes certain the community living center quality assurance performance improvement procedures adhere to

Veterans Health Administration requirements, including the use of data to track effectiveness of quality assurance activities, and supports improvement in community living center nursing care.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The CLC QAPI committee will identify quality concerns related to quality of life, quality of care, and/or residents' choice and create performance improvement action plans. The performance improvement plans will be reviewed at subsequent CLC QAPI meetings to include updated metric data and continuous efforts until sustained improvement is achieved.

To demonstrate compliance, the ACNS of Geriatrics will report performance improvement plan progress and actions taken to the Executive Director at the Quality and Patient Safety Committee, which will be captured in the meeting minutes.

Recommendation 8

The VA Western New York Health Care System Executive Director ensures completion of the chief geriatric physician's focused professional practice evaluation for cause per Veterans Health Administration requirements.

_X _Concur

____Nonconcur

Target date for completion: March 2025

Director Comments

Following Credentialing and Privileging VHA Directive 1100.21(1), Privileging, from December 23, 2024, to March 17, 2025, VHA conducted a focused professional practice evaluation (FPPE) of the Chief of Geriatrics and Extended Care (GEC) for cause. The Executive Committee of the Medical Staff Credentialing and Privileging Committee reviewed the results on March 19, 2025, and voted to revoke the clinical privileges of the Chief of GEC. On May 31, 2025, the Chief of GEC retired.

OIG Comments

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

Recommendation 9

The VA Western New York Health Care System Executive Director evaluates community living center medical provider staffing to ensure staffing meets patient care needs and takes action as necessary, including continued recruitment to fill vacancies.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

Recruitment and hiring efforts to ensure provider staffing meets patient care needs is ongoing for the Batavia CLC. As of April 2025, one full time Nurse Practitioner was hired, one full time physician was recruited, and is currently in the onboarding process, and one physician position has been approved and posted. Recruitment needs and efforts are being monitored by the Chief of Staff.

Recommendation 10

The VA Western New York Health Care System Executive Director ensures review of education plans, education needs assessments, and completion of a system dementia education plan as well as initial and ongoing Staff Training in Assisted Living Residences-VA training, as expected, for all community living center nursing staff, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

A facility dementia education plan was developed and implemented as required by VHA directive 1140.12, Dementia System of Care, and trainings were assigned via the Talent Management System in January 2025. Review of the facility dementia education plan will be added to the Dementia Committee agenda as an annual item for review, discussion, and proposal to the executive leadership team for concurrence. Compliance will be monitored until 90% compliance is met for six consecutive months.

Initial and annual CLC nursing competency and training plans are being reviewed and updated by the Associate Chief of Nursing for Geriatrics, in consultation with the education department, to address educational needs for the CLC nursing staff. The final competency and training plans will be presented to the Executive leadership team for concurrence.

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