



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in
Administrative Actions for a
Patient's Inpatient Mental
Health Unit and Community
Living Center Admissions at
the Tuscaloosa VA Medical
Center in Alabama



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations that staff at the Tuscaloosa VA Medical Center (facility) in Alabama denied a patient's request to be discharged and did not ensure the patient's access to a [patient advocate](#), as required by Veterans Health Administration (VHA) and facility policy.¹ The inspection also evaluated OIG-identified concerns related to Inpatient Mental Health Unit and Community Living Center (CLC) staff's administrative actions during the patient's admissions, including: [informed consent](#) for treatment documentation; decision-making capacity evaluation; VHA and state of Alabama [commitment](#) requirements compliance; and VHA [against medical advice](#) (AMA) discharge requirement compliance.² Additionally, the OIG identified concerns regarding staff's assignment of a [surrogate decision-maker](#) and CLC staff's management of the patient's correspondence.

Synopsis of the Patient's Inpatient Mental Health Unit and CLC Care Early 2018–Summer 2021

In early 2018 (month 1), the patient, in their late 50s with a history of psychiatric admissions, was transported by emergency medical services to a non-VA hospital after calling 911 and transferred to the facility's Inpatient Mental Health Unit later that day for [psychosis](#) and [delusions](#). Four days later, an inpatient psychiatrist (inpatient psychiatrist 1) documented that the patient requested to be discharged AMA. Beginning the following day, facility staff had regular contact with a family member of the patient regarding the patient's care. Approximately three weeks later (month 2), a psychiatrist (inpatient psychiatrist 2) providing weekend coverage documented that the patient "probably has progressive [dementia](#)," and the next day noted that the patient "probably needs [[neuropsychological evaluation](#)] at some point before discharge." Twenty days later, per the patient's request, another inpatient psychiatrist (inpatient psychiatrist 3) referred the patient to the facility's [mental health residential rehabilitation treatment program](#) and the program manager declined the referral based on "a diagnosis of dementia and therefore is not psychiatrically appropriate for [[residential rehabilitation treatment program](#)] care."

¹ VHA Handbook 1160.06, Inpatient Mental Health Services, September 16, 2013. Alabama Code, 22:52-10.4, Findings Necessary for Inpatient Treatment; 22:52-10.5, Facilities for Inpatient Treatment; Length of Treatment; Cost. VHA Directive 1003.04, VHA Patient Advocacy Program, February 7, 2018. A patient advocate is an individual who supports and protects a patient's healthcare rights. Facility Memorandum No. 00-24, Patient Advocate Program, March 15, 2018.

² Underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

In late 2018 (month 10), “Due to dementia and psychosis,” inpatient psychiatrist 3 transferred the patient to the facility’s long-stay mental health CLC.³ In summer 2019 (month 17), the patient was readmitted to the Inpatient Mental Health Unit for worsening agitation, aggression, and inconsistent medication compliance, and was discharged back to the CLC five months later (month 22). The same month, a second family member notified facility staff that the family member with whom they had contact had died. Staff then communicated about the patient’s care with the second family member.

In spring 2020 (month 29), a psychologist conducted an “in person capacity assessment” and concluded that the patient lacked medical decision-making capacity and had “symptoms of cognitive impairment occurring in the context of schizophrenia.” In fall 2020 (month 33), a physician continued to document that the patient’s diagnoses included dementia. That same month, a neuropsychologist concluded that the patient (1) exhibited cognitive impairment related to [schizophrenia](#), (2) did “not meet criteria for dementia,” and (3) “would benefit from remaining in a supervised and structured living setting.” In late 2020 (month 35), the patient was transferred from the CLC to the Inpatient Mental Health Unit due to “inherent safety concerns,” “Destructive behavior,” and medication noncompliance. In early 2021 (month 37), the patient was transferred to the CLC and remained there as of summer 2021 (month 42).

OIG Findings

The OIG recognizes and appreciates the facility staff’s dedication to providing quality care that addressed the patient’s challenging mental health needs. However, as discussed below, the OIG identified deficiencies in the facility staff’s administrative actions related to the patient’s admissions.

The OIG substantiated that staff denied the patient’s requests to be discharged from the Inpatient Mental Health Unit and CLC. Inpatient Mental Health Unit and CLC staff failed to follow VHA- and facility-required informed consent procedures and did not adequately communicate the purpose, risks, and benefits of treatment to the patient, as required by VHA.⁴ The OIG also found that staff did not provide the patient, who repeatedly requested discharge and questioned the nature of the admission, sufficient opportunity to refuse treatment and did not pursue processes to retain the patient through a commitment. The OIG concluded that staff misunderstanding and lack of knowledge contributed to a lack of adherence to informed consent and commitment requirements.

³ Facility Memorandum No. GEC-11, *Community Living Center (CLC) Admission Process*, March 31, 2017. The CLC includes seven programs, including a mental health program that provides long-stay admissions of greater than 90 days.

⁴ VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatment and Procedures*, August 14, 2009, amended June 25, 2020 and January 4, 2021. Facility Memorandum No. 11-23, *Releases from Inpatient Care*, September 6, 2018.

The OIG found that Inpatient Mental Health Unit and CLC staff did not conduct sufficient or timely evaluation of the patient's decision-making capacity. Patients with potential cognitive deficits, such as those with schizophrenia and dementia, should be referred to a neuropsychologist, a specialist trained to differentiate between potential causes of a patient's cognitive changes and the duration of a patient's loss of decision-making capacity.⁵ In late spring 2020, approximately two years and four months after the patient first requested to leave the facility, staff completed a decision-making capacity assessment. Additionally, the OIG found that Inpatient Mental Health Unit and CLC staff documented unsupported, conflicting information in the patient's electronic health record (EHR) regarding the patient's decision-making capacity.⁶ Further, the OIG found that the patient's dementia diagnosis, that prohibited discharge options for the patient, remained unconfirmed from early 2018 until the fall 2020 neuropsychological evaluation that concluded the patient did not meet criteria for dementia. The Interim Associate Chief of Staff of Geriatrics and Extended Care told the OIG that the patient's neuropsychological evaluation was delayed due to the patient's lack of cooperation and mistrust of staff and that involving providers who had not previously met with the patient allowed for completion of the neuropsychological evaluation.⁷

VHA requires that facility staff assess a patient for voluntary or involuntary status when admitted to an inpatient mental health unit. Staff must follow state requirements when committing a patient on involuntary status.⁸ Staff must initiate a commitment to provide treatment when a patient refuses treatment or demands discharge and meets state-defined legal requirements.⁹ The OIG found that although the patient repeatedly requested discharge, the patient remained on voluntary status during admissions to the Inpatient Mental Health Unit and CLC for nearly 2 years and 11 months. The OIG found that Inpatient Mental Health Unit staff did not adequately assess the patient's admission status as voluntary or involuntary and did not follow VHA or state of Alabama commitment requirements in early 2018 and summer 2019, the first two of the

⁵ Katya Rascovsky, "A Primer in Neuropsychological Assessment for Dementia," *Practical Neurology*, July/ August 2016, accessed February 26, 2021, <https://practicalneurology.com/articles/2016-july-aug-a-primer-in-neuropsychological-assessment-for-dementia>. Ryan Schroeder, Phillip Martin, and Anne Walling, "Neuropsychological Evaluations in Adults," *American Family Physician*, 99 no. 2 (January 2019): 101-108, accessed February 26, 2021, <https://www.aafp.org/afp/2019/0115/afp20190115p101.pdf>. Christina Ting et al., "Differentiating the Cognitive Profile of Schizophrenia from That of Alzheimer Disease and Depression in Late Life. *PLoS (Public Library of Science) ONE*, 5 no. 4 (April 2010): e10151, accessed February 26, 2021, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0010151>.

⁶ VHA Handbook 1004.01(4). VHA defines decision-making capacity as a clinical judgment regarding a patient's ability to understand and evaluate treatment risks and benefits and communicate medical decisions.

⁷ VHA Geriatrics and Extended Care Service is responsible for care for aging and chronically ill veterans through geriatrics and long term care programs including CLCs.

⁸ VHA Handbook 1160.06.

⁹ VHA Handbook 1160.06.

patient's three Inpatient Mental Health Unit admissions.¹⁰ In late 2020, following the OIG team's communication of allegations regarding the patient's admission status to facility staff and leaders, Inpatient Mental Health Unit staff filed a petition for commitment of the patient that was approved by a probate court, as required by VHA and state law.¹¹

The OIG found that Inpatient Mental Health Unit staff did not comply with AMA discharge requirements, including submission of a petition for a commitment, when the patient requested an AMA discharge.¹² The OIG found that Inpatient Mental Health Unit staff did not document the patient's AMA requests and consent to notify [next of kin](#) in a templated AMA note in the patient's EHR, as required by facility policy.¹³ Additionally, when the patient requested to leave, Inpatient Mental Health Unit staff did not discharge the patient within 24 hours, obtain the patient's signature on an AMA form, or immediately submit a petition for commitment of the patient, as required.¹⁴ Three of five Inpatient Mental Health Unit staff interviewed by the OIG reported that staff did not follow up on the patient's request to be discharged AMA because the patient refused to sign the AMA form; however, staff did not document a refusal by the patient to sign in a commitment petition, as required.¹⁵

The OIG determined that Inpatient Mental Health Unit and CLC staff did not comply with requirements to properly identify a surrogate decision-maker. Although Inpatient Mental Health Unit staff communicated with the patient's family member regarding the patient's care starting in early 2018, and then communicated with a second family member starting in late 2019, staff did not document identification of either family member as a surrogate decision-maker until late spring 2020, approximately two years and four months after the patient's admission to the facility. The OIG determined that Inpatient Mental Health Unit and CLC staff's misunderstanding and lack of knowledge contributed to the failure to comply with surrogate decision-maker assignment requirements.

The OIG also found that CLC staff did not address ethical concerns regarding the appropriateness of the patient's surrogate decision-maker. In spring 2020, CLC staff documented that the patient received a hurtful and harshly worded letter from the second family member that instructed the patient to not contact the second family member. A CLC nurse practitioner discontinued an ethics consult that was placed to evaluate the appropriateness of the second

¹⁰ VHA Handbook 1160.06. Alabama Code, 22:52-10.4, Findings Necessary for Inpatient Treatment; 22:52-10.5, Facilities for Inpatient Treatment; Length of Treatment; Cost.

¹¹ VHA Handbook 1160.06. Alabama Code, 22:52-10.4, Findings Necessary for Inpatient Treatment; 22:52-10.5, Facilities for Inpatient Treatment; Length of Treatment; Cost.

¹² Facility Memorandum No. 11-78, *Processing Against Medical Advice (AMA) Demands*, September 12, 2018. Facility Memorandum No. 11-23.

¹³ Facility Memorandum No. 11-78; Facility Memorandum No. 11-23.

¹⁴ Facility Memorandum No. 11-78; Facility Memorandum No. 11-23.

¹⁵ Facility Memorandum No. 11-23.

family member's continued involvement in the patient's care decisions. The CLC nurse practitioner told the OIG that the ethics consult was discontinued because the treatment team evaluated the second family member's ability to act in the best interest of the patient and the second family member declined the option to relinquish the role of surrogate decision-maker. Inpatient Mental Health Unit and CLC staff's failure to properly identify and document a surrogate decision-maker for the patient may have contributed to delays in determining the patient's appropriate admission status.

The OIG substantiated that CLC staff failed to ensure the patient's access to the patient advocate. In late spring 2019, a CLC nurse documented that the patient requested to speak with a patient advocate and later that same month, another CLC nurse offered to contact a patient advocate regarding the patient's concerns related to medication side effects and the patient agreed.

In an interview with the OIG, the service-level advocate could not recall those late spring 2019 requests to meet with the patient. However, the service-level advocate reported receiving complaints directly from the patient during daily interactions in the CLC that included requests for discharge. The service-level advocate told the OIG that the patient advocate was not notified due to awaiting identification of a discharge placement by the treatment team that would resolve the patient's concerns and because the patient had not specifically requested to speak with the patient advocate. The service-level patient advocate reported being unaware of the requirement to enter patient complaints into the patient advocate tracking system and had never used the system.

Staff were unable to provide documentation to support that the patient's complaint was entered into the patient advocate tracking system, as required by VHA.¹⁶ CLC staff's failure to ensure the patient's access to the patient advocate and adequately address or track the patient's complaints within the required time frame prevented resolution or facility leader review.

The OIG found that CLC staff did not properly manage a letter from the patient that was intended for a public official.¹⁷ The treatment team discussed the patient's request with the second family member who requested that the treatment team withhold the letter because "It will not change [the patient's] situation or mental condition." The CLC social worker documented that the patient's letter would be mailed to the second family member. The OIG did not find evidence that the treatment team included the patient in the discussion about the letter or obtained the patient's agreement to provide the letter to the second family member, as advised by the [Integrated Ethics Council](#). The staff's lack of adherence to ethical guidelines potentially violated the patient's right to communicate with a public official.

¹⁶ VHA Directive 1003.04.

¹⁷ VHA Directive 1003.04.

The OIG made seven recommendations to the Facility Director related to informed treatment consent processes, decision-making capacity evaluation completion and documentation, commitment requirements, AMA discharge procedures, surrogate decision-maker assignment, patient advocate reporting and tracking processes, and management of the patient's correspondence request.

Comments

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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Abbreviations

AMA	against medical advice
CLC	Community Living Center
EHR	electronic health record
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations that Tuscaloosa VA Medical Center (facility) staff denied a patient's request to be discharged and did not ensure the patient's access to a [patient advocate](#), as required by Veterans Health Administration (VHA) and facility policy.¹

Background

The facility, part of Veterans Integrated Service Network (VISN) 7, is located in Tuscaloosa, Alabama, and operates one community-based outpatient clinic. From October 1, 2019, through September 30, 2020, the facility served 15,450 patients and had a total of 317 operating beds, including 43 inpatient beds and 134 community living center (CLC) beds.² The facility provides services that include primary care, mental health, and long-term and rehabilitative care; and has an academic affiliation with the University of Alabama School of Medicine. The facility operates two inpatient mental health units that provide acute psychiatric services.³ The CLC includes seven programs, including a mental health program that provides long-stay admissions of greater than 90 days.⁴ VHA CLC long-stay mental health programs provide care to patients with "chronic stable mental illness coupled with geriatric or other syndromes that render them less able to function in non-institutional settings."⁵

Prior OIG Reports

In a 2020 report, the OIG identified surrogate decision-making, clinical, and patient rights deficiencies at the VA facility in Louisville, Kentucky, and made 15 recommendations. Relevant to this inspection, the report included four recommendations related to involuntary hold

¹ VHA Handbook 1160.06, Inpatient Mental Health Services, September 16, 2013. Alabama Code, 22:52-10.4, Findings Necessary for Inpatient Treatment; 22:52-10.5, Facilities for Inpatient Treatment; Length of Treatment; Cost. VHA Directive 1003.04, VHA Patient Advocacy Program, February 7, 2018. Facility Memorandum No. 00-24, Patient Advocate Program, March 15, 2018. Underlined terms are links to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

² VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. CLCs are VA-owned facilities typically on or near VA property that provide long-term skilled-nursing care and may also offer short or long-term specialty programs.

³ Facility Memorandum No. 116-1, *Organization and Delivery of Mental Health Services*, September 9, 2018.

⁴ Facility Memorandum No. GEC-11, *Community Living Center (CLC) Admission Process*, March 31, 2017.

⁵ VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers, September 2, 2012.

admission, decision-making capacity assessment, and patient surrogate assignment processes. As of August 10, 2021, the one recommendation regarding involuntary hold remained open.⁶

In a 2020 inspection report of the facility, the OIG made 14 recommendations including that the Facility Director ensures a multidisciplinary committee reviews [life-sustaining treatment](#) plans for patients who lack decision-making capability and do not have a surrogate. This recommendation was closed on February 12, 2021.⁷

Allegations and Related Concerns

On April 6, 2020, the OIG received an allegation that the patient was denied discharge from the facility. The OIG identified concerns related to Inpatient Mental Health Unit and CLC staff's administrative actions during the patient's admissions, including

- [informed consent](#) for treatment documentation,
- decision-making capacity evaluation,
- VHA and state of Alabama [commitment](#) requirement compliance, and
- VHA [against medical advice](#) (AMA) discharge requirement compliance.

Additionally, the OIG identified concerns regarding Inpatient Mental Health Unit and CLC staff's assignment of a [surrogate decision-maker](#).

The OIG also received an allegation that CLC staff failed to ensure the patient's access to the facility's patient advocate. The OIG identified a related concern regarding the management of the patient's correspondence.⁸

On May 11, 2020, the OIG requested that facility leaders review the allegations, and on July 9, received a response from the Facility Director. The OIG determined that the Facility Director's response did not adequately address the allegations, and on August 10, initiated a hotline inspection.

⁶ VA OIG, [Surrogate Decision-Maker, Clinical, and Patient Rights Deficiencies at the Robley Rex VA Medical Center in Louisville, Kentucky](#), Report No. 19-08666-212, August 5, 2020.

⁷ VA OIG, [Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama](#), Report No. 20-00130-194, September 2, 2020.

⁸ VHA Directive 1003.04. A patient advocate is an individual who supports and protects a patient's healthcare rights.

Scope and Methodology

The OIG initiated the healthcare inspection on August 10, 2020, and conducted a virtual site visit from October 19–27, 2020.⁹

The OIG team interviewed leaders from VISN 7 and the facility, a VA Office of General Counsel attorney, and facility staff familiar with the patient's care and relevant processes.

The OIG team reviewed relevant VHA directives, handbooks, and memoranda, and facility policies, standard operating procedures, and organizational charts. The OIG reviewed relevant Alabama state laws and The Joint Commission standards. Other documents reviewed included the patient's electronic health record (EHR), [Integrated Ethics Council](#) meeting minutes, and facility documents related to the patient's care.

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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

⁹ The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," March 11, 2020, accessed November 10, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam Webster, *Definition of pandemic*, accessed November 10, 2020, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Patient Case Summary

In early 2018 (month 1), the patient, in their late 50s, was transported by emergency medical services to a non-VA hospital after calling 911 to get “this knot on my belly checked, and I usually come in for 1-2 months to the psych wards to be checked out until the parasites leave me.” The non-VA emergency department nurse noted that the patient denied having a mental health diagnosis, although reported five admissions to psychiatric units. A drug screen performed at the non-VA hospital was negative for [psychoactive substances](#). The patient was transferred from the non-VA hospital to the facility's Inpatient Mental Health Unit for [psychosis](#) and [delusions](#).

At the facility, a nurse practitioner (admitting nurse practitioner) described the patient as “Oriented to person, place, rambling.” The admitting nurse practitioner documented that the patient presented to “have an abdominal mass evaluated,” and an [ultrasound](#) indicated that the patient had a [hernia](#).¹⁰ The admitting nurse practitioner noted that the patient denied substance use, and that the patient's EHR included a history of “[cannabis](#), [amphetamine](#), [cocaine](#) and [alcohol dependence](#)” and the patient had “been out of the VA system for years.”

Three days later, an inpatient social worker documented that the patient was “hospitalized voluntarily,” believed the admission was for hernia surgery, was delusional, and lacked insight. The inpatient social worker also noted that the patient was “[competent for VA purposes](#),” did not have a “VA [guardian](#),” and was “Legally [Competent](#).” That same day, an inpatient psychiatrist (inpatient psychiatrist 1) described the patient as “confused” with “impaired” abstract thinking and unable to complete a short cognitive test. Inpatient psychiatrist 1 diagnosed the patient with chronic [schizophrenia](#) and documented that if the patient refused an orally administered [antipsychotic](#) medication, inpatient psychiatrist 1 would pursue commitment of the patient and use a [long-acting, injectable medication](#).

The following day, inpatient psychiatrist 1 documented that the patient requested to be discharged AMA. Inpatient psychiatrist 1 noted the need for commitment if the patient signed an AMA request form. That same day, an inpatient nurse documented that the patient's goal for the day was “to fill out AMA.”¹¹ The following day, inpatient psychiatrist 1 documented that the patient “didn't ask about ama [*sic*] today and took [oral antipsychotic medication] x2 nights” and again noted the need for commitment if the patient signed an AMA request form. The patient and inpatient social worker contacted a family member, and following the call, the family member called the inpatient social worker back. The family member reported that the patient had been

¹⁰ The type of hernia with which the patient was diagnosed did not necessarily require surgical care. The admitting nurse practitioner told the OIG that the patient declined treatment for the hernia.

¹¹ The OIG modified a portion of the quoted text from upper to lower case for readability purposes.

transient and homeless for years and had “a long history of noncompliance with medications” and “needed to be locked up in a state home because [the patient] is a danger to [self].”

Six days later, an inpatient nurse documented that the patient was “yelling at unseen [*sic*] person in day area” and physically attacked an inpatient nurse after being escorted to a medication room. Inpatient Mental Health Unit staff placed the patient in [four-point restraints](#) and administered [sedative](#) medication. The following week, the patient told inpatient psychiatrist 1, “I didn’t sign admission papers.” Inpatient psychiatrist 1 documented that the patient demonstrated paranoid ideation, delusions, poor judgment, and limited insight. The following day, the inpatient social worker documented that the treatment team met with the patient who “presented with little insight and very delusional” and was requesting discharge from the facility. The inpatient social worker noted that a discharge disposition would “be explored upon stabilization.”

One week later (month 2), the patient continued to exhibit delusions and had resumed taking the oral antipsychotic medication. Two days later, a psychiatrist (inpatient psychiatrist 2) providing weekend coverage documented that the patient “probably has progressive [dementia](#),” and the next day noted that the patient “probably needs [[neuropsychological evaluation](#)] at some point before discharge.” Two days later, another inpatient psychiatrist (inpatient psychiatrist 3) met with the patient and noted, “Patient will be referred for Psychological testing when stable.” Seventeen days later, inpatient psychiatrist 3 and the patient discussed disposition planning and the patient requested referral to a [domiciliary](#). Inpatient psychiatrist 3 referred the patient to the facility’s [mental health residential rehabilitation treatment program](#) and the program manager declined the referral based on “a diagnosis of dementia and therefore is not psychiatrically appropriate for [residential rehabilitation treatment program] care.”

Six days later, the inpatient social worker documented that the patient had limited discharge disposition options due to a “limited income” and the need for supervision. Approximately three weeks later (month 3), inpatient psychiatrist 3 noted that the patient was “stabilized” and “compliant with medication” and placed referrals for the facility’s mental health and homeless residential rehabilitation treatment programs. Four days later, a residential rehabilitation treatment program nurse practitioner determined the patient was unstable for admission due to “dementia and confusion.” The residential rehabilitation treatment program manager documented that the patient “maintains the delusion that [the patient] was sent to the hospital for hernia surgery,” and recommended that the patient remain on the Inpatient Mental Health Unit until a placement could be identified in Florida where the patient wanted to return.

One week later, the inpatient social worker contacted the family member to discuss the option of the patient residing with the family member. The family member informed the inpatient social worker about not being able to assist with the patient’s housing due to an inability to care for the patient. Five weeks later (month 5), inpatient psychiatrist 3 noted that the patient “has dementia and delusion,” was cooperative, and sleeping and eating well. The treatment plan included the patient’s referral to another Alabama VA facility’s dementia unit. Four days later, the treatment

team met with the patient, whose chief complaint was, “How long will I have to be here. [sic]” Inpatient psychiatrist 3 noted that the patient could only be discharged to a dementia or highly supervised unit. Approximately three weeks later, in summer 2018, the inpatient social worker documented the patient “has been referred to CLC Long Term Care Unit,” and approximately two months later (month 7), the patient was accepted with a pending admission date.

In fall 2018 (month 9), inpatient psychiatrist 3 noted that the patient continued to have chronic delusions and lacked insight and that mood and behaviors were “controlled” by the prescribed medications. Almost two weeks later (month 10), the inpatient social worker noted that the treatment team was completing an application for a Michigan VA facility CLC, where the family member resided.

One week later, a Michigan VA facility program coordinator spoke with the patient’s family member, who denied serving as the patient’s surrogate decision-maker, and stated that “the VA” was making medical decisions for the patient. The program coordinator noted the absence of a neuropsychological evaluation to “properly diagnose” dementia, and that the patient’s symptoms appeared consistent with the patient’s schizophrenia diagnosis. A Michigan VA facility CLC social worker noted concerns about the potential for the environment to “feel very restrictive” for the patient and result in problematic behavior, that the patient lacked a medical decision-maker, and the patient “does not wish for an admission to a CLC.”

Six days later, inpatient psychiatrist 3 placed a consult for “psychological testing for dementia [diagnosis],” and then discontinued the consult since the patient was to be discharged to the facility’s CLC. The next day, “Due to dementia and psychosis,” inpatient psychiatrist 3 transferred the patient to the facility’s CLC long-stay mental health CLC. Inpatient psychiatrist 3 documented that the patient agreed with the discharge, lacked insight with short and long-term memory deficits, was “Competent for VA Purposes,” and that the patient’s family member participated in the discharge plan. The inpatient social worker noted that the patient was “Psychiatrically Stable for Outpatient Care” and able to comprehend discharge instructions. The inpatient social worker also noted that the patient’s [Social Security](#) benefits were discontinued due to hospitalization, and as a result, the patient did not have funds for expenses to obtain a guardian.

The following day, a CLC nurse practitioner documented that the patient was “not committed per court order” to the CLC. A CLC social worker noted that the patient had: “questionable” “decision-making for [patient’s] own care and safety,” the “mental capacity to understand treatment,” “no family that are able to obtain guardianship,” and poor “discharge potential” “due to the level of supervision and safety [the patient] needs.” The CLC social worker also noted the patient’s family member requested that the patient receive continued care at the facility.

Three weeks later (month 11), a CLC psychiatrist documented that the patient had two incidents of verbal aggression, physical agitation, and threatening of staff since CLC admission, with the second incident resulting in police involvement and sedating medications being administered to

the patient. The CLC psychiatrist noted that the patient's dementia diagnosis was not clearly established and recommended that the CLC psychologist conduct a cognitive test. The following day, the patient called the VA police and reported being kidnapped by CLC staff. The patient told a CLC nurse that the patient was not "committed [*sic*] here and no one will let [the patient] out." Four days later, the family member told the CLC social worker that the patient repeatedly asked to "check [the patient] out of this facility." The CLC social worker noted, "no discharge plans are being pursued" due to the patient's elopement risk and history of medication noncompliance.

The patient remained on the CLC without significant issue until spring 2019 (month 17), when the patient became agitated and aggressive and called VA police. The VA police, a privacy officer, and the CLC psychologist met with the patient who had been administered sedating medications. The following morning, the CLC psychiatrist noted that the patient refused oral antipsychotic medications and a long-acting, injectable medication would be considered if the patient continued to refuse. Later that day, the patient requested to speak to a patient advocate and asked for a copy of the police report.

Three days later, the patient told a CLC nurse practitioner about wanting to be discharged to reside with the family member, and asked, "They are not suppose [*sic*] to keep you against your will, then why is this a locked unit. [*sic*]" The CLC nurse practitioner noted that the patient continued to refuse medications. Two days later the patient became aggressive and threatening to staff members. A CLC nurse spoke with the family member, who was in agreement with staff's "[show of force](#)" when necessary to manage the patient's behaviors. The following day, the CLC social worker and another CLC nurse spoke with the patient, who repeatedly requested discharge either to the family member's home or an independent living facility near the family member's home.

Four days later, the patient asked a CLC nurse to contact the Federal Bureau of Investigations regarding medication side effect concerns.¹² The CLC nurse offered to contact the patient advocate to speak with the patient and the patient agreed. Two days later, the CLC psychiatrist recommended transfer of the patient to the Inpatient Mental Health Unit for worsening agitation, aggression, and inconsistent medication compliance. The CLC psychiatrist noted that the patient had poor judgment, lacked insight, and that the patient's threatening behavior interfered with a cognition assessment.

That same day, the patient was admitted to the Inpatient Mental Health Unit. The admitting psychiatrist (inpatient psychiatrist 4) planned to consider psychological testing to differentiate between dementia and other cognitive deficiencies, and discharge the patient to the CLC upon stabilization. Approximately three weeks later (month 18), the inpatient psychiatrist 4

¹² Federal Bureau of Investigation, "About FBI," accessed January 29, 2021, <https://www.fbi.gov/about/faqs>. The Federal Bureau of Investigations is a government security organization.

documented that the patient was “under commitment for treatment.”¹³ The following day, a social worker and inpatient psychiatrist 4 called the family member, who noted the patient “sounded ‘normal’” and agreed to the patient’s placement in the family member’s home as a discharge option, if decided upon by the patient and treatment team.

In summer 2019 (month 20), inpatient psychiatrist 4 noted that the patient was “stabilizing.” When the patient requested discharge and to be picked up by the family member, inpatient psychiatrist 4 encouraged the patient to continue medications and consider return to the CLC for sooner discharge. The patient declined to return to the CLC, and stated that the CLC was long-term care so the patient would not be discharged, and requested to remain on the Inpatient Mental Health Unit until discharge.

The following month (month 21), the social worker and inpatient psychiatrist 4 spoke to the patient’s family member who continued to consider the patient’s discharge to the family member’s home and had concerns regarding the patient’s medication adherence. Three weeks later (month 22), the patient achieved a perfect score on a cognitive test. Inpatient psychiatrist 4 excluded dementia from the patient’s diagnoses and noted that the patient’s memory appeared intact and that the patient declined further testing.

Five days later, a second family member called and notified the patient and treatment team that the family member who the staff had been speaking with about the patient had died. The patient asked the second family member to pick the patient up from the facility. The second family member declined due to a lack of stable housing and stated that the patient needed to remain at the facility. Fifteen days later, the patient was discharged from the Inpatient Mental Health Unit to the facility’s CLC.

In early 2020 (month 24), the second family member told the CLC social worker about going through the court system for guardianship of the patient. The CLC social worker informed the second family member that the patient continued to request discharge and the second family member asked that the patient remain at the facility. The following month (month 25), the CLC social worker documented that the patient was “Unable to make decisions for [the patient’s] own care due to mental health,” and identified the second family member as [next of kin](#). Approximately two weeks later (month 26), the second family member called the CLC social worker and expressed that the patient was in “the best place [the patient] has been in 30-years” and requested again that the patient continue to receive care at the facility. Eighteen days later, a CLC nurse practitioner documented that the patient had removed bedroom window casings and had requested discharge to a [community residential care](#) home or to live with the second family member. The CLC nurse practitioner noted that the patient was “here for long stay care.”

¹³ The OIG modified the quoted text from upper to lower case for readability purposes.

The following month (month 27), the CLC nurse documented that the patient received a letter from the second family member that included “very hurting and harsh content” and instructed the patient “never to contact [the family member] again.” The patient requested to speak with a pastor “about something personal.” Two days later, the CLC nurse practitioner documented that the second family member’s letter was “very derogative, blunt, and degrading.” The CLC nurse practitioner noted staff concerns about the patient’s depression and suicidal thoughts and initiated safety measures, that included patient checks every 30 minutes, a room check at every shift, and a psychiatric evaluation as soon as possible. During a telephone call with a facility chaplain, the patient discussed the second family member’s “hurtful” letter and requested a public official’s address to mail a request for assistance with discharge from the facility. The facility chaplain documented a plan to notify the CLC social worker and the “unit chaplain” of the patient’s request.

Two days later, the second family member told the CLC social worker about a history of conflict and frustration with the patient. The second family member also reported receiving phone calls from the patient “several times each day.” The second family member agreed to continue to make medical decisions for the patient in collaboration with the treatment team under the condition that the patient was not allowed to contact the second family member and had phone privileges removed.

Two weeks later (month 28), the treatment team decided to place an ethics consult to evaluate the appropriateness of the second family member’s continued involvement in the patient’s care decisions and a psychology consult to assess the patient’s capacity to make end-of-life and other healthcare decisions. Five days later, during another call with the chaplain, the patient requested the public official’s phone number and restated a plan to write a letter to request assistance with discharge from the facility. The chaplain informed the patient that the CLC social worker would be notified.

Two days later, the CLC social worker documented that the patient is “unable to make decisions for [the patient’s] own care due to mental health” and identified the second family member as next of kin. One week later, the CLC psychologist was unable to complete an evaluation due to the patient’s agitation and would consider consulting a neuropsychologist to complete the evaluation “to introduce an examiner unknown” to the patient. The CLC psychologist noted that the patient’s mental illness was a barrier to independence and that the patient would likely require extensive supervision if discharged. Two days later, the second family member denied having contact information for other family members and “stated that knowing [the patient’s] mental health illness, [the second family member] would not want [the patient] to be resuscitated” in the event of a medical emergency.

One week later (month 29), a psychologist evaluated the patient for capacity to make life-sustaining treatment decisions. The psychologist noted that the patient lacked insight about the patient’s psychiatric condition or reason for “continued involuntary placement.” The patient

declined additional cognitive testing, and expressed delusional ideas related to end-of-life care options. The patient denied trusting anyone to serve as a surrogate decision-maker, including the second family member. The psychologist concluded that the patient lacked capacity to make life-sustaining treatment decisions or to select a surrogate decision-maker due to severe psychiatric symptoms. The CLC psychiatrist further documented that it was unlikely that the patient's decision-making capacity would improve with psychiatric treatment.

Five days later, the second family member declined the treatment team's offer to assume decision-making on behalf of the patient. The second family member reported "that even with the past history between them" the second family member "is able to make decisions taking into account [the patient's] best interest." Two days later, a CLC nurse practitioner discontinued the ethics consult based on the discussion with the second family member and completed a life-sustaining treatment plan that identified the second family member as "VA-authorized surrogate if/when patient loses decision-making capacity."¹⁴

The following month (month 30), the treatment team contacted the second family member regarding the patient's request to mail a letter to a public official. At the request of the second family member, the treatment team and privacy officer agreed not to mail the letter to the public official and provided the letter to the second family member. Twelve days later, another CLC nurse practitioner informed the second family member of the patient's "decline in functioning" and refusal to have bloodwork drawn. The CLC nurse practitioner referred to the second family member as the patient's guardian and obtained "informed consent" to administer a mood-stabilizing medication and obtain bloodwork if the patient declined. Sixteen days later (month 31), the CLC social worker noted that the second family member was no longer seeking legal guardianship due to expense and would continue to help with medical decision-making.

Two months later, in fall 2020 (month 33), a neuropsychologist determined that the patient did not meet criteria for dementia, and recommended that the patient remain in a supervised setting due to psychiatric symptoms. In late 2020 (month 35), the patient was transferred from the CLC to the Inpatient Mental Health Unit due to "inherent safety concerns," "Destructive behavior," and medication noncompliance. The next day, Inpatient Mental Health Unit staff filed a petition for a commitment of the patient that was granted by a probate court. Approximately two months later, the CLC social worker documented that the probate court issued an outpatient mental health treatment order committing the patient for no more than 150 days of care at "Alabama Department of Mental Health/Veterans Administration Medical Center with the condition that the [patient] shall follow the directions and treatment plan as established by the said designated mental health facility." The patient was transferred to the CLC and remained there as of summer 2021 (month 42).

¹⁴ The OIG modified the quoted text from upper to lower case for readability purposes.

Inspection Results

The OIG identified deficiencies in the facility staff's administrative actions related to the patient's admissions; however, the OIG recognizes and appreciates the facility staff's dedication to provide quality care that addressed the patient's challenging mental health needs.

Failure to Complete Required Administrative Actions

The OIG substantiated that the patient was denied discharge from the facility's Inpatient Mental Health Unit and CLC. The OIG found that Inpatient Mental Health Unit and CLC staff did not adequately provide the patient an explanation of treatment and did not obtain or document the patient's consent for treatment prior to or during the patient's admissions, as required by VHA and facility policy.¹⁵

The OIG found that Inpatient Mental Health Unit and CLC staff's evaluation of the patient's decision-making capacity and diagnoses were delayed.¹⁶ Further, Inpatient Mental Health Unit staff did not comply with VHA and state of Alabama commitment and facility AMA discharge requirements.¹⁷ The OIG found that Inpatient Mental Health Unit and CLC staff did not properly assign a surrogate decision-maker for the patient or address ethical concerns related to a family member's serving as surrogate decision-maker.¹⁸

Failure to Document Informed Consent for Treatment

VHA patients "have the right to accept or refuse any medical treatment or procedure recommended to them." Unless otherwise specified, staff must obtain a patient's voluntary informed consent for all treatments and procedures. VHA requires that staff document written or oral consent in the patient's EHR.¹⁹ Providers must determine whether a patient has decision-making capacity (discussed below) to obtain informed consent and are required to re-obtain informed consent when there is a change in the patient's condition.²⁰ When a patient is transferred from a non-VA facility, the referring and accepting providers are responsible for ensuring that the patient's informed consent to transfer is documented on a form completed by

¹⁵ VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatment and Procedures*, August 14, 2009, amended June 25, 2020 and January 4, 2021. Facility Memorandum No. 11-23, *Releases from Inpatient Care*, September 6, 2018.

¹⁶ VHA Handbook 1004.01(4).

¹⁷ VHA Handbook 1160.06; Alabama Code, 22:52-10.4, Findings Necessary for Inpatient Treatment; 22:52-10.5, Facilities for Inpatient Treatment; Length of Treatment; Cost; Facility Memorandum No. 11-23, *Releases from Inpatient Care*, September 6, 2018.

¹⁸ VHA Handbook, 1104.01(4).

¹⁹ VHA Handbook 1004.01(4). In most cases, a brief statement in the patient's EHR such as "patient consented to treatment plan" is sufficient for documenting consent.

²⁰ VHA Handbook 1004.01(4).

the referring physician.²¹ Facility staff must also inform patients that a voluntary inpatient mental health unit admission may lead to conversion to involuntary status, inability to leave at will, and seclusion or restraint use.²²

In early 2018, when the patient was transferred to the facility from a non-VA facility, transfer documentation did not include the patient's consent for admission to the facility's Inpatient Mental Health Unit, as required.²³ Later that month, the patient told inpatient psychiatrist 1, "I didn't sign admission papers." Inpatient psychiatrist 1 noted that the patient believed to have been kidnapped. When asked if a patient's confusion regarding purpose of admission leads to concern about the patient's ability to consent to voluntary admission, inpatient psychiatrist 1 told the OIG that generally, mentally ill or confused patients transferred from a non-VA facility were admitted and medicated to "try to get them a bit more competent." Inpatient psychiatrist 3 was unsure about documentation processes for facility admission consent and told the OIG that when a patient is transferred to the facility, consent is obtained by referring staff.²⁴

In late spring 2018, the admitting nurse practitioner included schizophrenia and dementia as the patient's diagnoses on the CLC application form. The form included the patient's initials on the patient signature line. The CLC Admissions Coordinator told the OIG that the patient's initials indicated the patient's consent for treatment. However, there was no statement of consent or information about admission status on the form. The admitting nurse practitioner told the OIG that consent should be obtained prior to a patient's transfer from a non-VA facility to the facility and that informed consent was often not documented.

The OIG determined that Inpatient Mental Health Unit staff did not obtain the patient's informed consent for treatment in late spring 2019, when the patient was readmitted from the CLC. When interviewed by the OIG, inpatient psychiatrist 4 reported that consent was not obtained because the patient was transferred from the CLC and therefore, the patient was assumed to be a voluntary admission. The OIG did not find evidence that Inpatient Mental Health Unit or CLC staff discussed or documented the patient's consent for admission or procedures except when the CLC psychologist met with the patient to "gain informed consent for the patient's upcoming capacity evaluation."²⁵

Inpatient Mental Health Unit and CLC staff failed to follow VHA- and facility-required informed consent procedures and did not adequately communicate the purpose, risks, and

²¹ VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

²² VHA Handbook 1160.06.

²³ VHA Directive 1094.

²⁴ The Chief of Psychiatry told the OIG that the facility did not have an emergency department and that patients were transferred to the Inpatient Mental Health Unit from the facility's outpatient clinics, other VA facilities, and non-VA hospitals.

²⁵ The CLC psychologist obtained the patient's consent for the evaluation after the OIG initiated the inspection.

benefits of treatment to the patient, as required by VHA.²⁶ The OIG found that staff did not provide the patient, who repeatedly requested discharge and questioned the nature of the admission, sufficient opportunity to refuse treatment and did not pursue processes to retain the patient through a commitment. The OIG concluded that staff misunderstanding and lack of knowledge contributed to a lack of adherence to informed consent and commitment requirements.

Delayed Decision-Making Capacity and Diagnostic Evaluations

VHA defines decision-making capacity as a clinical judgment regarding a patient's ability to understand and evaluate treatment risks and benefits and communicate medical decisions. When a patient's decision-making capacity is questioned, a provider must determine capacity by conducting a clinical evaluation that is documented in the patient's EHR. When a patient's lack of decision-making capacity is based on a psychiatric diagnosis, staff must consult a psychiatrist or licensed psychologist "to ensure that the underlying cause of the lack of decision-making capacity is adequately addressed."²⁷ A surrogate decision-maker may be appointed for patients who lack decision-making capacity.²⁸

Providers use cognitive tests to quickly assess cognitive function and factors such as orientation and memory in patients with suspected deficits.²⁹ Although useful for general screening, cognitive tests may not be adequate for all patients. Patients with potential cognitive deficits, such as those with schizophrenia and dementia, should be referred to a neuropsychologist. Neuropsychologists are specialists who can complete a lengthier, more comprehensive neuropsychological evaluation in cases such as when a patient is younger than 65, to differentiate between potential causes of a patient's cognitive changes, and when discrepancy exists between cognitive tests scores and a patient's presentation.³⁰ Neuropsychological evaluations can also be helpful in determining a patient's decision-making capacity.³¹ For the purposes of identifying the need for a surrogate decision-maker, differentiation between possible causes of cognitive

²⁶ VHA Handbook 1004.01(4); Facility Memorandum No. 11-56, *Informed Consent*, July 2, 2019.

²⁷ VHA Handbook 1004.01(4).

²⁸ VHA Handbook 1004.01(4).

²⁹ Stanford Health Care, "Cognitive and Neuropsychological Tests," accessed February 26, 2021, <https://stanfordhealthcare.org/medical-conditions/brain-and-nerve/dementia/diagnosis/cognitive-neuropsychological-tests.html>.

³⁰ Katya Rascovsky, "A Primer in Neuropsychological Assessment for Dementia," *Practical Neurology*, July/August 2016, accessed February 26, 2021, <https://practicalneurology.com/articles/2016-july-aug/a-primer-in-neuropsychological-assessment-for-dementia>.

³¹ Ryan Schroeder, Phillip Martin, and Anne Walling, "Neuropsychological Evaluations in Adults," *American Family Physician*, 99 no. 2 (January 2019): 101-108, accessed February 26, 2021, <https://www.aafp.org/afp/2019/0115/afp20190115p101.pdf>.

impairment, such as schizophrenia and dementia, is important for understanding the cause and duration of a patient's loss of decision-making capacity.³²

The OIG found that Inpatient Mental Health Unit and CLC staff documented unsupported, conflicting information regarding the patient's decision-making capacity. In early 2018, three days after the patient's Inpatient Mental Health Unit admission, an inpatient social worker documented that the patient was "Legally Competent" and "Competent for VA purposes" the same day that inpatient psychiatrist 1 noted that the patient described the patient as "confused" with "disorganized" thinking, "rambling" speech, and unable to complete a cognitive test. When interviewed by the OIG, the inpatient social worker reported documenting "Competent for VA purposes" because the patient was not on a probate order for commitment to the Inpatient Mental Health Unit. However, the patient's commitment to the Inpatient Mental Health Unit would not be the sole factor to determine the patient's ability to manage finances.³³ The inpatient social worker was unfamiliar with the process for managing treatment decisions for Inpatient Mental Health Unit patients who lacked decision-making capacity and told the OIG that a commitment was not pursued because the patient did not sign an AMA form to leave against medical advice. Concerns regarding the AMA discharge process are discussed below.

In early 2018, inpatient psychiatrist 2 documented that the patient had "very poor attention span," was "unable to discern orientation," and "probably has progressive dementia." Inpatient psychiatrist 2 recommended a neuropsychological evaluation to further evaluate the dementia diagnosis prior to Inpatient Mental Health Unit discharge. That same month, the patient was denied admission to the facility's residential rehabilitation treatment program due to the dementia diagnosis. In fall 2018, the patient was denied admission to the Michigan VA CLC, and the program coordinator noted the lack of a neuropsychological evaluation to support the patient's dementia diagnosis.

The following week, on the day before the patient's discharge, inpatient psychiatrist 3 requested a psychological evaluation, and subsequently canceled the request due to the patient's transfer to the long-stay mental health CLC. On the day of discharge, inpatient psychiatrist 3 documented that the patient had refused to participate in a cognitive test, had memory deficits and insight was "absent," and also that the patient was "Competent for VA purposes." Inpatient psychiatrist 3 told the OIG that the neuropsychological evaluation was ordered to evaluate the patient's dementia diagnosis because the patient "got better" and communication with inpatient psychiatrist 3 had improved. Inpatient psychiatrist 3 reported discontinuing the order for the neuropsychological evaluation at the time of the patient's transfer to the CLC and left it to the

³² Christina Ting et al., "Differentiating the Cognitive Profile of Schizophrenia from That of Alzheimer Disease and Depression in Late Life. *PLoS (Public Library of Science) ONE*, 5 no. 4 (April 2010): e10151, accessed February 26, 2021, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0010151>.

³³ "What does VA's term "incompetent" mean?," VA Inquiry & Information System, accessed January 7, 2021, https://iris.custhelp.va.gov/app/answers/detail/a_id/2902/kw/"competent%20for%20VA%20purposes".

discretion of CLC providers to follow up. Inpatient psychiatrist 3 reported that the documentation that the patient was “Competent for VA purposes” was likely because inpatient psychiatrist 3 did not have any documentation that the patient was not competent to manage VA benefits; however, the patient was not receiving VA monetary benefits.

The day after the patient's admission to the CLC, the CLC social worker documented that the patient was accepted for “Long Stay Dementia focused care” and documented additional conflicting information that the patient's “decision making for [patient's] own care and safety is questionable” and that the patient had “mental capacity to understand treatment.” In late 2018, the CLC psychiatrist recommended that the CLC psychologist evaluate the patient's dementia diagnosis. When interviewed by the OIG, the CLC psychologist reported that the patient declined a cognitive test and believed the CLC psychologist was a kidnapper.

In fall 2019, a cognitive test did not indicate cognitive impairment, and inpatient psychiatrist 4 excluded dementia from the patient's diagnoses. CLC staff did not conduct additional testing or order a neurological evaluation to further evaluate the patient's cognitive test result.

The OIG did not find evidence that CLC staff requested another neuropsychological evaluation of the patient until spring 2020, when the patient refused an assessment for “capacity for independent living.” Nine days later after the CLC staff requested the evaluation, a psychologist conducted an “in person capacity assessment” and concluded that the patient lacked medical decision-making capacity and “symptoms of cognitive impairment occurring in the context of schizophrenia.” In fall 2020, a physician continued to document that the patient's diagnoses included dementia. That same month, the neuropsychologist completed an evaluation of “cognitive and emotional functioning... to assist in differential diagnosis in the context of schizophrenia and possible cognitive impairment.” The neuropsychologist concluded that the patient (1) exhibited cognitive impairment related to schizophrenia, (2) did “not meet criteria for dementia,” and (3) “would benefit from remaining in a supervised and structured living setting.”³⁴ The Interim Associate Chief of Staff of Geriatrics and Extended Care told the OIG that the patient's neuropsychological evaluation was delayed due to the patient's lack of cooperation and mistrust of staff and that involving providers who had not previously met with the patient allowed for completion of the neuropsychological evaluation.³⁵

The OIG found that Inpatient Mental Health Unit and CLC staff's evaluation of the patient's decision-making capacity and diagnostic evaluations were delayed and that Inpatient Mental Health Unit and CLC staff documented unsupported, conflicting information in the patient's EHR regarding the patient's decision-making capacity. Further, Inpatient Mental Health Unit and CLC staff did not conduct sufficient or timely evaluation of the patient's decision-making

³⁴ The neuropsychologist's capacity evaluation was conducted after the OIG team initiated the inspection.

³⁵ VHA Geriatrics and Extended Care Service is responsible for care for aging and chronically ill veterans through geriatrics and long term care programs including CLCs.

capacity. In late spring 2020, approximately two years and four months after the patient first requested to leave the facility, staff completed a decision-making capacity assessment.

Therefore, staff failed to determine the appropriateness of the patient's voluntary admission status and a need for a surrogate decision-maker, as discussed below. Additionally, the OIG found that the dementia diagnosis, that prohibited discharge options for the patient, remained unconfirmed from early 2018 until the fall 2020 neuropsychological evaluation which concluded that the patient did not meet criteria for dementia.

Noncompliance with Commitment Requirements

The OIG found that Inpatient Mental Health Unit and CLC staff failed to follow VHA policy and Alabama state law regarding the patient's admission status and commitment procedures.³⁶ Further, the OIG found that Inpatient Mental Health Unit staff did not comply with AMA discharge requirements including submission of a petition for a commitment when the patient requested an AMA discharge.³⁷

VHA requires that facility staff assess a patient for voluntary or involuntary status when admitted to an inpatient mental health unit. Staff must follow state requirements when committing a patient on involuntary status.³⁸ Staff must initiate a commitment to provide treatment when a patient refuses treatment or demands discharge and meets state-defined legal requirements.³⁹ To initiate a commitment, the probate court must find "clear and convincing" evidence that the patient is mentally ill, a threat to self or others, will continue to experience mental distress and diminished ability to independently function if not treated, and cannot make a reasonable and informed decision regarding treatment.⁴⁰ A commitment exceeding 150 days, or approximately five months, requires a petition for renewal.⁴¹

The OIG found that although the inpatient social worker documented that the patient was "hospitalized voluntarily," the OIG did not find evidence in the patient's EHR that Inpatient Mental Health Unit staff adequately assessed the patient's status as voluntary or involuntary status at the time of admission in early 2018. Five of five Inpatient Mental Health Unit staff interviewed by the OIG reported that the patient's admission status was voluntary. In fall 2018, when the patient was admitted to the CLC, the CLC nurse practitioner documented that the patient was "not committed per court order" to the CLC. The CLC social worker told the OIG

³⁶ VHA Handbook 1160.06. Alabama Code, 22:52-10.4, Findings Necessary for Inpatient Treatment; 22:52-10.5, Facilities for Inpatient Treatment; Length of Treatment; Cost.

³⁷ Facility Memorandum No. 11-78, *Processing Against Medical Advice (AMA) Demands*, September 12, 2018. Facility Memorandum No. 11-23.

³⁸ VHA Handbook 1160.06.

³⁹ VHA Handbook 1160.06.

⁴⁰ Alabama Code 22:52-10.4, Findings Necessary for Inpatient Treatment.

⁴¹ Alabama Code 22:52-12.2, Renewal Petition Time Limit for Certain Patients.

that all CLC admissions were voluntary. When asked if the patient was aware that the CLC admission was voluntary, the CLC social worker told the OIG that the patient did not comprehend the meaning of a voluntary admission.

In summer 2019, when the patient was readmitted to the Inpatient Mental Health Unit, inpatient psychiatrist 4 documented that the patient was “under commitment for treatment.” However, the OIG found no evidence of notification or submission of a petition to a probate court for commitment.⁴² Inpatient psychiatrist 4 told the OIG that the documentation was referring to an administrative agreement to admit the patient to the Inpatient Mental Health Unit for psychiatric stabilization with a plan to discharge the patient back to the CLC due to limited placement options.

In summer 2019, inpatient psychiatrist 4 documented that the patient declined transfer from the Inpatient Mental Health Unit to the CLC. However, in fall 2019, Inpatient Mental Health Unit staff discharged the patient back to the CLC. The Interim Associate Chief of Staff of Geriatrics and Extended Care told the OIG that the patient remained in the CLC due to the second family member's wishes. Although a family member was involved in the decision-making process regarding the patient's CLC admission, staff did not thoroughly consider the appropriateness of the surrogate decision-maker assignment, as discussed below. In late 2020, when the patient was readmitted to the Inpatient Mental Health Unit and following the OIG team's communication of concerns, staff filed a petition for commitment of the patient as required by VHA and state law, that was granted by a probate court.⁴³ Approximately two months later, the CLC social worker documented that the probate court issued an outpatient mental health treatment order committing the patient for no more than 150 days of care at “Alabama Department of Mental Health/Veterans Administration Medical Center with the condition that the [patient] shall follow the directions and treatment plan as established by the said designated mental health facility.” The Interim Associate Chief of Staff of Geriatrics and Extended Care reported that the patient gave consent to be readmitted to the CLC from the Inpatient Mental Health Unit.

Noncompliance with AMA Discharge Requirements

When a patient requests to leave AMA, facility policy instructs the attending provider to review the patient's oral or written request.⁴⁴ The clinical staff member who becomes aware of the patient's AMA request is required to document the request and whether the patient consents to notify next of kin in an “AMA titled note” in the patient's EHR. If the treatment team decides to discharge the patient AMA as requested, the patient must be released within 24 hours.⁴⁵ If the

⁴² The OIG modified the quoted text from upper to lower case for readability purposes.

⁴³ VHA Handbook 1160.06.

⁴⁴ Facility Memorandum No. 11-23.

⁴⁵ Facility Memorandum No. 11-78.

treatment team recommends holding the patient, the attending provider must immediately initiate the commitment process and obtain the patient's signature on an AMA form.⁴⁶ When a patient wishes to leave but refuses to sign an AMA form, the provider should document the patient's refusal in the commitment petition.⁴⁷

From early 2018 through late 2020, the patient was admitted to the Inpatient Mental Health Unit three times. In early 2018, four days after admission, inpatient psychiatrist 1 documented that the patient requested to be discharged AMA, and if the patient signed an AMA request, inpatient psychiatrist 1 would pursue commitment of the patient. That same day, an inpatient nurse noted that the patient's goal for the day was "to fill out AMA."⁴⁸

Inpatient psychiatrist 1 told the OIG that a commitment was not pursued because the patient continued taking medications and did not discuss an AMA discharge again. Inpatient psychiatrist 1 told the OIG that the nurse usually provided patients the AMA form. An inpatient social worker told the OIG that the patient requested discharge multiple times during the admission but that the patient's plans were based on unrealistic beliefs, such as conspiracies. Inpatient psychiatrist 3 also told the OIG that a commitment was not pursued because the patient did not sign an AMA form.

In summer 2019, while the patient was readmitted to the Inpatient Mental Health Unit, inpatient psychiatrist 4 documented that the patient continued to request to be discharged. Inpatient psychiatrist 4 told the OIG that the patient requested to be discharged but then withdrew the requests and by not signing an AMA form, never pursued the wish to be discharged. The OIG found that Inpatient Mental Health Unit staff did not document the patient's AMA requests and consent to notify next of kin in an AMA titled note in the patient's EHR, as required by facility policy.⁴⁹ Additionally, when the patient requested to leave, Inpatient Mental Health Unit staff did not discharge the patient within 24 hours or immediately submit a petition for commitment of the patient, as required.⁵⁰ Further, Inpatient Mental Health Unit staff did not obtain the patient's signature on an AMA form. Three of five Inpatient Mental Health Unit staff interviewed by the OIG reported that staff did not follow up on the patient's request to be discharged AMA because the patient refused to sign the AMA form. However, Inpatient Mental Health Unit staff did not document a refusal to sign by the patient in a commitment petition, as required.⁵¹

In late 2020, the patient was transferred from the CLC for readmission to the Inpatient Mental Health Unit. Inpatient Mental Health Unit staff filed a petition for a commitment of the patient

⁴⁶ Facility Memorandum No. 11-23; Facility Memorandum No. 11-78.

⁴⁷ Facility Memorandum No. 11-78.

⁴⁸ The OIG modified a portion of the quoted text from upper to lower case for readability purposes.

⁴⁹ Facility Memorandum No. 11-78.

⁵⁰ Facility Memorandum No. 11-78; Facility Memorandum No. 11-23.

⁵¹ Facility Memorandum No. 11-78.

that was granted by a probate court. The OIG found that although the patient repeatedly requested discharge, the patient remained on voluntary status during admissions to the Inpatient Mental Health Unit and CLC for nearly 2 years and 11 months. Further, Inpatient Mental Health Unit staff did not adequately assess the patient's admission status as voluntary or involuntary and did not follow VHA or state of Alabama commitment requirements in early 2018 and summer 2019, the first two of the patient's three Inpatient Mental Health Unit admissions. In late 2020, following the OIG team's communication of allegations regarding the patient's admission status to facility staff and leaders, Inpatient Mental Health Unit staff filed a petition for commitment of the patient as required.⁵² The petition was approved by a probate court. Additionally, Inpatient Mental Health Unit staff did not comply with facility AMA discharge requirements. As a result, the patient was treated without proper probate court oversight to ensure the patient's rights regarding commitment criteria or duration of admission.

Improper Assignment of a Surrogate Decision-Maker

The OIG determined that Inpatient Mental Health Unit and CLC staff did not comply with requirements to properly identify a surrogate decision-maker. Inpatient Mental Health Unit and CLC staff did not document the identification of a surrogate decision-maker for the patient until late spring 2020, approximately two years and four months after the patient's admission to the facility, and did not address ethical concerns regarding the appropriateness of the patient's surrogate decision-maker.

VHA requires that a provider seek an authorized surrogate when a patient lacks decision-making capacity without the likelihood of regaining decision-making capacity in "a reasonable period of time."⁵³ Staff must also seek a surrogate for treatments that do not require signature consent. Providers are required to document surrogate identification efforts and outcomes in the patient's EHR.⁵⁴ Additionally, facility policy requires that CLC staff document involvement of the patient or a family member significant in the decision-making process when administering antipsychotic medication to patients.⁵⁵

The OIG found that although Inpatient Mental Health Unit staff began communicating with the family member regarding the patient's care in early 2018, staff did not document identification of the family member as a surrogate decision-maker or efforts to identify another surrogate decision-maker for the patient. The admitting nurse practitioner told the OIG that the patient's family member was consulted regarding treatment decisions, but was uncertain whether a formal process occurred to identify the family member as the surrogate decision-maker. In fall 2018, the

⁵² VHA Handbook 1160.06.

⁵³ VHA Handbook 1004.01(4).

⁵⁴ VHA Handbook 1004.01(4).

⁵⁵ Facility Memorandum GEC-12, Community Living Center (CLC) Psychotropic Medication Management, October 15, 2018.

inpatient social worker documented an inability to obtain a guardian for the patient due to the patient's limited funds. The inpatient social worker told the OIG that a surrogate decision-maker was not appointed for the patient and that the family member was not involved in treatment decisions for the patient. When interviewed by the OIG, inpatient psychiatrist 3 was unsure of the surrogate decision-maker assignment process or circumstances that would require staff to seek a surrogate decision-maker for a patient on the Inpatient Mental Health Unit.

In late spring 2019, CLC staff documented that the patient's family member agreed with staff's "show of force," if necessary. In fall 2019, while the patient was readmitted to the Inpatient Mental Health Unit, inpatient psychiatrist 4 noted that after learning from the second family member of the family member's death, the patient requested to be picked up and the second family member stated that the patient needed to remain at the facility. Inpatient Mental Health Unit staff did not document identification of the second family member as the patient's surrogate decision-maker. Additionally, although the patient received antipsychotic medications throughout the CLC admission, the OIG found that CLC staff did not document involvement of either of the patient's two family members in medication decisions until a discussion with the second family member in July 2020.

In early 2020, after the patient returned to the CLC, the CLC social worker documented that the second family member was pursuing guardianship of the patient and the following month, referred to the second family member as the patient's next of kin. In late spring 2020, a CLC nurse practitioner identified the second family member as the patient's "VA-authorized surrogate" in a life-sustaining treatment plan.⁵⁶ When interviewed by the OIG, the CLC social worker denied that a formal process existed to designate a surrogate decision-maker for a patient, and that staff typically attempted to identify a spouse or family member. The CLC social worker reported that a psychologist, physician, or nurse practitioner was responsible for documenting assignment of a patient's surrogate decision-maker. In fall 2020, the Associate Chief of Staff of Mental Health told the OIG that Inpatient Mental Health Unit staff did not consider a surrogate decision-maker for the patient because staff had become aware of the option to identify a surrogate decision-maker in "the last few months." The OIG determined that Inpatient Mental Health Unit and CLC staff's misunderstanding and lack of knowledge contributed to the failure to comply with surrogate decision-maker assignment requirements.

Ethical Concerns

VHA requires that staff ensure that a patient's surrogate for life-sustaining treatment decisions understands the patient's condition. Staff must also ensure that a surrogate understands the responsibility to make decisions in the patient's best interest and consistent with the patient's

⁵⁶ The OIG modified a portion of the quoted text from upper to lower case for readability purposes.

values.⁵⁷ A provider must notify the Chief of Staff, or designee, and consult with the local Integrated Ethics program officer or VA legal counsel when the provider considers a surrogate decision-maker to be acting against the patient's wishes or best interests.⁵⁸

In spring 2020, CLC staff documented that the patient received a hurtful and harshly worded letter from the second family member that instructed the patient to not contact the second family member. The treatment team discussed the second family member's letter 18 days later, and placed an ethics consult to evaluate the appropriateness of the second family member's continued involvement in the patient's care decisions; and a psychology consult to assess the patient's capacity to make end-of-life and other healthcare decisions. In late spring 2020, the second family member declined the treatment team's offer to assume decision-making on behalf of the patient and reported the ability to make treatment decisions in the patient's best interest. Two days later, a CLC nurse practitioner discontinued the ethics consult based on the discussion with the second family member and identified the second family member as the VA-authorized surrogate in the patient's life-sustaining treatment plan. The CLC nurse practitioner told the OIG that the ethics consult was discontinued because the treatment team evaluated the second family member's ability to act in the best interest of the patient and the second family member declined the option to relinquish the role of surrogate decision-maker.

The Integrated Ethics Council discussed the patient's case during a spring 2020 committee meeting, with a plan to follow up during the next month's committee meeting; however, those meeting minutes did not include any related documentation. When interviewed by the OIG, an ethics consultation coordinator reported notifying a CLC team member that before the consult could be reviewed, staff needed to conduct a decision-making capacity evaluation to determine the need for a surrogate decision-maker for the patient. Another ethics consultation coordinator told the OIG that the consult was not reviewed further because it was discontinued.

When interviewed by the OIG, the Chief of Staff reported the understanding that the Integrated Ethics Council determined that the second family member would remain as the patient's surrogate decision-maker. The Chief of Staff told the OIG about continued concern related to the second family member's role as surrogate decision-maker and possible Integrated Ethics Council review. Following the OIG's initiation of the inspection in fall 2020, the Facility Director, who serves as the Integrated Ethics Co-Chair, consulted with an Office of General Counsel attorney regarding the patient's surrogate decision-maker assignment. The Facility Director reported that the attorney found it acceptable for the second family member to remain as surrogate decision-maker with ongoing reevaluation of the assignment. The attorney also noted that if there were unresolved conflicts about the surrogate decision-maker assignment, the provider "must consult the facility's Ethics Consultation Service." The attorney asked the Facility Director to provide a

⁵⁷ VHA Handbook 1004.03(1), *Life-sustaining Treatment Decisions*, January 11, 2017, amended March 19, 2020.

⁵⁸ VHA Handbook, 1004.01(4).

“VHA ethics opinion for our review;” however, the attorney told the OIG that an ethics review was not received.

Inpatient Mental Health Unit and CLC staff's failure to properly identify and document a surrogate decision-maker for the patient may have contributed to delays in determining the patient's appropriate admission status. Additionally, by discontinuing the ethics consult, staff did not adequately address the second family member's assignment as surrogate decision-maker and ability to act in the patient's best interest.

Failure to Ensure the Patient's Access to the Patient Advocate

The OIG substantiated that CLC staff failed to ensure the patient's access to the patient advocate. VHA defines a service-level advocate as a designated employee at the point of service who assists patients with addressing and resolving concerns when initial attempts at resolving were unsuccessful.⁵⁹ Service-level advocates must enter patient complaints into a patient advocate tracking system.⁶⁰ Facility policy requires that each unit has a service-level advocate. Staff are responsible for responding to patient concerns and referring patient concerns to the service-level advocate when further assistance is needed. The facility service-level advocate told the OIG that when unable to resolve a patient concern at the service level, the next step would be to seek assistance from the patient advocate. Patient concerns that are not resolved within seven days by the patient advocate are referred to the respective service chief and facility leaders, as needed.⁶¹

In late spring 2019, the day after the patient became agitated and contacted VA police, a CLC nurse documented that the patient requested to speak with a patient advocate. The OIG did not find evidence in the patient's EHR that the CLC nurse referred the patient's request to the service-level advocate or patient advocate. When interviewed by the OIG, the CLC nurse could not recall the response to the patient's request, but reported typically notifying the service-level advocate. Later the same month, another CLC nurse offered to contact a patient advocate regarding the patient's concerns related to medication side effects and the patient agreed. The CLC nurse documented that the “Patient advocate” was notified of the patient's concern and did not add the service-level advocate or patient advocate as signers.

When interviewed by the OIG, the service-level advocate reported typically receiving an EHR notification of a patient's request to meet. In an interview with the OIG, the service-level advocate could not recall the requests for that month to meet with the patient. However, the service-level advocate reported receiving complaints directly from the patient during daily

⁵⁹ VHA Directive 1003.04; Facility Memorandum No. 00-24. VHA policy uses the term service-level advocate and facility policy uses the term service line advocate. For the purposes of this report, the OIG uses the term service-level advocate.

⁶⁰ VHA Directive 1003.04.

⁶¹ Facility Memorandum No. 00-24.

interactions in the CLC that included requests for discharge. The service-level advocate told the OIG that the patient advocate was not notified due to awaiting identification of a discharge placement by the treatment team that would resolve the patient's concerns and because the patient had not specifically requested to speak with the patient advocate. The service-level patient advocate reported being unaware of the requirement to enter patient complaints into the patient advocate tracking system and had never used the system.

The patient advocate reported to the OIG the expectation that the service-line advocate would have provided notification of the patient's concerns, given that they were repeated and unresolved. The patient advocate reported not receiving notification of the patient's concerns until fall 2020, when the service-line advocate requested assistance with entering the patient's complaint in the patient advocate tracking system following contact with the OIG. However, staff were unable to provide documentation to support that the patient's complaint was entered into the patient advocate tracking system, as required by VHA.⁶² The patient advocate reported that long-stay mental health CLC staff did not enter complaints in the patient advocate tracking system due to lack of both staff buy-in and knowledge of the system. CLC staff's failure to ensure the patient's access to the patient advocate and adequately address or track the patient's complaints within the required time frame prevented resolution or facility leader review.⁶³

Unethical Management of the Patient's Correspondence

The OIG found that CLC staff did not properly manage a letter from the patient that was intended for a public official.⁶⁴ The Joint Commission requires that facility staff provide patients with the "phone number and address needed to file a complaint with the relevant state authority."⁶⁵ Facility policy advises that patients should receive comprehensible information about the complaint process and can submit verbal or written complaints.⁶⁶ Patients also have the right to free and private communication that includes staff assistance with sending and receiving mail.⁶⁷

Twice in spring 2020, the patient reported wanting to send a public official a letter for assistance obtaining discharge from the facility. The patient requested the public official's address and phone number from the chaplain who documented that the request would be referred to the CLC social worker. In summer 2020, the CLC social worker consulted with the Integrated Ethics

⁶² VHA Directive 1003.04

⁶³ VHA Directive 1003.04.

⁶⁴ VHA Directive 1003.04.

⁶⁵ The Joint Commission Standard 01.07.01, *Rights and Responsibilities of the Individual*, effective July 1, 2020; VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. The Joint Commission is an accrediting body that sets hospital quality and performance standards.

⁶⁶ Facility Memorandum No. 11-42, *Patient Rights/Responsibilities*, August 8, 2017.

⁶⁷ Facility Memorandum No. 11-42.

Council regarding the patient's request to send a letter to the public official. The Integrated Ethics Council reviewed the request and recommended that the treatment team meet with the second family member, reexplain the reasons for denying discharge to the patient, and if the patient agreed, the second family member "could take responsibility for the letter." If the patient did not agree, the Integrated Ethics Council advised that the patient's "wishes should be honored in mailing the letter" to the public official.

Later that month, the treatment team discussed the patient's request with the second family member who requested that the treatment team withhold the letter because "It will not change [the patient's] situation or mental condition." The treatment team consulted with the privacy officer who was in agreement with the decision. The CLC social worker documented that the patient's letter would be mailed to the second family member. The OIG did not find evidence that the treatment team included the patient in the discussion about the letter or obtained the patient's agreement to provide the letter to the second family member.

When interviewed by the OIG, an ethics consultation coordinator reported the understanding that the patient's letter would be mailed to the public official based on discussion with the CLC social worker. The CLC social worker told the OIG that the treatment team's decision to mail the letter to the second family member was based on the second family member's input that it was not necessary to send the letter to the public official. A CLC physician told the OIG that since the treatment team did not open the letter to honor the patient's privacy, the treatment team deferred to the second family member's decision regarding the letter because the letter might have included threats and because the patient's cognitive functioning was impaired. In an interview with the OIG, the Chief of Staff reported the expectation that the patient's mail would have been sent to the public official as requested.

CLC staff failed to follow the Integrated Ethics review guidance and did not involve the patient in the decision of giving the patient's letter intended for a public official to the second family member rather than mailing it. The staff's lack of adherence to ethical guidelines potentially violated the patient's right to communicate with a public official.

Conclusion

The OIG identified deficiencies in the facility staff's administrative actions related to the patient's admissions; however, the OIG recognizes and appreciates the facility staff's dedication to provide quality care that addressed the patient's challenging mental health needs.

The OIG substantiated that the patient was denied discharge from the facility's Inpatient Mental Health Unit and CLC. Inpatient Mental Health and CLC staff failed to follow VHA- and facility-required informed consent procedures and did not adequately communicate the purpose, risks,

and benefits of treatment to the patient, as required by VHA.⁶⁸ The OIG found that staff did not provide the patient, who repeatedly requested discharge and questioned the nature of the admission, sufficient opportunity to refuse treatment and did not pursue processes to retain the patient through a commitment. The OIG concluded that staff misunderstanding and lack of knowledge contributed to a lack of adherence to informed consent and commitment requirements.

Inpatient Mental Health Unit and CLC staff's evaluations of the patient's decision-making capacity and diagnoses were delayed and Inpatient Mental Health Unit and CLC staff documented unsupported, conflicting information in the patient's EHR regarding the patient's decision-making capacity. Further, Inpatient Mental Health Unit and CLC staff did not conduct sufficient or timely evaluation of the patient's decision-making capacity. In late spring 2020, approximately two years and four months after the patient first requested to leave the facility, staff completed a decision-making capacity assessment. Therefore, staff failed to determine the appropriateness of the patient's voluntary admission status and a need for a surrogate decision-maker. Additionally, the OIG found that the dementia diagnosis, that prohibited discharge options for the patient, remained unconfirmed from early 2018 until the fall 2020 neuropsychological evaluation, which concluded that the patient did not meet criteria for dementia.

Although the patient repeatedly requested discharge, the patient remained on voluntary status during admissions to the Inpatient Mental Health Unit and CLC for nearly 2 years and 11 months. Further, Inpatient Mental Health Unit staff did not adequately assess the patient's admission status as voluntary or involuntary and did not follow VHA or state of Alabama commitment requirements in early 2018 and summer 2019, the first two of the patient's three Inpatient Mental Health Unit admissions. In late 2020, following the OIG team's communication of allegations regarding the patient's admission status to facility staff and leaders, Inpatient Mental Health Unit staff filed a petition for commitment of the patient as required.⁶⁹ The petition was approved by a probate court. Additionally, Inpatient Mental Health Unit staff did not comply with facility AMA discharge requirements. As a result, the patient was treated without proper probate court oversight to ensure the patient's rights regarding commitment criteria or duration of admission.

Inpatient Mental Health Unit and CLC staff's failure to properly identify and document a surrogate decision-maker for the patient may have contributed to delays in determining the patient's appropriate admission status. Additionally, by discontinuing the ethics consult, staff did

⁶⁸ VHA Handbook 1004.01(4); Facility Memorandum No. 11-56, *Informed Consent*, July 2, 2019.

⁶⁹ VHA Handbook 1160.06. Alabama Code, 22:52-10.4, Findings Necessary for Inpatient Treatment; 22:52-10.5, Facilities for Inpatient Treatment; Length of Treatment; Cost.

not adequately address the family member's assignment as surrogate decision-maker and ability to act in the patient's best interest.

The OIG substantiated that CLC staff failed to ensure the patient's access to the patient advocate. CLC staff's failure to adequately address or track the patient's complaints within the required time frame prevented resolution or facility leader review, as required by VHA.⁷⁰ Additionally, CLC staff failed to follow the Integrated Ethics review guidance and did not involve the patient in the decision of giving the patient's letter intended for a public official to the second family member rather than mailing it. The staff's lack of adherence to ethical guidelines potentially violated the patient's right to communicate with a public official.

The OIG made seven recommendations. The Veterans Integrated Service Network and Facility Directors concurred with the seven recommendations and provided an acceptable action plan.

Recommendations 1–7

1. The Tuscaloosa VA Medical Center Director reviews informed treatment consent processes for the Inpatient Mental Health Unit and Community Living Center, confirms staff understanding of required processes, and monitors compliance.
2. The Tuscaloosa VA Medical Center Director ensures decision-making capacity evaluation completion and documentation, as required by Veterans Health Administration policy, and monitors compliance.
3. The Tuscaloosa VA Medical Center Director evaluates staff compliance with Veterans Health Administration and state of Alabama commitment requirements, confirms staff understanding of required processes, and consults with the Office of General Counsel regarding state law, as warranted.
4. The Tuscaloosa VA Medical Center Director ensures adherence to Tuscaloosa VA Medical Center policies regarding against medical advice discharge procedures, and monitors compliance.
5. The Tuscaloosa VA Medical Center Director consults with VA National Center for Ethics in Healthcare and reconsults the Office of General Counsel as needed to evaluate the appropriateness of the patient's assigned surrogate decision-maker, and takes action as warranted.

⁷⁰ VHA Directive 1003.04, *Patient Advocacy Program*, February 7, 2018; Facility Memorandum No. 00-24, *Patient Advocate Program*, March 15, 2018.

6. The Tuscaloosa VA Medical Center Director ensures staff completion of required patient advocate reporting and tracking processes, and monitors compliance.
7. The Tuscaloosa VA Medical Center Director evaluates the Community Living Center staff's management of the patient's correspondence request, including the Integrated Ethics consultation, and takes action as warranted.

Glossary

To go back, press “alt” and “left arrow” keys.

against medical advice. A voluntarily admitted inpatient's request for hospital discharge without the treatment team's agreement about the patient's readiness for discharge.⁷¹

alcohol use disorder. Habitual and problematic use of alcohol that affects an individual's functioning and may cause emotional and physical problems. Alcohol use disorder was previously referred to as alcohol abuse and dependence.⁷²

amphetamine use disorder. Habitual and problematic use of amphetamines, or drugs that can be obtained legally through prescription to treat health problems such as attention problems and weight concerns. Illicit amphetamines are obtained without a prescription for a mood-altering effect, and include methamphetamines. Amphetamine use disorder was previously referred to as amphetamine abuse and dependence.⁷³

antipsychotics. Medications that are prescribed to manage psychiatric symptoms of schizophrenia and other psychotic disorders.⁷⁴

cannabis use disorder. Habitual and problematic use of cannabis, a psychoactive substance, that can significantly impair an individual's functioning in interpersonal, social, occupational, and other activities. Cannabis use disorder was previously referred to as cannabis abuse and dependence.⁷⁵

⁷¹ Facility Memorandum No. 11-78, *Processing Against Medical Advice (AMA) Demands*, September 12, 2018.

⁷² Diagnostic and Statistical Manual of Mental Disorders, “Alcohol-related disorders,” accessed February 4, 2021, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16>; Substance Abuse and Mental Health Services Administration, “Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health,” accessed February 18, 2021, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactAdultMI-2016.pdf>.

⁷³ Diagnostic and Statistical Manual of Mental Disorders, “Stimulant use disorder,” accessed February 4, 2021, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16>; MedlinePlus, “Substance use – amphetamines,” accessed February 1, 2021, <https://medlineplus.gov/ency/patientinstructions/000792.htm>; “Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health,” Substance Abuse and Mental Health Services Administration, accessed February 18, 2021, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactAdultMI-2016.pdf>.

⁷⁴ Mayo Clinic, “Schizophrenia,” accessed February 1, 2021, <https://www.mayoclinic.org/diseases-conditions/schizophrenia/diagnosis-treatment/drc-20354449>; “Mental Health Medications,” National Institute of Mental Health, accessed June 15, 2021, <https://www.nimh.nih.gov/health/topics/mental-health-medications/>.

⁷⁵ Diagnostic and Statistical Manual of Mental Disorders, “Cannabis-related disorders,” accessed February 4, 2021, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16>; “Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health,” Substance Abuse and Mental Health Services Administration, accessed February 18, 2021, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactAdultMI-2016.pdf>.

cocaine use disorder. Habitual and problematic use of cocaine, a stimulant, that can significantly impair an individual's functioning in interpersonal, social, occupational, and other activities. Cocaine use disorder was previously referred to as cocaine abuse and dependence.⁷⁶

commitment. Consignment to a mental institution.⁷⁷

community residential care. A residential setting for patients who are unable to reside alone due to medical and psychiatric conditions and do not require a higher level of care, such a hospital or nursing home.⁷⁸

competent. A court of law determination that a patient is competent or legally capable of making healthcare decisions.⁷⁹

competent for VA purposes. A term used and defined by VA to signify an adult's ability to manage their finances.⁸⁰

delusions. A psychotic symptom characterized by an individual's fixed, false beliefs.⁸¹

dementia. A group of symptoms that affects a person's memory, thinking, and social behavior, and may interfere with daily life.⁸²

domiciliary. One of the mental health residential rehabilitation treatment programs that provides rehabilitative and clinical treatment for veterans with a wide range of problems and conditions including posttraumatic stress disorder, substance abuse, unemployment, and homelessness.⁸³

⁷⁶ Diagnostic and Statistical Manual of Mental Disorders, "Stimulant use disorder," accessed February 4, 2021, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16>; "Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration. accessed February 18, 2021, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactAdultMI-2016.pdf>.

⁷⁷ Merriam-Webster, "Commitment," accessed March 4, 2021, <https://www.merriam-webster.com/dictionary/commitment>.

⁷⁸ "Community Residential Care," VA Geriatrics and Extended Care, accessed February 24, 2021, https://www.va.gov/GERIATRICAL/pages/community_residential_care.asp.

⁷⁹ VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatments and Procedures*, amended January 4, 2021.

⁸⁰ "What does VA's term "incompetent" mean?" VA Inquiry & Information System, accessed January 7, 2021, https://iris.custhelp.va.gov/app/answers/detail/a_id/2902/kw/"competent%20for%20VA%20purposes".

⁸¹ "Schizophrenia," The National Institute of Mental Health. accessed September 2, 2020, https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml#part_145430.

⁸² Mayo Clinic, "Dementia – symptoms and causes," accessed October 6, 2020, <https://www.mayoclinic.org/diseases-conditions/dementia/symptoms-causes/syc-20352013>.

⁸³ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. VA Homeless Programs. "Definitions of MH RRTPs," accessed June 15, 2021, https://www.va.gov/HOMELESS/docs/DCHV_Definitions_of_MHRRTPs.pdf.

four-point restraints. A type of restraint of all extremities (arms and legs), typically used for agitated patients who pose a danger to themselves or others.⁸⁴

guardian. An individual who is legally appointed by a court to make healthcare decisions for an individual who is deemed legally incompetent.⁸⁵

hernia. A small portion of tissue or internal organ that pushes through a weak section of muscle.⁸⁶

informed consent. The explanation of a treatment or procedure by medical staff, including possible risks and benefits, so that a patient can make a decision about their care.⁸⁷

Integrated Ethics Council. A leadership body that oversees the VA Integrated Ethics program and consultation to assist staff, patients, and families with resolution of ethical issues.⁸⁸

life-sustaining treatment. A type of treatment intended to extend the life of a patient expected to die soon without medical intervention. Life-sustaining treatments include artificial nutrition, hydration, and mechanical ventilation.⁸⁹

long-acting antipsychotic injectable medication. A medication administered biweekly or monthly through an injection to reduce the symptoms of schizophrenia and improve the behavior of schizophrenic patients, particularly for patients who have challenges adhering to daily medication schedules.⁹⁰

mental health residential rehabilitation treatment programs. Programs, including domiciliaries, that provide rehabilitative and clinical treatment for veterans with a wide range of problems and conditions including posttraumatic stress disorder, substance abuse, unemployment, and homelessness.⁹¹

⁸⁴ "Eliminating Physical Restraints in the Psychiatric Emergency Department," Icahn School of Medicine at Mount Sinai, accessed March 31, 2021, <https://health.mountsinai.org/blog/eliminating-physical-restraints-in-the-psychiatric-emergency-department/>.

⁸⁵ VHA Handbook 1004.01 (4).

⁸⁶ "Hernia," MedLinePlus, accessed August 25, 2020, <https://medlineplus.gov/hernia.html>.

⁸⁷ "Definition of Informed Consent," National Cancer Institute, accessed on November 30, 2020, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/informed-consent>.

⁸⁸ "IntegratedEthics," National Center for Ethics in Health Care, accessed February 25, 2021, <https://www.ethics.va.gov/integratedethics.asp>.

⁸⁹ VHA Handbook 1004.03 (1).

⁹⁰ "Schizophrenia," National Institute of Mental Health, accessed August 26, 2020, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>.

⁹¹ VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, amended November 16, 2015.

neuropsychological evaluation. A series of assessments used to determine how well the brain is functioning and can also be used to identify the cause of a patient's cognitive changes such as aging, a neurological illness, or other mental health diagnosis.⁹²

next of kin. A patient's relative who is age 18 or older who may serve as the patient's surrogate and are in prioritized in the following order: "spouse, child, parent, sibling, grandparent, grandchild."⁹³

patient advocate. An individual who actively supports to ensure the protection of a patient's healthcare rights.⁹⁴

psychoactive substances. Illicit and licit drugs that cause changes in an individual's cognition, and affect.⁹⁵

psychosis. A psychological condition in which an individual loses touch with reality and is characterized by hallucinations and delusional beliefs.⁹⁶

schizophrenia. A severe, chronic mental illness that leads to alterations in thinking, mood, social functioning, and cognitive symptoms. Symptoms may include hallucinations (false sensory perceptions without an actual stimulus), delusions (strongly held beliefs not based in reality), reduced motivation and reduced expression of emotion, and difficulty with concentration, memory, or processing information. Patients with schizophrenia may experience cognitive deficits such as memory impairment.⁹⁷

sedatives. A class of prescription medications used to help an individual feel relaxed and calm.⁹⁸

show of force. A demonstration of a person's accessible forces and readiness to utilize them.⁹⁹

⁹² "Neuropsychological testing and assessment," Cleveland Clinic, accessed October 6, 2020, <https://my.clevelandclinic.org/health/diagnostics/4893-neuropsychological-evaluation>.

⁹³ VHA Handbook 1004.01(4).

⁹⁴ VHA Directive 1003.04.

⁹⁵ "Psychoactive substances," World Health Organization, accessed February 1, 2021, https://www.who.int/substance_abuse/terminology/psychoactive_substances/en/#:~:text=Psychoactive%20substances%20are%20substances%20that%2C%20when%20taken%20in,licit%20and%20illicit%2C%20of%20interest%20to%20drug%20policy.

⁹⁶ Merriam-Webster, "Definition of psychosis," accessed September 24, 2020, <https://www.merriam-webster.com/dictionary/psychosis>.

⁹⁷ "Schizophrenia," The National Institute of Mental Health, accessed August 26, 2020, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml>.

⁹⁸ Merriam-Webster, "Definition of Sedative," accessed February 1, 2021, <https://www.merriam-webster.com/dictionary/sedative>; "Facts about Antianxiety and Sedative Medications," VA Mental Illness Research, Education and Clinical Center, accessed June 15, 2021, https://www.mirecc.va.gov/visn22/Family_Consultation_Handouts/Facts_about_Antianxiety_and_Sedative_Medications_Veteran_and_Family_Handout.pdf.

⁹⁹ Oxford English Dictionary, "show of force," accessed March 1, 2021, https://www.lexico.com/definition/show_of_force.

Social Security. A program of benefits provided by the Social Security Administration, a federal system that manages monetary benefits, to individuals including those with insufficient or no income, or disabilities. Monetary benefits may be reduced when a recipient is in the hospital.¹⁰⁰

surrogate decision-maker. An individual legally authorized under VA policy to make decisions on behalf of a patient who lacks decision-making capacity.¹⁰¹

ultrasound. An imaging technique utilizing sound to create photos of internal structures within the body and is useful for diagnosing conditions.¹⁰²

¹⁰⁰ Merriam-Webster, "Definition of social security," accessed January 27, 2021, <https://www.merriam-webster.com/dictionary/social%20security>; "Understanding Supplemental Security Income Living Arrangements – 2021 Edition," Social Security Administration, accessed March 31, 2021, <https://www.ssa.gov/ssi/text-living-ussi.htm>.

¹⁰¹ VHA Handbook 1004.01(4).

¹⁰² "Ultrasound," Mayo Clinic, accessed February 24, 2021, <https://www.mayoclinic.org/tests-procedures/ultrasound/about/pac-20395177>.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 31, 2021

From: Director, VA Southeast Network (VISN07)

Subj: Draft Report: Healthcare Inspection—Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have had the opportunity to review the Draft Report: Healthcare Inspection – Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama.
2. I concur with Tuscaloosa VA Medical Center's action plan and ongoing implementation for recommendations 1-7.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

David M. Walker, MD, MBA
Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 28, 2021

From: Director, Tuscaloosa VA Medical Center (679)

Subj: Healthcare Inspection—Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama

To: Director, VA Southeast Network (10N07)

1. I have reviewed the report titled Deficiencies in Administrative Actions for a Patient's Inpatient Mental Health Unit and Community Living Center Admissions at the Tuscaloosa VA Medical Center in Alabama.
2. I concur with all the recommendations outlined in this report.

(Original signed by:)

John F. Merkle, FACHE, VHA-CM
Director

Facility Director Response

Recommendation 1

The Tuscaloosa VA Medical Center Director reviews informed treatment consent processes for the Inpatient Mental Health Unit and Community Living Center, confirms staff understanding of required processes, and monitors compliance.

Concur.

Target date for completion: October 1, 2021

Director Comments

In the bill of rights (42 C.F.R. § 9501), the code specifies that, “a person admitted to a program or facility for the purpose of receiving mental health services should be accorded the following: (D) The right not to receive a mode or course of treatment, established pursuant to the treatment plan, in the absence of such person’s informed, voluntary, written consent to such mode or course of treatment, except treatment- (i) during an emergency situation if such treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or (ii) as permitted under applicable law in the case of a person committed by a court to a treatment program or facility.”

For all new admissions to the Tuscaloosa VA Medical Center [TVAMC] for the purpose of receiving mental health services, the accepting practitioner will request a VA 10-0431a form (Consent for Clinical Treatment/ Procedure) be completed, signed and faxed to the Admissions Coordinator or their surrogate prior to admission, whenever possible, to document consent for admission and subsequent treatment. If this is not possible, an informed consent discussion between the Veteran and the practitioner will occur upon admission. The consent form will explicitly state if the Veteran is to be admitted to a secure unit. If a practitioner reasonably expects that a Veteran will require psychotropic medications during the admission, this information may also be added to the consent form. A paper copy of the signed consent form, along with the *Patient Rights and Responsibilities* document, will be given to the Veteran.

The facility memorandum 11-56, Informed Consent, will be updated to include this information. All practitioners involved in admissions to TVAMC programs for the purpose of receiving mental health services, including, but not limited to, medical and psychiatric practitioners, admissions coordinators, social workers and appropriate administrative personnel will receive training on this addition to the policy by October 1, 2021. Quality Management will start monitoring and reporting compliance at the beginning of Q1FY22 [quarter 1 fiscal year 2022] (October 1, 2021).

Recommendation 2

The Tuscaloosa VA Medical Center Director ensures decision-making capacity evaluation completion and documentation, as required by Veterans Health Administration policy, and monitors compliance.

Concur.

Target date for completion: November 1, 2021

Director Comments

Capacity is fluid for Veterans with serious mental illness who are receiving mental health treatment. Their capacity might be quite limited when their mental illness is decompensated and as they continue to improve with treatment, they may regain capacity. Any policies regarding capacity evaluations must address this fluidity. In contrast, once a patient with a dementia diagnosis loses capacity, they do not regain it since dementia is a longstanding progressive illness. It is therefore very important to determine if a Veteran's cognitive impairment is due to a serious mental illness or dementia. Sometimes, the only way to truly make this determination is to observe the Veteran over long periods of time.

Core clinical interdisciplinary team members (RNs, Physicians, Advanced Practice Nurse (APN) and Social Workers) will receive training on the difference between competency and capacity and how they are determined. Associate Chief of Staff and Associate Chief Nurse for Mental Health will review templated notes to ensure that the word *competency* is not inappropriately included in templates. Target: 90% of core clinical interdisciplinary team members will receive training on competency vs capacity by September 1, 2021. Reviews of mental health templated notes will be completed by September 1, 2021.

All licensed independent providers (LIPs) who have authority to add diagnoses to a Veteran's problem list in the electronic medical record will receive training on diagnosing dementia, delirium, acute encephalopathy, psychosis, etc. to ensure that Veterans are not inappropriately diagnosed with dementia, which can significantly impact their options for placement due to the expectation that the cognitive impairment in dementia will not improve, whereas cognitive impairment in delirium, acute encephalopathy, and psychosis will likely improve with proper treatment. Target: 90% of LIPs will attend training by September 30, 2021.

If a patient has active psychosis, they generally do not have the capacity for complex medical decision making. Therefore, neurocognitive testing should not be required on admission, but will be encouraged in situations where the practitioner is unsure if cognitive impairment is due to serious mental illness or dementia just based on clinical presentation. A formal capacity evaluation should be considered when the patient's mental illness is stabilizing but they are still exhibiting cognitive impairments.

In the long stay mental health recovery CLC neighborhood, each resident admitted to the long stay mental health recovery CLC neighborhood will undergo a capacity evaluation by a psychologist at least once per year. However, capacity evaluation will be ordered whenever the interdisciplinary treatment team feels there might have been a change which would affect the resident's treatment plan and/or consent for the existing treatment plan. The yearly capacity evaluation will focus on capacity for medical decision making, but capacity evaluations may be performed to evaluate capacity for other complex cognitive functions such as managing finances and living independently. Target: This information will be incorporated into an SOP [standard operating procedure] for Long Stay Mental Health Recovery no later than November 1, 2021. All CLC medical and psychiatric practitioners, including psychologists will receive education on this topic by November 1, 2021.

Recommendation 3

The Tuscaloosa VA Medical Center Director evaluates staff compliance with Veterans Health Administration and state of Alabama commitment requirements, confirms staff understanding of required processes, and consults with the Office of General Counsel regarding state law, as warranted.

Concur.

Target date for completion: October 1, 2021

Director Comments

Medical center policy MCP 116-11, Initiating and Processing Commitments for Patients Admitted Voluntarily Who Request AMA Release will be reviewed with the Probate Judge to ensure it follows the State law. Tuscaloosa VA Medical Center will consult with the Office of General Counsel as warranted. The policy will be updated as needed and training will be provided to staff.

Recommendation 4

The Tuscaloosa VA Medical Center Director ensures adherence to Tuscaloosa VA Medical Center policies regarding against medical advice discharge procedures, and monitors compliance.

Concur.

Target date for completion: October 1, 2021

Director Comments

The current medical center policy MCP 11-78, Processing Against Medical Advice (AMA) Demands will be updated to include differences in the procedure for processing AMA demands

in the inpatient acute psychiatry unit versus processing AMA demands in the CLC. CLC practitioners need more than 24 hours to process AMA demands in order to meet long term care regulations. Target: MCP 11-78 will be revised and submitted to the Director for approval by October 1, 2021.

Veterans will receive written information on requesting discharge Against Medical Advice (AMA) on admission. The information will explain, in plain language, the process for requesting discharge AMA. Target: this informational sheet will be created and its integration into the admissions process will occur by September 1, 2021.

Recommendation 5

The Tuscaloosa VA Medical Center Director consults with VA National Center for Ethics in Healthcare and reconsults the Office of General Counsel as needed to evaluate the appropriateness of the patient's assigned surrogate decision-maker, and takes action as warranted.

Concur.

Target date for completion: August 31, 2021

Director Comments

The patient's assigned surrogate decision-maker is [their] only relative. The Tuscaloosa VA Medical Center will consult with VA National Center for Ethics in Healthcare to evaluate the appropriateness of the patient's assigned surrogate decision-maker. At the present time, however, the patient is demonstrating evidence of capacity for some decision making. However, [the patient] has no insight regarding [their] serious mental illness and delusions. Therefore, the patient will make [their] own decisions regarding [their] care, when appropriate. Since [the patient] has now reached the maximal benefit of [their] mental health treatment, we are pursuing discharge options. Ideally, [the patient] would be placed somewhere that can provide minor supervision when needed. However, [the patient] prefers a vagrant lifestyle. We are consulting with VA National Center for Ethics in Healthcare regarding the appropriateness of discharging the patient to a vagrant lifestyle/homelessness.

Recommendation 6

The Tuscaloosa VA Medical Center Director ensures staff completion of required patient advocate reporting and tracking processes, and monitors compliance.

Concur.

Target date for completion: November 2020

Director Comments

Patient Advocate, Service Line Advocates (SLAs), and Service Chiefs have been trained in the PATS-R system for reporting and tracking patient complaints. Patient Advocate and the Chief of Social Work monitor compliance regarding all patient complaints in PATS-R being addressed in a timely manner. In the CLC, contact information for the Patient Advocate and SLAs, as well as contact information for the Office of Inspector General, Alabama State Long-Term Care Ombudsman, the Area Agency on Aging (AAA) and the Aging and Disability Resource Center (ADRC), and the Alabama Department of Mental Health, are all included in the CLC Resident Orientation Handbook and posted in common areas.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure including compliance data for the long-stay mental health CLC SLA reporting and tracking of patient complaints.

Recommendation 7

The Tuscaloosa VA Medical Center Director evaluates the Community Living Center staff's management of the patient's correspondence request, including the Integrated Ethics consultation, and takes action as warranted.

Concur.

Target date for completion: October 1, 2021

Director Comments

According to 38 C.F.R. § 17.33, "each patient has the right to communicate freely and privately with persons outside the facility, including government officials, attorneys, and clergymen. To facilitate these communications each patient shall be provided the opportunity to meet with visitors during regularly scheduled visiting hours, convenient and reasonable access to public telephones for making and receiving phone calls, and the opportunity to send and receive unopened mail."

A CLC Communication SOP will be composed which will cover CLC residents' rights regarding mail and telephone privileges as well as procedures for disseminating information to CLC residents. CLC staff will receive training on patient rights, to include the right to communicate freely and privately with persons outside the facility. This training will be added to the CLC New Employee Orientation as well. Including this information in an SOP and in CLC New Employee Orientation will ensure the collective knowledge of the residents' rights is sustained. The SOP will be composed and approved by August 31, 2021 and training will occur in the month of September. We will use multiple modalities for training, such as GEC [Geriatrics and Extended

Care] Town Halls, electronic communication, staff meetings, etc. Target: 90% existing staff trained by October 1, 2021.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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