DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

HEALTHCARE INSPECTION | REPORT #20-02968-170 | JUNE 22, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation that improper feeding of a patient by a registered nurse (RN) at the St. Albans Community Living Center (CLC), VA New York Harbor Healthcare System (facility) in Queens, New York, contributed to the death of that patient. The OIG team identified additional concerns related to inaccurate electronic health record (EHR) documentation and an inadequate facility review of the care of the patient who died.

Synopsis of Events[1]

The patient lived at the CLC from mid-2018 to early 2020 and had a medical history that included gastroesophageal reflux disease, dementia, and mental health disorders.

The patient required total assistance for all activities of daily living (ADL), including feeding.[2] In late 2019, after completing a swallowing evaluation for a regular consistency diet, the Chief of Speech Language Pathology determined that the patient had oral phase dysphagia with adequate tolerance of regular consistency food and the patient's diet was upgraded to regular consistency. The Chief recommended aspiration precautions when feeding the patient. Precautions included having the patient's head upright and centered, alternating fluids with bites of food, making sure food in the mouth was cleared between bites, and feeding the patient only when alert.

Early on a day soon after the start of the pandemic (day at issue), the patient developed a fever and providers determined the patient should be transferred to the Brooklyn VA Medical Center to rule out coronavirus (COVID-19) infection. After being fed lunch, the patient was transferred to the Brooklyn VA Medical Center Emergency Department. Following evaluation in the Emergency Department, the patient was admitted to an acute care medical unit to rule out COVID-19. Within approximately 30 minutes after arrival to an acute care medical unit, the patient was found blue and unresponsive, a code blue (code) was called, and cardiopulmonary resuscitation (CPR) was initiated.

The OIG learned through interviews that a facility respiratory therapist used a video laryngoscope to aid in intubating the patient during the code and saw that a large piece of chicken was obstructing the patient's airway. Two code team physicians reported using forceps to remove the chicken. The patient regained cardiac function for a short time following intubation, but then developed an abnormal rapid heart rhythm. Ultimately, all resuscitative

[1] The synopsis summarizes events described in the patient's EHR and OIG interviews with pertinent staff members.

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

efforts failed, and the patient was pronounced dead at 5:38 p.m. The attending physician on the acute care unit documented in the EHR that the aspiration of proteinaceous material caused the death. The OIG determined that the piece of chicken was larger than was appropriate to feed the patient.

Healthcare Inspection Results

The OIG substantiated that improper feeding by a CLC RN contributed to the death of the patient. The OIG team learned through interviews that the CLC RN fed the patient chicken at lunch in the CLC on the day at issue. The OIG determined that the piece of chicken was larger than was appropriate to feed to the patient.

When interviewed by the OIG, the CLC RN verbalized feeding practices in accordance with the Chief of Speech Language Pathology's aspiration precautions. However, during the interview the CLC RN was unable to describe the size of the piece of chicken fed to the patient.

A code team physician documented two separate notes in the EHR with differing measurements of the chicken removed from the patient's airway. One EHR code note included the size of the chicken as .8 centimeters (cm) x 3 cm x 5 cm and the second note, documenting the code team's interventions, indicated a measurement of 8 cm x 3 cm x 5 cm. During an interview with the OIG, the code team physician reported not having seen the piece of chicken and that the measurements were "probably what I was told." The physician was unable to provide clarification on the differing documented measurements. The OIG was unable to determine the exact size of the chicken but based on the information received, including a picture of the piece of chicken removed from the patient's airway, it did not have a dimension of 8 cm but was larger than an appropriate size to feed to the patient. According to EHR documentation and interviews, the last time the patient ate was at the CLC. The OIG concluded, through interviews with staff who participated in the code and saw the chicken, that a piece of chicken was lodged in the patient's trachea when intubation was performed. The chicken was most likely the same chicken fed to the patient while in the CLC and was not cut to the proper size.

The OIG found that training documents created by the facility nurse educator and speech language pathologists stated that residents should be fed "small bites, slowly." The CLC RN attended resident feeding training; however, the facility did not have a requirement to confirm that the CLC RN was observed feeding residents safely. In May 2020, resident feeding was added as a competency for CLC nursing staff.

CLC nursing staff did not include accurate information in the patient's EHR. On the day at issue, two CLC nursing assistants entered an ADL note in the patient's EHR. Each note contained differing accounts of the amount of food the patient ate at breakfast. Additionally, there was no documentation in the EHR that the patient had been fed or ate lunch. An accurate and complete EHR is an integral component in quality patient care.

Facility leaders completed a supervisory fact-finding review (fact-finding), code review, and clinical disclosure after learning that a piece of chicken was removed from the patient's airway during intubation.[3] The OIG determined the removal of a large piece of chicken from the patient's trachea during intubation was an adverse clinical outcome.[4] Facility leaders, however, did not: (1) consider the circumstances of the patient's death to warrant further review, (2) expand the scope of the fact-finding beyond interviews with two CLC RNs, or (3) address the differing accounts between the Associate Chief of Staff CLC and acute care physicians related to the cause of the patient's death. The Associate Chief of Staff CLC found that the patient's death was from a cardiac cause while the acute care physicians attributed the death to aspiration of a proteinaceous material. Facility leaders were satisfied that a careful investigation had been performed and determined that no gaps in practice were identified; however, the Associate Chief of Staff CLC and CPR Subcommittee did not address the size of the chicken in the reviews. Without a comprehensive review of the patient's care on the day at issue, facility leaders were unable to determine the underlying cause of the patient's adverse clinical outcome and implement changes to reduce the likelihood of recurrence.

During the virtual site inspection, the OIG found that the CPR Subcommittee had not reviewed the code but following the OIG's inquiry about a review, the Subcommittee reviewed the code, four and a half months after the patient's adverse clinical outcome. The OIG found that the CPR Subcommittee did not address information from the code team and completed an insufficient review of the patient's code by not initiating actions to determine the accuracy of the EHR code documentation.

The OIG found that no facility staff member submitted an electronic patient incident report of the patient's adverse clinical outcome in accordance with facility policy. The Associate Director for Patient Care Services told the OIG that an incident report should have been submitted by the person who was aware that a piece of chicken was removed from the airway. A nursing staff member involved in the code told the OIG of being unaware of the requirement, or not having been told by a supervisor, to write an incident report for the patient's adverse event. If a report had been completed, it could have prompted a more comprehensive review of the event.

The facility completed a clinical disclosure of the removal of chicken from the patient's airway during intubation but did not provide an institutional disclosure to the patient's spouse that the CLC RN improperly fed the patient a piece of chicken that was larger than was appropriate for the patient. The Performance Improvement Manager thought that the patient's death was routine and that an institutional disclosure was not needed, and the Associate Director for Patient Care Services reported that an institutional disclosure was not completed but could not state a reason

[3] VA Employee Education System, *Administrative Investigations: Do it Right the First Time Resource Guidebook*, July 2004. The fact-finding process is "used for initial gathering of facts associated with a particular incident."

[4] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher-level care.

for the disclosure not being completed. The OIG concluded that the facility did not complete an institutional disclosure to provide an explanation to the patient's spouse that the CLC RN improperly fed the patient a piece of chicken that was larger than appropriate for the patient. When institutional disclosures are not completed as required, patients and their families may inadvertently be denied their rights.[5]

The OIG made seven recommendations to the Facility Director related to CLC nursing staff competency for resident feeding, training on documentation requirements related to feeding of residents, documentation of resident feeding, completing a review of the care provided to the patient, the CPR Committee evaluating issues and making recommendations for improvement, identifying adverse events and submitting incident reports, and institutional disclosure.

Comments

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

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

Contents

Abbreviations

ACOS	Associate Chief of Staff
ADL	activities of daily living
CLC	community living center
cm	centimeters
CPR	cardiopulmonary resuscitation
EHR	electronic health record
°F	degree Fahrenheit
OIG	Office of Inspector General
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an allegation that improper feeding of a patient by a registered nurse (RN) at the St. Albans Community Living Center (CLC), VA New York Harbor Healthcare System (facility) in Queens, New York, contributed to the death of that patient.

Background

The facility, part of Veterans Integrated Service Network (VISN) 2, includes three campuses located in Queens, Manhattan, and Brooklyn, New York. From October 1, 2018, through September 30, 2019, the facility served 48,155 patients and had a total of 416 operating beds, including 171 inpatient beds, 66 domiciliary beds, and 179 CLC beds. The CLC provides extended care such as skilled nursing, palliative care, and respite care to residents, and offers primary care, specialized geriatric programs, and rehabilitation. The Manhattan and Brooklyn campuses provide medical, surgical, psychiatric, and specialty care.

Allegation and Concerns

In April 2020, the OIG received a complaint alleging that on a day soon after the start of the coronavirus (COVID-19) pandemic (day at issue), improper feeding by an RN (CLC RN) contributed to the death of a patient. The complainant stated that the patient had a fever and was fed lunch by the CLC RN. Due to the fever, the patient was transferred to the Brooklyn VA Medical Center where a large piece of chicken was found deep in the patient's airway during a code blue (code).[1] Staff initiated resuscitation, however, ultimately, all resuscitative efforts failed, and death was pronounced at 5:38 p.m. on the day at issue.

The OIG team identified additional concerns related to inaccurate electronic health record (EHR) documentation and an inadequate facility review of the care of the patient who died.

[1] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC),* August 13, 2008. The Veterans Health Administration refers to a veteran who lives in the CLC as a resident. In this report, patient will be used when referring to the veteran discussed in this report. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

Scope and Methodology

The OIG initiated a healthcare inspection on May 21, 2020, and conducted a virtual site review July 20–23, 2020. The OIG interviewed the patient's spouse and private duty companion; Associate Director for Patient Care Services; Associate Chief of Staff (ACOS) CLC; Performance Improvement Manager; Chiefs of Pulmonology, Nutrition and Food Service, Anesthesia, and Speech Language Pathology; a CLC Nurse Manager; Patient Safety Manager; a nurse educator; and CLC and Brooklyn VA Medical Center clinical staff who cared for the patient.[2]

The OIG reviewed the patient's EHR from summer 2010 through spring 2020, relevant Veterans Health Administration (VHA) and facility policies, nursing staff training records, committee meeting minutes, the patient's death certificate, emergency medical services transport log, nutrition and food service documentation, and pictures and video of the chicken removed from the patient.

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 1105, 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 leadership 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.

[2] Facility Nursing Policy 118-25, *Use of Private Duty Companions,* June 2020. A private duty companion is a person hired by residents, families, or significant others to spend time with residents in a VA CLC. Private pay companions provide emotional support, engage in activities with residents, and accompany them to tests or treatments. (This policy was issued after the time frame of this inspection; therefore, the information is used for definitional purposes only.)

Patient Case Summary

The patient, who was in their 70s, lived at the CLC from summer 2018 to spring 2020 and had a medical history that included coronary artery disease, high blood pressure, hyperlipidemia, gastroesophageal reflux disease, hypothyroidism, dementia, head injury, depression, posttraumatic stress disorder, and psychotic disorder.[3]

In 2010, after reporting increasing memory loss to a psychiatrist, the patient completed a neuropsychological evaluation, which revealed memory problems. However, due to the patient's significant depression and posttraumatic stress disorder, it was impossible to determine the extent of underlying cognitive impairment. The neuropsychologist recommended treatment of the patient's depression and posttraumatic stress disorder with follow-up cognitive testing "within a year or when symptoms of depression/[posttraumatic stress disorder] are improved." A brain magnetic resonance imaging scan performed in 2010 revealed microvascular changes and an electroencephalogram performed in 2011 was normal. Laboratory evaluation was unremarkable at that time, except for elevated cholesterol levels. The patient had repeat neuropsychological testing in 2011, which revealed evidence of mild cognitive impairment.

In early 2012, the patient saw an Ear, Nose, and Throat physician regarding difficulty swallowing, chronic nasal congestion, and throat clearing. The physician started the patient on an anti-acid medication for treatment of gastroesophageal reflux disease and advised to follow up in four months. At the follow-up visit, the patient reported persistent difficulty swallowing, especially with dry foods such as bread. The physician increased the dose of the patient's anti-acid medication, ordered an imaging study of the esophagus, and consulted gastroenterology for further evaluation. The imaging study of the esophagus, performed in summer 2012, showed no abnormalities. The following month, the patient saw a gastroenterologist and again reported difficulty swallowing solid foods. The gastroenterologist recommended gargling with warm salt water and follow-up in six weeks. At the follow-up visit in fall 2012, the patient reported throat dryness, but no swallowing issues. The patient was discharged from the gastroenterology clinic with a recommendation to follow up in primary care. During an appointment two months later, the patient's primary care physician advised the patient to continue anti-acid medication for gastroesophageal reflux disease.

In 2014, the patient demonstrated very poor cognitive function in all areas tested to assess for dementia. The patient's cognitive impairment was deemed severe. In summer 2018, the patient was hospitalized at the facility for dehydration and failure to thrive. Upon discharge, the patient was admitted to the CLC. While at the CLC, the patient was treated for dementia, anxiety, high blood pressure, coronary artery disease, asthma, hypothyroidism, and gastroesophageal reflux

[3] The OIG uses the singular form of they (their) in this instance for privacy purposes.

disease. The patient required total assistance for all activities of daily living (ADL), including feeding.

The facility dental service followed the patient for grinding of the teeth, chronic inflammation, and recession of the gums. The dentist noted that it was very difficult to examine the patient's teeth due an inability to follow verbal instructions. The dentist required an assistant to help with opening the patient's mouth during examinations and teeth cleaning as the patient tended to bite down on the toothbrush and other dental instruments.

In summer 2018, while at the CLC, the patient had a swallowing evaluation. The study concluded that the patient demonstrated minimal chewing ability and no reflexive swallow. A speech language pathologist recommended a mechanical soft consistency diet, aspiration precautions, and mouth care following each meal.[4]

The patient received a mechanical soft consistency diet summer 2018 through late 2019, when the Chief of Speech Language Pathology performed a repeat swallowing evaluation following the spouse's request for the patient to have a regular consistency diet. During the swallowing evaluation, the patient exhibited prolonged chewing and uncoordinated movement of food around the mouth; however, no residual food was noted in the oral cavity. The Chief of Speech Language Pathology monitored the patient over the subsequent week to assess the patient's ability to tolerate a regular consistency diet over multiple meals. The patient continued to demonstrate prolonged chewing with uncoordinated manipulation of food and pocketing of a small amount of food in the mouth after swallowing. The patient was able to clear residual food with tongue movement and liquid consumption following trials of regular consistency solids. At the end of the trial, the Chief of Speech Language Pathology concluded that the patient had oral phase dysphagia with adequate tolerance of regular consistency foods and the patient's diet was upgraded to regular consistency. Standard aspiration and other feeding precautions including (1) keeping the patient's head at midline, (2) providing liquids intermittently, (3) ensuring the oral cavity is empty between bites of food, (4) feeding the patient only when alert, and (5) monitoring the patient for reduced intake and fatigue were recommended.

On the morning of the day at issue, a nursing assistant entered an EHR note at 7:30 a.m. stating that the patient ate 25 percent of the breakfast meal. Approximately three hours later, the patient developed a fever of 101 degrees Fahrenheit (°F), cough, lethargy, and hypoxemia with an oxygen saturation of 91 percent on room air.

[4] The OIG considers the terms mechanical soft diet and mechanical soft consistency diet the same within the context of this report.

The patient's temperature was taken three times at the CLC:

7:31 a.m. – 98.2°F

9:44 a.m. – 100.6°F

10:27 a.m. – 101.0°F

The patient's oxygen level was measured twice at the CLC:

9:44 a.m. – 91 percent on room air[5]

9:50 a.m. – 95 percent on 3 liters/minute of oxygen

The day prior, the patient's temperature was normal at 98.6°F and oxygenation was normal at 98 percent on room air.

At approximately 11:30 a.m., a CLC nurse practitioner examined the patient and noted abnormal sounds in the left lung and decreased breath sounds in the right lung. The ACOS CLC consulted with a provider in the facility's Infectious Disease Service who recommended that the patient be transferred to the Brooklyn VA Medical Center Emergency Department to rule out coronavirus (COVID-19) infection. The CLC nurse practitioner completed the transfer note at 12:08 p.m. There was no documentation regarding the patient's intake at lunch on the day at issue.

During transport to the Emergency Department, the patient developed increased respiratory distress requiring suctioning of excessive saliva and an increase in supplemental oxygen from 3 liters to 6 liters by nasal cannula. The emergency medical service transport log indicated that the patient arrived at the Emergency Department at 1:43 p.m. The patient was registered in the Emergency Department at 1:55 p.m. An Emergency Department nurse triaged the patient and documented taking vital signs at 2:33 p.m., which revealed an elevated blood pressure and temperature, normal heart rate and respiratory rate, and a normal oxygen saturation on 3 liters of supplemental oxygen. The patient screened positive for possible COVID-19 infection, was assigned an emergency severity index of 3, and was placed in an isolation room. In the Emergency Department, the physician assistant completed a physical exam and assessed laboratory and x-ray test results. The patient's exam revealed a normal mouth and throat, abnormal lung sounds, a normal white blood cell count, and a normal chest x-ray. Swabs of the mouth and nose were taken in the Emergency Department to test for COVID-19 infection. The COVID-19 tests returned positive one week later.

The Emergency Department physician assistant entered an order for admission to the acute care medical unit at 2:36 p.m., with a diagnosis of sepsis and rule out COVID-19. The acute care

[5] There was conflicting EHR documentation as to whether the patient was receiving supplemental oxygen at 9:44 a.m.

medical resident (medical resident) completed a physical exam of the head, ear, nose, and throat and documented hearing gurgling sounds, which were suspected to come from the patient's upper respiratory tract. Coarse breath sounds were heard during the examination of the lungs.[6] The medical resident's physical exam did not specifically report findings from the examination of the mouth or throat.

The patient was transferred to the acute care medical unit and arrived on the unit at approximately 4:30 p.m. Soon after arrival, the patient was found pulseless and blue by one of the acute care nurses. At 5:01 p.m., a code was called and cardiopulmonary resuscitation (CPR) was initiated. A code team physician completed an EHR Code Note noting that medications were initially administered and "…during code.8cm [*sic*] x 3cm x 5cm chicken piece was observed in the airway during the intubation and was removed with forceps."[7] The patient regained cardiac function for a short time following intubation, but then developed an abnormal rapid heart rhythm. Despite treatment, the patient's heart rhythm deteriorated. Ultimately, all resuscitative efforts failed, and the patient was pronounced dead at 5:38 p.m. The attending physician on the acute care unit documented in the EHR that the aspiration of proteinaceous material caused the death. An autopsy was not completed and according to the City of New York death certificate, the patient's immediate cause of death was asphyxia due to aspiration of a food bolus with complicating dementia and that significant contributing conditions were hypertensive and arteriosclerotic cardiovascular disease. Seventeen days after the patient's death, the City of New York medical examiner documented on the patient's Notice of Death that COVID-19 was confirmed.

Inspection Results

1. Allegation: Improper Feeding by a CLC RN

The OIG substantiated that improper feeding by the CLC RN contributed to the death of the patient. VHA policy states that "when a resident is unable to feed themselves, appropriately-trained staff provides that service, as needed."[8] The OIG team learned through interviews that the CLC RN fed the patient chicken at lunch in the CLC on the day at issue.

[6] The medical resident documented completion of and findings from the physical exam in the EHR Intern Admission Note and the supervising physician cosigned the note.

[7] The abbreviation for centimeter is cm. As the size of the piece of chicken is at issue in this report, the OIG includes the exact representation of the words and measurements that were entered into the EHR. As written, it is unclear whether the period indicates end punctuation or a decimal point. The same physician documented the size of the chicken as 8 cm x 3 cm x 5 cm in a different EHR note used to capture information about the code team's interventions during the patient's code. The OIG addresses the differing accounts of the measurement in the Inspection Results section of this report.

[8] VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

Approximately five hours later when the patient was intubated, a large piece of chicken was removed from the patient's airway. The OIG determined that the CLC RN fed the patient a piece of chicken that was larger than appropriate for the patient.

Aspiration Precautions and Nurse Feeding Practices

The OIG determined that the CLC RN verbalized the recommended feeding precautions for feeding the patient to prevent aspiration. However, during an interview with the OIG, the CLC RN was unable to describe the size of the piece of chicken fed to the patient.

The patient required total assistance from nursing staff for all ADL including feeding. During interviews, RNs told the OIG that certified nursing assistants, RNs, and licensed practical nurses fed CLC residents who were unable to feed themselves. In late 2019, the Chief of Speech Language Pathology determined that the patient had oral phase dysphagia and recommended nursing staff follow aspiration precautions when feeding the patient. Precautions included having the patient's head upright and centered, alternating fluids with bites of food, ensuring food in the mouth was cleared between bites, and feeding the patient only when alert.

On the morning of the day at issue, in the CLC, the patient developed a fever, cough, lethargy, and hypoxemia. CLC nursing staff told the OIG a change was noted in the patient's demeanor, stating the patient was not behaving normally and was less vocal than usual.

The Chief of Nutrition and Food Service provided the OIG the CLC menu and packaging describing the chicken served to the patient on the day at issue. The OIG verified that chicken was on the lunch menu and during an interview the Chief of Nutrition and Food Service told the OIG the patient was served a whole, cooked, 4-ounce chicken breast for lunch. The CLC RN told the OIG of feeding the patient between 11:30 a.m. and 12:00 p.m. and having taken the following actions: (1) the chicken breast was cut into bite-sized pieces, (2) the patient was fed one of the bite-sized pieces of chicken, two spoons of pasta, and took water between bites, (3) the patient's mouth was checked for residual food and none was found. While the patient typically ate the majority of meals, the CLC RN reported that after feeding the patient the piece of chicken and pasta, the patient did not want to continue eating. When interviewed, the CLC RN was unable to recall or provide a comparable sized object to describe the piece of chicken fed to the patient despite the OIG offering comparisons of the chicken documented in the EHR.

The CLC RN described the feeding practices for the patient to the OIG as ensuring the patient was (1) in an upright position, (2) fed slowly, one spoon of food at a time, and (3) allowed to finish what was in the mouth before being fed additional food or water. The OIG determined the CLC RN verbalized feeding practices in accordance with the Chief of Speech Language Pathology's aspiration precautions.

Acute Care and Code Findings

The OIG found that the patient was not fed while at the Brooklyn VA Medical Center and determined that the last time the patient ate was at the CLC.

The patient was transferred from the CLC to the Brooklyn VA Medical Center Emergency Department and arrived at approximately 1:43 p.m. Two separate oral cavity evaluations were performed by acute care physicians and a physician assistant in the Emergency Department.[9] The providers who conducted the evaluations told the OIG that no food was found in the patient's mouth. Both acute care physicians told the OIG that the patient made gurgling sounds, which appeared to be from the patient's airway. One of the physicians documented the finding in the EHR Intern Admission Note, which the second physician cosigned.

The patient's condition was severe enough to warrant admission to an acute care medical unit. At approximately 5:00 p.m., within approximately 30 minutes of arrival to the unit, an acute care RN found that the patient was blue and unresponsive and called a code.

The OIG interviewed seven staff members present in the patient's room during the code and found differing accounts of the number and size of the chicken pieces removed from the patient's airway. A facility respiratory therapist told the OIG of having used a video laryngoscope to aid in intubating the patient during the code and saw that a piece of chicken was obstructing the patient's airway. Two code team physicians reported using forceps to remove a piece of chicken from the airway; one piece of chicken was removed prior to the placement of a breathing tube into the airway and a second piece was removed after placement of the breathing tube.

Several staff stated seeing a piece of chicken removed from the patient and described the piece as "large," "big," "sizable," "not small," and "not bite size." Three staff members provided approximations of the size of the piece of chicken; one described it to be between 2 and 3 inches, another stated the chicken was 3 cm x 5 cm x 1.5 cm, and the third stated it was 1.2 cm x 2.5 cm x 3 cm. A code team physician documented two separate notes in the EHR with differing measurements of the chicken. One note included the size of the piece of chicken as .8 cm x 3 cm x 5 cm and the second noted a measurement of 8 cm x 3 cm x 5 cm. During an interview with the OIG, the code team physician reported not having seen the piece of chicken and that the measurements were "probably what I was told." The physician was unable to provide clarification on the differing documented measurements. The OIG was unable to determine the exact size of the chicken but determined that based on the information available, the chicken did not have a dimension of 8 cm as documented in the EHR.

Clinical staff involved in the code told the OIG that the piece of chicken did not appear to be digested or regurgitated, and described the chicken as whole, well formed, and without stomach

[9] The acute care physicians included a resident and attending physician who supervised the resident.

juices present. When asked whether chest compressions from CPR would lead to regurgitating or vomiting chicken from the stomach to the airway, two pulmonologists stated it would not be a common finding and did not think that the patient had vomited. The pulmonologists indicated that if the patient had regurgitated the chicken during the code, they would have expected to see stomach fluids and digested chicken pieces.

The facility respiratory therapist used the video laryngoscope to take several pictures and a short video of a piece of chicken after it was removed from the patient because it was not common to find such a large piece of food in a patient's airway.

After a review of the pictures and video, the OIG determined that the pictures and video appeared to be taken of the same piece of chicken. The chicken looked to be formed with no signs of gastric juices.

The OIG found that the patient was not fed while at the Brooklyn VA Medical Center and determined that the last time the patient ate was at the CLC. While unable to determine the size of the largest piece of chicken removed during the code, the OIG concluded that a large piece of chicken was lodged in the patient's trachea when intubation was performed. The chicken was most likely the same chicken served and fed to the patient while in the CLC and was not cut to the proper size.

CLC RN Training and Competency

The OIG found that the CLC RN who fed the patient attended dysphagia and resident feeding training. However, the facility did not have a formal process in place to assess the CLC RNs' or other nursing staff's competency to safely feed residents.

From September 2018–May 2020, the CLC RN completed five training sessions with topics including types of dysphagia (including oral dysphagia), aspiration precautions, and safe resident feeding techniques. One training presented by the facility nurse educator and speech language pathologist emphasized that residents should be fed "small bites, slowly."

When the OIG asked whether CLC nursing staff were assessed feeding residents, the CLC Nurse Manager stated that following a dysphagia training held in 2018, nursing staff provided a return demonstration of how to feed residents. The CLC Nurse Manager also reported observing nursing staff feed residents "many times" during informal, undocumented rounds in the CLC. The OIG reviewed nursing staff's annual competencies and found that resident feeding was not a required competency to be assessed in 2019. Due to the informal process, the OIG was unable to confirm that the CLC RN was observed feeding residents.

The OIG concluded that the CLC RN attended resident feeding training, however, at the time of the inspection, the facility did not have a requirement to confirm that the CLC RN was observed

feeding residents safely. In May 2020, resident feeding was added as a competency for CLC nursing staff.

2. Concern: Inaccurate EHR Documentation

The OIG determined that the day at issue documentation of the patient's food intake in the EHR was inaccurate.

VHA policy states the Chief, Nurse Executive is responsible for ensuring that nursing staff provide timely feeding assistance to patients, assess and document the percentage of meals consumed by a patient, and document symptoms or signs of difficulty swallowing or feeding in the EHR.[10] EHR entries must be recorded directly after the care event occurs to ensure that correct documentation is available.[11]

The OIG team learned through interviews that the facility process for documenting a resident's meal consumption was for CLC nursing assistants to write an EHR ADL note for all assigned residents at the end of each shift. Nursing assistants reported determining the quantity of food a resident consumed after feeding the resident, asking the staff member who fed the patient, or viewing the food remaining on a resident's food tray after the meal. Nursing assistants were also required to include where the resident ate and whether a resident required feeding assistance, but were not required to specify who fed the resident in the EHR.

The OIG found that on the day at issue, two CLC nursing assistants entered ADL notes in the patient's EHR that contained differing accounts of the amount of food the patient ate at breakfast. During interviews, one of the CLC nursing assistants reported entering one of the ADL notes in error. Additionally, the OIG did not find documentation in the EHR that the patient had been fed or ate lunch. The CLC RN told the OIG of feeding the patient lunch but did not provide a reason for the absence of documentation of the patient's meal consumption.

The OIG concluded that nursing staff did not document the patient's food intake in accordance with VHA requirements. An accurate and complete EHR is an integral component in quality patient care.

3. Concern: Inadequate Facility Review of the Patient's Death

The OIG acknowledged that facility leaders completed a supervisory fact-finding review (fact-finding), code review, and clinical disclosure after learning that a piece of chicken was

[10] VHA Directive 1171, *Management of Patients with Swallowing (Oropharyngeal Dysphagia) and Feeding Disorders*, April 14, 2017. The directive uses the term Chief, Nurse Executive. For the same position, the facility uses the title, Associate Director for Patient Care Services. Within the context of this report, the OIG considers the terms to refer to the same position.

[11] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

removed from the patient's airway during intubation.[12] However, the OIG found differing accounts from the ACOS CLC and acute care physicians related to the cause of the patient's death, and leaders did not address the differing accounts. In addition, the CPR Subcommittee did not take action after its code review, and facility leaders did not complete a patient incident report or an institutional disclosure.[13]

Adverse Event Reporting and Follow-up Actions

The OIG determined the removal of a piece of chicken from the patient's trachea during intubation that was larger than was appropriate to feed to the patient was an adverse clinical outcome.[14] Facility leaders, however did not (1) consider the circumstances of the patient's death to warrant further review, (2) expand the scope of the fact-finding beyond interviews of two CLC RNs, or (3) address the differing accounts between the ACOS CLC and acute care physicians related to the cause of the patient's death.

VHA established a Patient Safety Program with a goal to prevent harm to patients. VHA requires staff to report adverse events, review those events to identify underlying causes, and implement changes needed to reduce the likelihood of recurrence.[15]

The OIG found that 65 minutes after the patient's death, the Chief of Pulmonology sent an email to the Associate Director for Patient Care Services and Chiefs of Staff and Medicine with information that "a 8 cm x 3 cm x 5 cm" piece of chicken was removed from the patient's trachea during intubation and that the patient's death was caused by asphyxiation on the piece of chicken. The ACOS CLC completed a fact-finding three days after the patient's death and provided a summary to facility leaders noting that prior to the patient's transfer by ambulance to the Brooklyn VA Medical Center, CLC nursing staff fed the patient lunch and that the patient had not pocketed food from the meal.[16] The ACOS CLC concluded that the patient had a cardiopulmonary arrest and during CPR the "pt [*sic*] regurgitated stomach contents (a known complication of CPR) from lunch into the posterior pharynx and trachea."

The ACOS CLC included the following information from the patient's EHR in the fact-finding summary:

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[12] Department of Veterans Affairs Employee Education System, *Administrative Investigations: Do it Right the First Time Resource Guidebook*, July 2004. The fact-finding process is "used for initial gathering of facts associated with a particular incident."

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

[14] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher-level care.

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

[16] Facility leaders include the Facility Director, COS, Associate Director, and Associate Director for Patient Care Services.

- The facility's Emergency Department physician assistant documented a normal ear, nose, and throat, and oropharyngeal exam of the patient, administration of intravenous antibiotics, completion of blood tests, and COVID-19 nasal and oral tests.
- The patient was admitted to an acute care medical unit and at approximately 4:00 p.m., a physician saw the patient and documented that the patient had "gurgling sounds likely from upper resp [iratory] tract."[17]
- At 5:00 p.m., the patient was found pulseless and blue, CPR and intubation were initiated, and chicken pieces were found in the patient's airway.

During staff interviews and review of the EHR, the OIG learned additional details about the patient's care and condition. The emergency medical service transport log indicated that during transport, the patient required an increase of oxygen flow from 3 to 6 liters and needed suctioning of excess saliva. The patient's acute care physician and medical resident examined the patient in the Emergency Department and the patient made gurgling sounds, which appeared to come from the patient's airway.[18] The code team physician documented that the size of the piece of chicken removed from the patient's airway was 8 cm x 3 cm x 5 cm and the patient likely had respiratory failure due to aspiration of food. The acute care physician documented that "Aspiration of proteinaceous material deemed cause of death" in the EHR.

The ACOS CLC told the OIG of interviewing the CLC RN and another CLC RN who worked on the CLC unit the day of the patient's adverse clinical outcome but did not speak to any acute care providers as part of the fact-finding. The ACOS CLC stated that the CLC RN detailed cutting up and feeding chicken to the patient at lunch on the day at issue, feeding the patient slowly and appropriately, and that the patient had no difficulties chewing or swallowing during the meal.

The ACOS CLC stated that the patient's symptoms of being unresponsive and pulseless prior to the code were consistent with sudden death from a cardiac cause and not with asphyxiation due to aspiration of food. The ACOS CLC further explained that chicken could not have been sitting in the patient's trachea from when the patient ate lunch in the CLC until becoming pulseless and breathless. The ACOS CLC dismissed the possibility of the patient pocketing food from lunch because the CLC RN and two Emergency Department providers did not observe food while performing oral cavity exams.

Both the ACOS CLC and the Associate Director for Patient Care Services told the OIG of having no concerns about the care provided to the patient. Neither reported being aware of, nor

[17] The patient was evaluated by both an acute care physician and medical resident. The ACOS CLC did not specify which physician saw the patient.

[18] The ACOS CLC indicated in the fact-finding summary that the physician evaluated the patient on the acute care medical unit.

discussing the size of, the chicken removed from the patient's airway. The Associate Director for Patient Care Services recalled that when the ACOS CLC shared the results from the fact-finding, facility leaders were satisfied that a careful investigation had been performed and determined that no gaps in practice were identified.

Without a comprehensive review of the patient's care on the day at issue, facility leaders were unable to determine the underlying cause of the patient's adverse clinical outcome and implement changes to reduce the likelihood of recurrence.

CPR—Review of the Code

The OIG determined that the CPR Subcommittee reviewed the code four and a half months after the patient's adverse clinical outcome but did not address the code team's finding that a large piece of chicken was removed from the patient's airway during intubation.

VHA policy states that the facility has a CPR Committee, which is responsible for the review of CPR events and identification of "errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, clinical issues or patient care issues, such as failure to rescue, which may have contributed to the occurrence of a cardiopulmonary event."[19] Facility policy designates the CPR Committee to have responsibility for improving the management of all processes related to cardiopulmonary arrest.[20]

The CPR Committee Chairperson told the OIG that the facility CPR Subcommittee was responsible for reviewing codes including the cardiac arrest flowsheet used to capture information about the code team's interventions during a patient's code, but that the Subcommittee had not reviewed the patient's code prior to the OIG's hotline inspection. After the completion of the OIG team's virtual site review, the CPR Committee Chairperson reported that in summer 2020, the CPR Subcommittee reviewed the patient's code. The Subcommittee, however, did not acknowledge content of the EHR code documentation note in the review.

The OIG concluded that the CPR Subcommittee completed an insufficient review of the patient's code by not initiating actions to determine the accuracy of the EHR code documentation. The CPR Subcommittee's omission did not afford the opportunity to determine if any errors or deficiencies contributed to the patient's code and implement improvements to prevent future occurrence of similar events.

[19] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

[20] Facility Policy 111-01, *Cardio-Pulmonary Arrest Management,* December 2017.

Patient Incident Reporting

The OIG found that no facility staff member submitted an electronic patient incident report of the patient's adverse clinical outcome.

Facility policy identifies that all employees are responsible for notifying their supervisor of an adverse event and to initiate an electronic patient incident report after witnessing or becoming aware of the adverse event.[21]

During an interview with the OIG, the Patient Safety Manager reported having a discussion with facility quality management staff three days after the patient's death and being satisfied with an explanation that the patient regurgitated food during CPR. The Patient Safety Manager determined at the time of the patient's death that an incident report would not be warranted. When asked whether having aspiration identified as the patient's cause of death would be of concern, the Patient Safety Manager reported being unaware that the patient aspirated and acknowledged that a staff member with information about the patient's aspiration should have completed an incident report.

A nursing staff member involved in the code told the OIG of being unaware of the requirement, or not having been told by a supervisor to write an incident report for the patient's adverse event. The Associate Director for Patient Care Services told the OIG that an incident report should have been submitted by the person who was aware that a piece of chicken was removed from the airway; in this case the physician and not nursing staff.

The OIG determined that staff involved in the patient's code did not complete an electronic incident report of the adverse clinical outcome in accordance with facility policy, and if a report had been completed, it could have prompted a more comprehensive review of the event.

Institutional Disclosure

The OIG determined that the facility completed a clinical disclosure of the removal of chicken from the patient's airway during intubation but did not provide an institutional disclosure to the patient's spouse related to the CLC RN having improperly fed the patient a piece of chicken that was larger than was appropriate to feed to the patient.

An adverse event may warrant institutional disclosure.[22] The intent of institutional disclosure is to fully inform patients and their families about all clinically significant facts related to the harm caused by VA medical care and options to pursue potential compensation.[23]

[21] Facility Policy 00-14, *Patient Safety Program,* April 2016.

[22] VHA Directive 1004.08.

[23] VHA Directive 1004.08.

The OIG found EHR documentation that on the day at issue, the acute care physician called the patient's spouse during the code and after the patient expired. During an interview with the patient's spouse, the OIG was told the patient's spouse was called by the acute care physician and told that a piece of chicken was removed from the patient's airway during intubation. The patient's spouse learned the size of the piece of chicken after reading the patient's medical record.

When asked about completing an institutional disclosure, the ACOS CLC reported having completed a clinical disclosure to the patient's spouse and sharing the events that occurred including chicken being found in the airway, but did not document the discussion. The ACOS CLC told the OIG that if additional information became available, the details would be shared with the patient's spouse. The Associate Director for Patient Care Services reported that an institutional disclosure was not completed but could not state a reason for the disclosure not being completed. The Performance Improvement Manager thought that the patient's death was "routine" and that an institutional disclosure was not needed.

Approximately four months after the patient's death, the ACOS CLC completed an EHR note indicating that clinical disclosure was completed on the day of the patient's death and "that [the patient] had a cardiac arrest and during resuscitation with the placement of a tube in [the patient's] windpipe a piece of chicken was found."

The OIG concluded that the facility did not complete an institutional disclosure to provide an explanation to the patient's spouse that the CLC RN improperly fed the patient a piece of chicken that was larger than was appropriate to feed to the patient. When institutional disclosures are not completed as required, patients and their families may inadvertently be denied their rights.[24]

Conclusion

The OIG substantiated that improper feeding by a CLC RN contributed to the death of a patient. The OIG team learned through interviews that the CLC RN fed the patient chicken at lunch in the CLC on the day at issue. Approximately five hours later when the patient was intubated, a large piece of chicken was removed from the patient's airway. The OIG determined that the piece of chicken was larger than was appropriate to feed to the patient.

The Chief of Speech Language Pathology determined that the patient had oral phase dysphagia and recommended aspiration precautions when feeding the patient. Precautions included having the patient's head upright and centered, alternating fluids with bites of food, making sure food in the mouth was cleared between bites, and feeding the patient only when alert. The OIG determined the CLC RN verbalized feeding practices in accordance with the Chief of Speech

[24] VHA Directive 1004.08.

Language Pathology's aspiration precautions; however, was not able to describe the size of the piece of chicken fed to the patient.

The patient was transferred from the CLC to the Brooklyn VA Medical Center and admitted to an acute care medical unit. Within approximately 30 minutes after arrival to an acute care medical unit, the patient was found blue and unresponsive, and a code was called.

The OIG learned through interviews that a facility respiratory therapist used a video laryngoscope to aid in intubating the patient during the code and saw that a piece of chicken was obstructing the patient's airway. Two code team physicians reported using forceps to remove a piece of chicken from the airway; one piece of chicken was removed prior to the placement of a breathing tube into the airway and a second piece was removed after placement of the breathing tube. A code team physician documented two separate notes in the EHR with differing measurements of the chicken. One note included the size of the piece of chicken as .8 cm x 3 cm x 5 cm and the second noted a measurement of 8 cm x 3 cm x 5 cm. During an interview with the OIG, the code team physician reported not having seen the piece of chicken and that the measurements were "probably what I was told." The OIG was unable to determine the exact size of the chicken but determined that based on the information available, the chicken did not have a dimension of 8 cm.

The OIG determined that the patient was not fed while at the Brooklyn VA Medical Center and that the last time the patient ate was at the CLC. While unable to determine the size of the largest piece of chicken removed during the code, the OIG concluded that a piece of chicken larger than was appropriate to feed to the patient was lodged in the patient's trachea when intubation was performed. The chicken was most likely the same chicken served and fed to the patient while in the CLC and was not cut to the proper size.

The OIG found that training documents created by the facility nurse educator and speech language pathologists stated that residents should be fed "small bites, slowly." The CLC RN attended resident feeding training; however, the facility did not have a requirement to confirm that the CLC RN was observed feeding residents safely. In May 2020, resident feeding was added as a competency for CLC nursing staff.

CLC nursing staff did not include accurate information in the patient's EHR. On the day at issue, two CLC nursing assistants entered an ADL note in the patient's EHR and each note contained differing accounts of the amount of food the patient ate at breakfast. Additionally, there was no documentation in the EHR that the patient had been fed or ate lunch.

The OIG determined the removal of a large piece of chicken from the patient's trachea during intubation was an adverse clinical outcome. Facility leaders, however, did not (1) consider the circumstances of the patient's death to warrant further review, (2) expand the scope of the fact-finding beyond interviews with two CLC RNs, or (3) address the differing accounts between the ACOS CLC and acute care physicians related to the cause of the patient's death. Without a

comprehensive review of the patient's care on the day at issue, facility leaders were unable to determine the underlying cause of the patient's adverse clinical outcome and implement changes to reduce the likelihood of recurrence.

The CPR Subcommittee completed an insufficient review of the patient's code by not initiating actions to determine the accuracy of the EHR code documentation. The Subcommittee's omission did not afford the opportunity to determine if errors or deficiencies contributed to the patient's code and implement improvements to prevent future occurrence of similar events.

The OIG found that no facility staff member submitted an electronic patient incident report of the patient's adverse clinical outcome, and if a report had been completed, it could have prompted a more comprehensive review of the event.

The facility completed a clinical disclosure of the removal of chicken from the patient's airway during intubation but did not provide an institutional disclosure to the patient's spouse that the CLC RN improperly fed the patient a piece of chicken that was larger than was appropriate to feed to the patient. When institutional disclosures are not completed as required, patients and their families may inadvertently be denied their rights.

Recommendations 1–7

1. The VA New York Harbor Healthcare System Director reviews the process of evaluating the Community Living Center nursing staff's competency for resident feeding and validates their ability to safely feed residents.

2. The VA New York Harbor Healthcare System Director ensures that Community Living Center nursing staff are trained on documentation requirements related to feeding of residents and verifies compliance with requirements.

3. The VA New York Harbor Healthcare System Director evaluates documentation of resident feeding, including identifying the staff member who feeds a resident, and takes action as indicated.

4. The VA New York Harbor Healthcare System Director verifies that a comprehensive review of the patient's care and death is completed, and evaluates the usefulness of including the pictures and video of the chicken in the review, and takes action as indicated.

5. The VA New York Harbor Healthcare System Director ensures the Cardiopulmonary Resuscitative Committee evaluates identified issues and makes recommendations for improvement, confirms actions are implemented, and assesses the effectiveness of actions.

6. The VA New York Harbor Healthcare System Director verifies staff are aware of what constitutes an adverse event and the requirements to submit incident reports when witnessing or becoming aware of an adverse event.

7. The VA New York Harbor Healthcare System Director evaluates the circumstances surrounding the patient's death to determine if an institutional disclosure is warranted.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 10, 2021

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

Subj: Healthcare Inspection—Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens

To: Director, Office of Healthcare Inspections (54HL09)
Director, GAO/OIG Accountability Liaison Office (VHA 10B GOAL Action)

1. Thank you for the opportunity to review the Draft Report: Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens.

2. Please note concerns documented in the facility Director's response. I concur with the response and would appreciate further review of the concerns.

3. The facility has begun working on the recommendations identified.

(*Original signed by*:)

Joan E. McInerney, MD
VISN 2 Director

OIG Addendum

The OIG reviewed the concerns in the Facility Director memorandum. The OIG does not find the concerns warrant a change to the report.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 10, 2021[30]

From: Director, VA New York Harbor Healthcare System (630)

Subj: Healthcare Inspection—Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report assessing the transfer of the first Coronavirus Disease 2019 (COVID-19) patient from the Community Living Center (CLC) at St. Albans to the VA New York Harbor Healthcare System (VANYHHS) at the beginning of the pandemic crisis.

2. We are saddened by the loss of this, and every, patient. In this case, we had cared for this patient since summer 2018. Losing the patient to COVID-19 so early in the pandemic affected everyone in the CLC and heightened the need for the VANYHHS to quickly enforce COVID-19 protection precautions to protect patients and staff.

3. VANYHHS finds the registered nurse's (RN's) actions did not contribute to the patient's death and that the RN fed the patient ethically and properly. Most importantly, the RN respected the patient's right to self-determination: the patient's right to voluntarily eat lunch when the patient wanted to eat. It would have been ethically unjustifiable for the RN to intentionally withhold food after the patient indicated a desire to eat. We also note the RN stopped feeding the patient when the patient indicated that the patient did not want any more. It would have been ethically unjustifiable for the RN to force food into the patient's mouth against the will of the patient. We would like to highlight that the RN has been an employee of the CLC since summer 2016 and fed the patient many times during the patient's stay at the CLC and was familiar with the size of food the patient preferred and swallowed regularly without difficulty. In addition, the RN served as a preceptor training new employees on feeding CLC patients. On the day in question the RN fed the patient the usual size of food in a normal manner and the patient swallowed without difficulty. We cannot fault the RN for feeding a patient who wanted food and we cannot fault the RN for feeding the patient the size of food that the patient swallowed without difficulty. The patient was ethically and properly fed. OIG documents that the CLC RN described the feeding practices for the patient to the OIG, and the OIG determined that the CLC RN verbalized feeding practices in accordance with the Chief of Speech Language Pathology's aspiration precautions. Yet, the OIG substantiates that improper feeding by the CLC RN contributed to the death of the patient. The OIG documents that the exact size of the bite cannot be determined, and yet they conclude that the RN improperly fed the patient. We do not believe this conclusion is supported by the facts in the report.

4. OIG's review concludes that the patient aspirated on a piece of chicken fed to the patient at lunch. OIG believes the chicken was larger than what was appropriate to feed the patient. While we respect OIG's opinion, we disagree with this conclusion. It is important to clarify that in a patient on a normal diet, the size of food fed to the patient is not standardized and therefore, it is speculative to determine if the

[30] On May 12, 2021, the facility agreed to modifications for privacy purposes as identified by the OIG.

chicken was not the right size for the patient. Since the patient did not reject the piece of chicken using any of the patient's normal cues, it is safe to assume the patient was comfortable with the size.

5. After being fed lunch by the RN at the CLC between 11:00 a.m. and 11:30 a.m., the patient was transferred to the Brooklyn campus of VANYHHS at approximately 1:00 p.m. There was no evidence of the patient choking or being in distress during the patient's meal at the CLC or immediately after. Therefore, one can assume the patient did not choke or aspirate during the roughly five hours after the patient ate, which means the food was most likely where it belonged, in the patient's stomach. Unfortunately, as is true for every person with gastroesophageal reflux, food from the stomach can reflux up into the throat and fall into the trachea where it can choke people. In this case, it is likely the patient regurgitated multiple pieces of partially digested food, one of which was too large for the patient to aspirate deep into the patient's lungs and it got lodged in the patient's trachea. A well person would cough to get aspirated food out of the lungs and trachea, but this patient was seriously ill with COVID-19. The patient may not have been able to cough it out.

6. There were no overt signs/symptoms of aspiration/penetration during the patient's meal indicating likely adequate tolerance of same as the patient had no known history of silent aspiration. Given the absence of coughing during the patient's meal, there isn't any reason to believe the chicken entered the airway versus the esophagus. The patient's oral temperature was taken, and airway examined multiple times after the patient ate. The Emergency Department (ED) note documents that the patient's oral temperature was taken at 14:33 p.m. If the patient pocketed a large piece of chicken in the patient's mouth this would have been noted. Consultation with the Intensive Care Unit (ICU), Gastroenterology (GI) and Ear Nose and Throat (ENT) physicians all agree that there could not have been an airway obstruction for several hours and could speculate that a more likely scenario is that the piece of chicken was in the patient's esophagus or stomach prior to being dislodged or regurgitated.

7. In general, we think it is important to highlight in the report the impact and magnitude the COVID-19 pandemic had on the VA healthcare system. While all of VA was dealing with the evolving COVID-19 crisis, VANYHHS was under immense pressure, being located in the country's epicenter, New York City. Conditions were dire, and as a result, our clinical response to patients was the number one priority. Regrettably, regular meetings of subcommittees were rescheduled to allow for full time clinical response to occur.

8. We think it is important to include information from the literature related to the incidence of sudden death due to COVID-19 infections. We feel the Associate Chief of Staff of the CLC accurately pointed out that the patient's symptoms of being unresponsive and pulseless prior to the code were consistent with sudden death from a cardiac cause and not with asphyxiation due to aspiration of food.

9. We grieve every day with the country over the loss of our loved ones taken by COVID-19. We are proud of our nurse heroes that served Veterans through this devastating pandemic crisis. We are very conscientious about the care of our CLC patients and will take actions recommended by the OIG to strengthen the care we provide.

10. If you have any questions, please contact the Performance Improvement Manager.

(*Original signed by*:)

Martina A. Parauda
Director

Facility Director Response

Recommendation 1

The VA New York Harbor Healthcare System Director reviews the process of evaluating the Community Living Center nursing staff's competency for resident feeding and validates their ability to safely feed residents.

Concur.

Target date for completion: 50% of staff trained by May 15, 2021, all staff by August 15, 2021

Director Comments

New Nursing staff are evaluated using simulation in the classroom. New employees then work with their preceptor in the Community Living Center neighborhood and are coached in proper feeding techniques. Within one week of their tenure on the unit, the new employee is evaluated by the Nurse Educator. This is also included in the annual competency assessment.

Recommendation 2

The VA New York Harbor Healthcare System Director ensures that Community Living Center nursing staff are trained on documentation requirements related to feeding of residents and verifies compliance with requirements.

Concur.

Target date for completion: Audits to begin in April 2021. Audits will be completed monthly until 90% or greater compliance is achieved.

Director Comments

The process of documenting residents' response to feeding was devised by the collaborative efforts of Patient Services Education, Nursing leadership, Speech Pathology and Nursing Informatics and is taught to new hires during orientation. Ten resident records will be audited each month by Nursing Performance Improvement staff. Deficiencies will be forwarded to the relevant nurse manager and Patient Services Education will provide education for remediation.

Recommendation 3

The VA New York Harbor Healthcare System Director evaluates documentation of resident feeding, including identifying the staff member who feeds a resident, and takes action as indicated.

Concur.

Target date for completion: June 30, 2021

Director Comments

Nursing Performance Improvement and Nursing leadership evaluates the documentation of feeding and relates any opportunities for improvement to Patient Services Education and the relevant nurse manager on an annual basis. Nursing Informatics will evaluate the template for recording resident feeding and make modifications by May 15, 2021. Ten records will be audited for completeness of documentation monthly and deficiencies will be forwarded to Patient Services Education for remediation.

Recommendation 4

The VA New York Harbor Healthcare System Director verifies that a comprehensive review of the patient's care and death, is completed, and evaluates the usefulness of including the pictures and video of the chicken in the review, and takes action as indicated.

Concur.

Target date for completion: May 15, 2021

Director Comments

VANYHHS is using the root cause analysis process to perform a comprehensive review of the death. An interdisciplinary team consisting of the ACOS/Extended Care, Patient Safety Manager, Intensive Care physician, Performance Improvement Manager, CLC Nurse Manager and Chief Speech Language Pathology Section were tasked with the review. The team will review the medical record, mortality peer review, pictures and video, code sheets, Medical Examiner's death certificate and other relevant information concerning the death previously provided to the OIG audit team.

Recommendation 5

The VA New York Harbor Healthcare System Director ensures the Cardiopulmonary Resuscitative Committee evaluates identified issues and makes recommendations for improvement, confirms actions are implemented, and assesses the effectiveness of actions.

Concur.

Target date for completion: May 15, 2021

Director Comments

The CPR sub-committee reviews all code events and debriefing sheets with attention to noted deficiencies, including macro issues, namely cardiac arrest outcomes and to ensure proper American Heart Association (AHA) guidelines are adhered to. The OIG noted a 4-month delay

in the review of the code from March. This was due to sub-committee members absences due to either pandemic related illness or reassignments. In the future this will be prevented by assigning alternative staff to review codes should sub-committee members not be available.

The deficiencies are presented for discussion to the CPR committee as new business or findings at the sub-committee meetings. The committee will formulate specific recommendations to correct identified deficiencies, confirm implementation at the next quarterly meeting, and follow up on the effectiveness of the corrective actions at an appropriate time interval. The Committee met on April 13, 2021.

Recommendation 6

The VA New York Harbor Healthcare System Director verifies staff are aware of what constitutes an adverse event and the requirements to submit incident reports when witnessing or becoming aware of an adverse event.

Concur.

Target date for completion: May 30, 2021

Director Comments

The Joint Patient Safety Reporting system (JPSR) is the program by which staff report any adverse event including near misses. This program is presented to newly hired staff during orientation and reviewed annually as part of the Patient Safety Talent Management System module. The Patient Safety Manager presents adverse event reporting at Nursing orientation and participates in a daily quality management huddle reviewing the nursing 24-hour report and reaches out to staff requesting a JPSR when appropriate. Moving forward, the Patient Safety Manager will ensure a review of all mortalities are the daily huddle to ascertain if there are any circumstances related to the death that should be reported through JPSR. Incident reporting using JPSR is also included in the annual mandatory Patient Safety training.

Recommendation 7

The VA New York Harbor Healthcare System Director evaluates the circumstances surrounding the patient's death to determine if an institutional disclosure is warranted.

Concur.

Target date for completion: May 15, 2021

Director Comments

The interdisciplinary team tasked to complete the comprehensive review of the death was requested to make a recommendation if institutional disclosure is warranted after they complete

the review of the death. They will present their recommendations to the Director and Chief of Staff for concurrence.

Glossary

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

activities of daily living. A term used to collectively describe fundamental skills that are required to independently care for oneself such as eating, bathing, and mobility.[31]

adverse event. "Untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility."[32]

asphyxia. A lack of oxygen or excess of carbon dioxide in the body that results in unconsciousness and often death and is usually caused by interruption of breathing or inadequate oxygen supply.[33]

aspiration. When food, liquids, or stomach contents are pulled into an airway or lungs during breathing.[34]

arteriosclerosis. When the walls of arteries in the body become narrowed and stiff reducing the flow of blood.[35]

cardiopulmonary resuscitation. A sequential process designed to restore normal heart rhythm and normal breathing to someone whose heartbeat and breathing have stopped.[36]

cardiac arrest. The heart stops pumping and blood stops circulating in the body. If left untreated, this results in death. Coronary artery disease is a common cause of cardiac arrest in adults.[37]

clinical disclosure. "A process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care**."**[38]

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[31] VHA Handbook 1142.01.

[32] VHA Handbook 1050.01.

[33] Merriam-Webster, "asphyxia," accessed October 22, 2020, https://www.merriam-webster.com/dictionary/asphyxia.

[34] Merriam-Webster, "aspiration," accessed September 28, 2020, https://www.merriam-webster.com/dictionary/aspiration.

[35] Mayo Clinic, "arteriosclerosis/atherosclerosis," accessed December 11, 2020, https://www.mayoclinic.org/diseases-conditions/arteriosclerosis-atherosclerosis/symptoms-causes/syc-20350569.

[36] Mayo Clinic, "Cardiopulmonary Resuscitation (CPR): First Aid," accessed August 4, 2020, https://www.mayoclinic.org/first-aid/first-aid-cpr/basics/art-20056600.

[37] Merck Manual, "cardiac arrest," accessed April 27, 2020, https://www.merckmanuals.com/professional/critical-care-medicine/cardiac-arrest-and-cpr/cardiac-arrest?query=cardiac%20arrest.

[38] VHA Directive 1004.08.

code blue. Declaration of a medical emergency, summoning medical personnel and equipment to attempt resuscitation of a patient experiencing a cardiac arrest or respiratory failure.[39]

competency. "A complex integration of knowledge including professional judgement, skills, values [sic] and attitude" that are necessary to perform job tasks and duties. These skills, values, and attitudes are also assessed through on the job evaluations as well as the expectation to learn and demonstrate new ones.[40]

coronary artery disease. A disease that develops when the blood vessels that supply the heart muscle with blood become damaged and narrowed. Buildup of cholesterol containing deposits, or plaques, narrows the coronary arteries resulting in a decrease in blood flow to the heart, resulting in symptoms such as shortness of breath, chest pain, or a heart attack.[41]

coronavirus. Coronavirus disease (COVID-19) is a newly discovered infectious disease. It can be spread from person to person through droplet secretions, such as a cough or sneeze.[42]

dementia. A group of symptoms that result in cognitive and psychological changes, such as memory loss, impaired communication, confusion, disorientation, agitation, anxiety, and paranoia.[43]

electroencephalogram. A test used to detect electrical impulses in the brain by attaching electrodes to the scalp.[44]

emergency medical services. Private or public agencies that provide emergency medical care to patients following a serious injury or illness.[45]

emergency severity index. An Emergency Department algorithm that categorizes patients into five groups for triage, 1-Most Urgent to 5-Least Urgent.[46]

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[39] Merriam-Webster, "code blue," accessed April 28, 2020, https://www.merriam-webster.com/medical/code%20blue.

[40] Mika Fukada, "Nursing Competency: Definition, Structure and Development" Yonago Acta Medica 61, (2018): 001-007.

[41] Mayo Clinic, "coronary artery disease," accessed April 29, 2020, https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes/syc-20350613.

[42] World Health Organization (WHO), "coronavirus," accessed August 4, 2020, https://www.who.int/health-topics/coronavirus#tab=tab_1.

[43] Mayo Clinic, "dementia," accessed August 4, 2020, https://www.mayoclinic.org/diseases-conditions/dementia/symptoms-causes/syc-20352013.

[44] Mayo Clinic, "EEG (electroencephalogram)," accessed August 4, 2020, https://www.mayoclinic.org/tests-procedures/eeg/about/pac-20393875.

[45] National Highway Traffic Safety Administration Office of Emergency Medical Services, "What is EMS?," accessed April 5, 2020, https://www.ems.gov/whatisems.html.

[46] Agency for Healthcare Research and Quality, "Emergency Severity Index (ESI): A Triage Tool for Emergency Departments," accessed August 4, 2020, https://www.ahrq.gov/professionals/systems/hospital/esi/index.html.

esophagus. A tube-shaped muscle that carries food from the mouth to the stomach.[47]

failure to thrive. A condition seen in the frail elderly who may have one or more chronic illnesses. Symptoms include poor appetite, loss of weight, increased fatigue, and a progressive functional decline.[48]

gastroenterologist. A trained medical provider that specializes in the treatment of certain diseases of the stomach and intestines.[49]

gastroenterology. A branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines.[50]

gastroesophageal reflux disease. A condition that occurs when stomach acid flows back into the esophagus, causing irritation to the lining of the esophagus.[51]

hyperlipidemia. A condition resulting in excess fat in the blood.[52]

hypertensive. A person "affected with hypertension;" "abnormally high blood pressure."[53]

hypothyroidism. A condition in which the thyroid becomes underactive and does not produce enough hormones causing a chemical imbalance in the body.[54]

hypoxemia. A low level of oxygen in the arteries of the blood. It is caused by breathing or circulation problems and may lead to shortness of breath.[55]

institutional disclosure. "A formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal

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[47] Merriam-Webster, "esophagus," accessed August 4, 2020, https://www.merriam-webster.com/dictionary/esophagus.

[48] Stanford School of Medicine, "Adult Failure to Thrive," accessed October 4, 2020, https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/common-terminal-diagnoses/adult-failure-to-thrive/.

[49] Merriam-Webster, "gastroenterologist," accessed August 4, 2020, https://www.merriam-webster.com/medical/gastroenterologist.

[50] Merriam-Webster, "gastroenterology," accessed August 4, 2020, https://www.merriam-webster.com/dictionary/gastroenterology.

[51] Mayo Clinic, "gastroesophageal reflux disease (GERD)," accessed August 4, 2020, https://www.mayoclinic.org/diseases-conditions/gerd/symptoms-causes/syc-20361940.

[52] Merriam-Webster, "hyperlipidemia," accessed August 4, 2020, https://www.merriam-webster.com/dictionary/hyperlipidemia.

[53] Merriam-Webster, "hypertension," accessed September 28, 2020, https://www.merriam-webster.com/dictionary/hypertension. Merriam-Webster, "hypertensive," accessed December 12, 2020, https://www.merriam-webster.com/dictionary/hypertensive.

[54] Mayo Clinic, "hypothyroidism (underactive thyroid)," accessed August 4, 2020, https://www.mayoclinic.org/diseases-conditions/hypothyroidism/symptoms-causes/syc-20350284.

[55] Mayo Clinic, "hypoxemia," accessed August 4, 2020, https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930.

representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury."[56]

intubation. Insertion of a tube in the trachea to maintain the airway and provide ventilatory support.[57]

lethargy. A condition of drowsiness or sluggishness.[58]

magnetic resonance imaging. A noninvasive procedure using nuclear magnetic resonance atoms and radio waves to produce a computerized image of internal body tissues.[59]

mechanical soft diet. A type of diet used for people with difficulty swallowing and chewing food. It includes food that has been chopped, ground, pureed, or comes apart easily without a knife.[60]

microvascular. Tiny vessels found in the circulatory system, specifically those measuring less than 0.3 millimeters in diameter.[61]

mild cognitive impairment. "The stage between the expected cognitive decline of normal aging and the more serious decline of dementia. It can involve problems with memory, language, thinking and judgment that are greater than normal age-related changes."[62]

nasal cannula. A hollow two-pronged tube that is inserted into the nostrils to deliver a specific amount of oxygen.[63]

neuropsychological evaluation. A test to determine how well a person's brain is functioning. It evaluates a person's ability to read, speak, understand, pay attention, and remember.[64]

oral phase dysphagia. "Dysphagia is a swallowing disorder [...] Oral phase disorders usually result from: impaired control of the tongue; reduced mandibular movement; poor dentition; difficulty chewing solid food; and initiating swallows. When eating or drinking liquids, patients

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[56] VHA Directive 1004.08.

[57] Merriam-Webster, "intubation," accessed May 5, 2020, https://www.merriam-webster.com/dictionary/intubated.

[58] Merriam-Webster, "lethargy," accessed August 4, 2020, https://www.merriam-webster.com/dictionary/lethargy.

[59] Merriam-Webster, "magnetic resonance imaging," accessed August 4, 2020, https://www.merriam-webster.com/dictionary/magnetic%20resonance%20imaging.

[60] University of Wisconsin Health (UW Health), "Mechanical Soft Diet," accessed August 4, 2020, https://www.uwhealth.org/healthfacts/trauma/363.pdf.

[61] Merriam-Webster, "microvascular," accessed August 4, 2020, https://www.merriam-webster.com/dictionary/microvasculature.

[62] Mayo Clinic, "mild cognitive impairment (MCI)," accessed August 4, 2020, https://www.mayoclinic.org/diseases-conditions/mild-cognitive-impairment/symptoms-causes/syc-20354578.

[63] Merck Manual, "oxygen therapy," accessed August 5, 2020, https://www.merckmanuals.com/home/lung-and-airway-disorders/rehabilitation-for-lung-and-airway-disorders/oxygen-therapy.

[64] Cleveland Clinic, "neuropsychological evaluation," accessed August 4, 2020, https://my.clevelandclinic.org/health/diagnostics/4893-neuropsychological-evaluation.

may find it difficult to contain and manage liquids or foods in the oral cavity before swallowing. As a result, liquids and foods may spill prematurely into the pharynx, possibly resulting in aspiration and/or choking."[65]

oropharyngeal. "Of or relating to the oropharynx," which is the part of the pharynx that is behind the mouth and just above the epiglottis.[66]

oxygen saturation. A measurement of the amount of blood hemoglobin, a protein found in the red blood cells that carries oxygen from the lungs to other areas of the body.[67]

oxygenation. The process of supplying oxygen to the blood.[68]

pharynx. The name given to a portion of the passageway connecting the mouth and nose with the esophagus and lungs.[69]

pocketing or pocketed food. "Holding excess food in the mouth instead of chewing and swallowing it."[70]

posttraumatic stress disorder. "A disorder that develops in some people who have experienced a shocking, scary, or dangerous event."[71]

proteinaceous. Of, relating to, containing, resembling, or being protein.[72]

psychotic disorder. A type of mental disorder that causes a person to have irrational views and thoughts.[73]

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[65] VHA Directive 1171.

[66] Merriam-Webster, "oropharynx," accessed September 28, 2020, https://merriam-webster.com/dictionary/oropharynx. Merriam-Webster, "oropharyngeal," accessed December 12, 2020, https://merriam-webster.com/dictionary/oropharyngeal.

[67] MedlinePlus, "blood oxygen level," accessed August 5, 2020, https://medlineplus.gov/lab-tests/blood-oxygen-level/.

[68] Merriam-Webster, "oxygenate," accessed August 5, 2020, https://www.merriam-webster.com/dictionary/oxygenate.

[69] Merriam-Webster, "pharynx," accessed September 28, 2020, https://www.merriam-webster.com/dictionary/pharynx.

[70] American Speech-Language-Hearing Association, "Unsafe Chewing: Choking and Other Risks," accessed September 8, 2020, https://leader.pubs.asha.org/doi/10.1044/leader.ftr1.24112019.42.

[71] National Institute of Mental Health, "post-traumatic stress disorder," accessed August 4, 2020, https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml.

[72] Merriam-Webster, "proteinaceous," accessed September 30, 2020, https://www.merriam-webster.com/dictionary/proteinaceous.

[73] MedlinePlus, "psychotic disorders," accessed August 4, 2020, https://medlineplus.gov/psychoticdisorders.html.

reflexive swallow. An involuntary part of the swallowing process that coordinates the movement of foods and liquids from the mouth to the pharynx and esophagus. Initiation and coordination of these reflexes are essential to swallowing foods and liquids appropriately.[74]

sepsis. "A potentially life-threatening condition caused by the body's response to an infection."[75]

trachea. The tube or passageway that only air and other gases should normally travel to and from the lungs.[76]

triage. A term used to describe the methodology used by Emergency Department staff to "assess patients' severity of injury or illness within a short time after their arrival, assign priorities, and transfer each patient to the appropriate place for treatment."[77]

video laryngoscope. A device with a camera that can be passed through the mouth to see structures in the throat and airway.[78]

[74] Ivan M. Lang, "Brain Stem Control of the Phases of Swallowing," *Dysphagia* 24, (2009): 333-348.

[75] Mayo Clinic, "sepsis," accessed August 4, 2020, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214.

[76] Merriam-Webster, "trachea," accessed September 28, 2020, https://www.merriam-webster.com/dictionary/trachea.

[77] Michael Christ, et al., "Modern Triage in the Emergency Department," *Deutsches Arzteblatt International* 107, no. 50 (2010): 892-898. accessed August 4, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3021905/pdf/Dtsch_Arztebl_Int-107-0892.pdf.

[78] American Cancer Society, "laryngoscopy," accessed September 3, 2020, https://www.cancer.org/treatment/understanding-your-diagnosis/tests/endoscopy/laryngoscopy.html.

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