



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in the
Assessment and Care of a
Patient Seeking Geriatric
Services at the Fayetteville
VA Medical Center in North
Carolina



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of allegations that staff at the Fayetteville VA Medical Center (facility) in North Carolina failed to coordinate appropriate care of a patient seeking [community living center](#) (CLC) placement and [respite care](#), and did not provide medications for the patient while at a community [assisted living facility](#) (ALF).¹ The OIG identified additional concerns relating to the care provided by the facility [psychiatrist](#) to the patient and the coordination of the patient's specialty care.

The OIG did not substantiate that facility staff failed to coordinate placement for a patient seeking CLC care. Facility staff evaluated [consults](#) submitted for the patient's CLC placement in a manner consistent with policy. Between spring 2019 and summer 2020, four CLC consults were placed by [Care in the Community](#) (CITC) staff and [patient aligned care team](#) social workers and disapproved by the facility CLC screening committee because the patient's functional status did not warrant CLC placement. In the fall of 2020, the CLC screening committee approved the patient for a 30-day short stay community nursing home (CNH) placement.²

The OIG substantiated that facility staff failed to coordinate respite services for the patient. The community health nurse supervisor and community health nurse did not properly determine the patient's eligibility for [homemaker and/or home health aide](#) (H/HHA) services. As a result, the patient was not afforded the opportunity to receive H/HHA services until the fall of 2020.

The OIG determined that the community health nurse supervisor and community health nurse did not adequately evaluate the patient for H/HHA services in late 2018 and spring 2019. Community health nurses reported understanding that patients met criteria for H/HHA if they needed nursing home level of care and required assistance with at least two to three [activities of daily living](#), but did not consider the patient's diagnosis of [vascular dementia](#) when determining the patient's eligibility for services, as specified in Veterans Health Administration (VHA) policy.³

In addition, the OIG did not find that an interdisciplinary assessment was completed to determine the patient's eligibility for H/HHA services. The community health nurse and community health

¹ The underlined terms below are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

² Facility Charter, *Community Living Center/Community Nursing Home Screening Committee*, February 25, 2019. The CLC Screening Committee is an interdisciplinary team responsible for the review of CLC consults for CLC or CNH admissions and the decision to approve placement for a patient in a CLC or CNH.

³ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006. "The phrase 'in need of nursing home care' means that an interdisciplinary team has made a clinical judgement that the veteran, would, in the absence of home and community-based care services, need nursing home care."

nurse supervisor told the OIG that an interdisciplinary assessment only occurs if there are questions about a patient. However, this is inconsistent with VHA policy which states H/HHA eligibility is to be determined by an interdisciplinary assessment.⁴

The OIG did not substantiate that facility staff failed to provide medications for the patient while at a community ALF. However, the OIG found that when the patient needed to be seen by a community optometrist to obtain [glaucoma](#) medications, a community care optometry consult was not initiated. While the patient resided in the community ALF, requests for the patient's prescription medications were fulfilled by the patient's primary care provider and the psychiatrist, with the exception of eye drops for glaucoma. Twice, in the fall and winter of 2019, a primary care provider advised the family member through secure messaging that the glaucoma eye drop prescription was not managed by primary care, and that the prescription needed to be written by a community optometrist. The OIG was unable to find documented evidence that a community care optometry consult was placed for the patient.

VHA requires facilities to follow [involuntary commitment](#) (IVC) state law.⁵ Under North Carolina law, no individual shall be involuntarily committed to a 24-hour facility unless that individual is mentally ill or a substance abuser and dangerous to self or others.⁶ During the course of the review, the OIG identified that the psychiatrist used the IVC process in a manner that was inconsistent with the state's established parameters during the patient's spring 2019 appointment.⁷ The psychiatrist told the OIG that the family member reported that the patient needed to be hospitalized for medication management and changes in behavior, and agreed to assist the family member with the patient's hospitalization. However, the psychiatrist indicated that a "[behavioral health](#) admission was not necessarily warranted" and believed that the patient would not harm the family member, spouse, or themselves.

The OIG found that the psychiatrist reported being concerned about the patient's [decision-making capacity](#), but failed to adequately assess and document the patient's capacity to make informed decisions and to determine whether the patient had a [healthcare agent](#) who was authorized to make medical decisions. The psychiatrist reported not having assessed the patient's [cognition](#) at the spring 2019 appointment but believed "an assessment of [the patient's] cognition should have been done." The psychiatrist reported a practice of asking questions to assess patients' understanding of their psychiatric condition and treatment including consequences of consenting to or refusing treatment; however, did not generally document a patient's decision-making capacity. The OIG found that the patient had executed a [Health Care Power of Attorney](#)

⁴ VHA Handbook 1140.6.

⁵ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013; North Carolina General Statutes, Ch. 122C, Article 5 (2019).

⁶ North Carolina General Statutes, Ch. 122C, Article 5 (2019).

⁷ Facility policy 116-1, *Commitment Procedures for Psychiatric Patients Under Involuntary Commitment*, January 24, 2019.

and designated the patient's spouse as the healthcare agent and the family member who would take the responsibility if the spouse was unable to fulfill the duties.⁸ The psychiatrist was unable to remember if the patient's spouse was present at the spring 2019 appointment and was unsure whether the patient's spouse was the Health Care Power of Attorney.

The psychiatrist ultimately advised the patient that an emergency department visit was necessary to assess whether the current medications were appropriately prescribed, but did not discuss the necessity of a behavioral health admission with the patient because the psychiatrist did not believe the patient would agree to hospitalization. The psychiatrist subsequently initiated IVC based on pressure from the family.

The OIG determined that the patient's primary care providers and psychiatrist missed an opportunity to coordinate specialty care needs for the patient. One primary care provider did not order a [geriatrics](#) consult; a second primary care provider did not enter a geriatrics, [neurology](#), or optometry consult; and the psychiatrist did not enter a geriatrics, neurology, or [neuropsychological testing](#) consult.

The primary care providers, respectively, told the OIG of having "probably" offered the patient a geriatric consult, and having had a discussion with the family or recommending a referral for the patient's dementia, and usually offering patients CIRC for eye specialist care as needed; however, the OIG could not find documented evidence that the primary care providers placed neurology, geriatrics, or optometry consults. The psychiatrist reported that in 2018, geriatrics and neurology services were available at the facility but not at the Wilmington Health Care Center. The psychiatrist also reported that as a board certified geriatric psychiatrist it was within their scope of practice to treat the patient's dementia without a specialty referral. The OIG found that the psychiatrist acknowledged the patient's impairments due to the major neurocognitive disorder, and documented providing minimal supportive psychotherapy and a plan to place a community care consult for neuropsychological testing; however, there was no documented evidence that the psychiatrist entered community care consults for neuropsychological testing, geriatrics, or neurology. These missed opportunities denied the patient the chance to be evaluated and possibly receive needed or additional treatment and care by specialty providers.

The OIG made seven recommendations to the Facility Director related to evaluation and interdisciplinary assessment of H/HHA referrals, staff training on the eligibility criteria for H/HHA services, a review of the psychiatrist's use of IVC, assessment and documentation of patient decision-making capacity, identification of healthcare agents, and initiation of specialty care consults.

⁸ The OIG recognizes that there may be limitations on the authority of surrogates to make decisions regarding mental health treatment.

Comments

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



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Abbreviations

ADL	activities of daily living
ALF	assisted living facility
CLC	community living center
CITC	Care in the Community
CNH	community nursing home
EHR	electronic health record
GEC	Geriatrics and Extended Care
H/HHA	homemaker and/or home health aide
IVC	involuntary commitment
LTC	long-term care
OIG	Office of Inspector General
PACT	patient aligned care team
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of allegations that staff at the Fayetteville VA Medical Center (facility) in North Carolina failed to coordinate appropriate care of a patient seeking [community living center](#) (CLC) placement and [respite care](#), and did not provide medications for the patient while at a community [assisted living facility](#) (ALF).¹ The OIG identified additional concerns relating to the care provided by the facility [psychiatrist](#) to a patient and the coordination of specialty care.

Background

The facility is part of Veterans Integrated Service Network (VISN) 6, has six community-based outpatient clinics in the surrounding North Carolina area (Brunswick, Goldsboro, Hamlet, Jacksonville, Robeson County, and Sanford); two health care centers (located in Fayetteville and Wilmington); and an urgent care center located in Fayetteville, North Carolina. The Wilmington Health Care Center (WHCC) is an outpatient clinic that offers health care services to patients in the Wilmington and Brunswick catchment areas. The facility is a general medicine, surgery, and mental health facility, and provides primary care and limited pharmacy services. The Veterans Health Administration (VHA) classified the facility as a Level 1c complexity.²

Dementia

Dementia is a progressive condition defined as the chronic, acquired loss of [cognition](#), which impacts social and occupational functioning.³ Symptoms of dementia may include memory loss, decline in the ability to communicate, depressive symptoms, lack of insight, and gait impairment leading to falls. In addition, patients with dementia may display disinhibited, aggressive behavior and loss of impulse control. Clinicians diagnose dementia by taking a medical history from the patient and family members and conducting cognitive, [neurologic](#), and laboratory tests. When the diagnosis is unclear, [neuropsychological testing](#) may be helpful. Medication and non-pharmacologic treatments such as social interaction, cognitively stimulating activities, exercise, and sleep, focus on delay of cognitive decline and relief of symptoms. Caregiving of patients with dementia is stressful; education and support of family members is important, and may be associated with better outcomes for dementia patients who suffer from aggressive behavior.

¹ The underlined terms below are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

² VHA Office of Productivity, Efficiency and Staffing, “Facility Complexity Level Model Fact Sheet,” December 15, 2017. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

³ VHA Directive 1140.12, *Dementia System of Care*, October 24, 2019.

VHA's Dementia System of Care is an integrated service delivery network that provides primary and specialty care and promotes access to needed services to help patients with dementia and their caregivers maintain a positive and optimal quality of life.⁴

Geriatrics and Extended Care (GEC) Services

VHA, through Geriatrics and Extended Care (GEC) services, provides eligible patients an array of inpatient and outpatient services including [extended care](#); respite care, which includes [adult day health care](#); and [homemaker and/or home health aide \(H/HHA\) services](#); [geriatric evaluation](#); [hospice](#); and [palliative care](#).⁵ The GEC programs strive to ease the burden on elderly patients with chronic illness, and their family members or caregivers. The overall goal is to maximize each patient's functional independence by providing a continuum of comfort-oriented and supportive services in the home, community, inpatient, or outpatient settings.

Prior OIG Reports

Within the previous three years, the OIG published one report pertaining to the facility involving a similar topic in 2020.⁶ The report included one recommendation relating to community care [consults](#). As of April 14, 2021, this recommendation remains open and is pending follow-up action from the Fayetteville VA Medical Center.

Allegations and Related Concerns

On September 16, 2020, the OIG received a complaint alleging that the facility failed to coordinate appropriate care for a patient seeking CLC placement and respite care and provide medications for the patient while at a community ALF. The OIG identified additional concerns related to the medical practice of a [psychiatrist](#) and care coordination for the patient by primary care providers and the psychiatrist.

Scope and Methodology

The OIG initiated the healthcare inspection on November 2, 2020, and conducted a virtual site visit from December 14–17, 2020.

The OIG reviewed the patient's electronic health record (EHR) and non-VA medical records from October 2013 through February 2021, and documents relating to the referral and admission processes for GEC services and [involuntary commitment](#) (IVC). In addition, the OIG team

⁴ VHA Directive 1140.12.

⁵ VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016; VHA Handbook 1140.02, *Respite Care*, November 10, 2008.

⁶ VA OIG, *Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina*, Report No. 19-08256-124, May 19, 2020.

reviewed VHA and facility policies related to primary care, mental health, community care, and outpatient pharmacy services.

The OIG interviewed the complainant; the facility's Chiefs of Staff, Primary Care, Psychiatry, and GEC; the CLC Medical Director; relevant providers and clinical staff; and members of the CLC and Community Nursing Home (CNH) Screening Committee (CLC Screening Committee).⁷

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, §7, 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 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.

Patient Case Summary

The patient was in their 80's with a medical history of [hypertension](#), [coronary artery disease](#), [peripheral artery disease](#), [posttraumatic stress disorder](#), and depression, and received primary and mental health care from the facility.⁸ In fall 2013, the patient established care with the psychiatrist at the WHCC for management of posttraumatic stress disorder and depression. In summer 2015, after the patient reported concerns about memory and a family member reported concerns about the patient's disruptive behavior, the psychiatrist referred the patient for neuropsychological testing and adjusted the patient's [antidepressant](#) medication. An initial neuropsychological evaluation, completed a month later, yielded a diagnosis of [vascular dementia](#). In fall 2015, the psychiatrist prescribed [donepezil](#) to improve the patient's cognition. A facility [psychologist](#) completed a neuropsychological reevaluation in early 2017, confirmed the diagnosis of vascular dementia, and reported that the patient's cognition was stable.

A year later, in early 2018, a primary care provider (primary care provider 1) referred the patient for a [computed tomography scan](#) of the head after the patient reported headaches. The computed tomography scan showed brain [atrophy](#) and a prior [stroke](#), and primary care provider 1 ordered a consult for the facility neurology service to evaluate the patient's headaches. The neurology consult was not scheduled as the patient's family member told the scheduler of being unable to transport the patient to the facility and planning to contact primary care provider 1 for a

⁷ Facility Charter, *Community Living Center/Community Nursing Home Screening Committee*, February 25, 2019. The CLC Screening Committee is an interdisciplinary team responsible for the review of CLC consults for CLC or CNH admissions and the decision to approve placement for a patient in a CLC or CNH.

⁸ The OIG uses the singular form of they (their) in this instance for privacy purposes.

[community care](#) consult. There was no documented evidence in the EHR that the family member requested a community care neurology consult from primary care provider 1. At an appointment with the psychiatrist in the spring of 2018, the family member reported the patient's headaches had resolved. Also during that appointment the family member expressed a desire that the patient be referred to a "[geriatric](#) specific neurologist in the community" but did not have the name of the specialist; there is no documented evidence in the EHR that the psychiatrist ordered a geriatrics or neurology consult.

The following month, the family member reported that the patient's spouse would be undergoing surgery and would not be able to care for the patient. The psychiatrist submitted a consult for home respite care, noting that the patient had a diagnosis of vascular dementia, "poor safety awareness," and required supervision of medications. A facility community health nurse documented a functional assessment of the patient based on information obtained from the family member and concluded that the patient did not meet criteria for respite care because the family member said that the patient was "able to bathe and dress" themselves, and canceled the respite care consult.

Two weeks later, at a scheduled appointment with the psychiatrist, the family member reported the patient had become "more demanding and argumentative" and was concerned that the patient might have been taking medication inappropriately. The patient was at first reluctant, but on the recommendation of the psychiatrist, agreed to hospitalization and having the family member drive them to a community emergency department for evaluation. The patient was voluntarily admitted to a [community hospital behavioral health](#) unit for 10 days. Several days later, the patient was readmitted under an IVC to a community hospital behavioral health unit for three days after making statements of suicidal thoughts. The community hospital psychiatrist determined that the patient was not suicidal but was distressed over family conflicts.

A month later, the patient was seen by a new primary care provider (primary care provider 2) and another facility psychiatrist (supervisory psychiatrist).⁹ The supervisory psychiatrist reviewed the patient's medications and referred the patient to speech pathology for evaluation of dementia. The following month, a facility Speech Language Pathologist conducted a cognitive evaluation due to the patient's decline in memory. The evaluation, which included cognitive tests, concluded that the patient performed at the "low average" range for immediate memory, language, and attention recall, and "impaired" range for delayed memory recall. Primary care provider 2 documented that the family member "may want [the patient] to see neurology" for dementia but there is no evidence in the EHR that primary care provider 2 ordered a referral to neurology.

⁹ The supervisory psychiatrist was the Chief of Psychiatry and the psychiatrist's supervisor at the time of the inspection.

In late 2018, the family member contacted the psychiatrist and reported that the patient had been taking medications inappropriately and was agitated and verbally abusive. The family member requested the patient be admitted to the facility for “out of control behavior.” The psychiatrist advised the family member of their options which included bringing the patient to the facility’s urgent care to be evaluated for admission or petitioning for IVC. The psychiatrist tasked a mental health nurse with explaining the IVC process to the family member. The following day, a facility mental health nurse documented providing the IVC information to the family member in a [secure message](#). There is no evidence in the EHR that the patient was admitted to any hospital or that the family member initiated a petition for IVC at that time.

Later that month, the family member contacted a [patient aligned care team](#) (PACT) social worker and reported that the patient was verbally and physically aggressive and needed support with daily activities. The PACT social worker placed a consult for respite care, citing “caregiver distress,” and a consult for H/HHA for assistance with [activities of daily living](#) (ADLs). The community health nurse responded to these consults by speaking to the patient’s spouse by phone and completing a templated EHR note. The community health nurse informed the patient’s spouse that because the patient needed assistance with dressing and bathing, the patient did not qualify for services. In addition, the community health nurse informed the patient’s spouse that a home health agency would not accept a referral if the patient was “verbally and physically aggressive.” The community health nurse discontinued both consults noting that the “Veteran does not meet eligibility requirements” and suggested [adult day healthcare](#) be considered by the PACT social worker.

During the same month, primary care provider 2 met with the patient and documented that both the posttraumatic stress disorder and dementia were “stable.” In early 2019, during a patient appointment with the psychiatrist, the family member reported that the patient had “calmed down” compared to the previous month, acknowledged that the patient did not qualify for H/HHA and respite care services, and reported hiring a housekeeper.

In spring 2019, the family member contacted the psychiatrist and primary care provider 2 through secure messaging requesting respite care, and reported that the patient (1) could not be left alone, (2) needed assistance with managing medications, and (3) had set the kitchen on fire. A PACT nurse ordered a consult for H/HHA. The community health nurse supervisor discontinued the consult and recommended that the patient be evaluated for medical and mental stability as the EHR described the patient to be physically abusive, raising concern that it may be unsafe for staff who provide home care to enter the home. The psychiatrist advised the family member via secure messaging that hospitalization may be necessary, and that the family member or the patient’s spouse could pursue IVC. At the time of that secure message communication, the patient had an upcoming appointment scheduled with the psychiatrist in eight days, and the psychiatrist advised the family member to contact a WHCC mental health nurse for assistance with the IVC process.

During the scheduled spring 2019 outpatient psychiatric clinic appointment, the psychiatrist initiated a petition for IVC. The psychiatrist documented that the patient had “significantly impaired judgement and decision-making” and was “unsafe at home.” The patient was transported to a community hospital emergency department by the sheriff’s office where a community physician completed a commitment exam and the patient was admitted.¹⁰ During this hospitalization, the [Care in the Community](#) (CITC) social worker submitted three consults for CLC placement.¹¹ All three consults were denied due to the patient not meeting criteria for skilled rehabilitation or [long-term care](#) (LTC), and noted the patient required assisted living level of care. A facility PACT social work supervisor attended an interdisciplinary meeting at the community hospital, where the team acknowledged that the patient was not dependent with ADLs, and determined that the patient could be discharged to an ALF or home with 24-hour supervision. The family member was invited and encouraged to attend the meeting but did not. The patient had a prolonged hospitalization due to needing placement at discharge. After three months, the patient was discharged to a community ALF. Discharge medications were filled by the facility pharmacy.

Over the next year, the patient continued to reside in the community ALF. Requests for the patient’s prescription medications were fulfilled by primary care provider 2 and the psychiatrist, with the exception of eye drops for [glaucoma](#). Primary care provider 2 advised that the eye drops would need to be prescribed by an eye doctor. While the family member desired that the patient be placed in a LTC facility, community ALF staff reported that assisted living level of care was appropriate for the patient. In spring 2020, a family and treatment team conference was scheduled by the facility to develop a plan of care; however the family member left a voicemail requesting to cancel the conference. In summer 2020, the PACT social work supervisor entered a consult requesting CLC or CNH placement. The CLC Medical Director disapproved the consult because the patient did not meet eligibility for nursing home level of care. The CLC Medical Director recommended ALF, [Medical Foster Home](#), or H/HHA care for the patient. The CLC Medical Director spoke to the family member a month later to explain eligibility criteria for nursing home level of care and discussed the procedure for the patient to be reevaluated by the CLC screening committee.

That month, the family member brought the patient to a community physician for an examination. The community physician documented that the patient was dependent in multiple ADL’s and was unable to stand without assistance. Medical records from that visit were submitted to the CLC screening committee in support of a CLC consult ordered by primary care provider 2 in fall 2020. One day later, the CLC screening committee approved the consult for the

¹⁰ The OIG did not review the community hospital documentation related to the patient’s IVC during the community hospitalization.

¹¹ The CITC social worker’s title is Non-VA Community Care social worker. The OIG uses CITC, community care, and Non-VA Community Care synonymously within the context of this report.

patient to receive 30 days of care in a CNH. Due to [coronavirus disease \(COVID-19\)](#), the facility CLC was not accepting admissions, and the CLC Medical Director instructed the social worker to place the patient in a CNH. The process to find placement was protracted, as two nursing homes decided not to renew their contracts with the VA, one nursing home did not have an available bed, another determined the patient was not a “good fit” for their facility due to the patient’s behavior, and another was not accepting admissions due to an outbreak of COVID-19.

One month later, while awaiting nursing home placement, the patient was discharged from the ALF and returned home. Due to concerns about the patient’s safety, a PACT social worker submitted a report to adult protective services. In addition, the PACT social worker placed consults for H/HHA and respite care services, which were approved. A month after returning home, the patient was admitted to a community hospital following a fall and then discharged to a CNH for rehabilitation. Facility staff approved a consult, submitted by a GEC nurse, for the patient to receive long-term care in winter 2020. The patient died two months later at a community hospital after being admitted with a diagnosis of COVID-19 [pneumonia](#).

Inspection Results

1. Assessment of the Patient Seeking CLC Placement and Home Health Care Services

CLC Consults

The OIG did not substantiate that facility staff failed to coordinate appropriate care for a patient seeking CLC placement. Facility staff reviewed and dispositioned [consults](#) submitted for the patient’s CLC placement in a manner consistent with policy.

VHA policy states that veterans “are eligible to receive care in VA CLCs if they meet the current nursing home eligibility criteria, and if it is determined the veteran is in need of the level of care and services available in a particular VA CLC.” VHA outlines several factors to be assessed when determining a patient’s need for CLC care:

- Medical, nursing, and therapy needs
- Level of functional impairment
- Cognitive status
- Rehabilitation needs
- Special emphasis care needs (such as spinal cord injury, polytrauma, or end-of-life care)¹²

¹² VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

Facility policy states that the CLC screening committee will review all consults requesting CLC admission and the CLC Medical Director, after collaborating with the designated CLC Nurse Leader, makes the ultimate decision on CLC admission.¹³ Actions by the facility’s CLC screening committee are to be documented in the EHR after review of a CLC consult and supporting documentation.¹⁴ Both VHA and facility policy require that when the approved services are not available within VA, the care may be provided in the community.¹⁵

The OIG reviewed the patient’s EHR and found that between spring 2019 and fall 2020, CITC and PACT social workers submitted six consults for evaluation of the patient for CLC placement (see table 1).

Table 1. CLC Consult Evaluations

Consults Between Spring 2019 – Fall 2020	Reason for Request	Consult Disposition	CLC Screening Committee Comments
1	Short-term rehabilitation	Disapproved	Too high functioning for skilled rehabilitation. Requires ALF placement
2	Short-term rehabilitation	Disapproved	Does not meet the criteria for LTC
3	Long-term rehabilitation	Disapproved	Does not meet the criteria for LTC
4	CLC or CNH placement	Disapproved	Not eligible for nursing home level of care. ALF, Medical Foster Home, or H/HHA recommended
5	LTC placement	Approved	30-day short stay in CNH to determine LTC eligibility
6	LTC placement	Approved	30-day short-term rehabilitation in a CNH

Source: OIG review of documentation related to CLC consult evaluations of a patient.

The CITC social worker ordered the first three consult requests while the patient was in a community hospital. The CITC social worker uploaded documentation into the EHR with information about the patient’s clinical diagnosis and needs, and functional status received from a community hospital social worker, for the CLC screening committee to review. The CLC Medical Director or a CLC screening committee chairperson entered a CLC consult note in the

¹³ Facility Policy 11-43, *Community Living Center – Policies and Procedures*, May 9, 2017; Facility Policy 00-134, *Community Living Center/Community Nursing Home Screening Committee*, August 14, 2017.

¹⁴ Facility Charter, *Community Living Center/Community Nursing Home Screening Committee*, February 25, 2019. The CLC Screening Committee is an interdisciplinary team responsible for the review of CLC consults for CLC or CNH admissions and the decision to approve placement for a patient in a CLC or CNH.

¹⁵ Facility Policy 00-134; VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012.

EHR for each request and documented that the patient was disapproved for CLC placement and did not meet LTC criteria or was not eligible for nursing home care.

The PACT social work supervisor attended an interdisciplinary care team meeting at the community hospital in spring 2019 and documented in an Administrative Note in the EHR that the community hospital team determined that the patient (1) was not dependent in ADLs, (2) was not observed to be agitated or aggressive, and (3) would be best served in an ALF or at home with 24-hour supervision and monitoring. The PACT social work supervisor also documented that the community hospital team stated the patient had been maintained on an IVC due to concerns that the patient would leave the unit when not supervised by a sitter.

In summer 2020, after receiving a request from the family member for the patient to be evaluated for CLC placement, the PACT social work supervisor submitted a consult. The consult was disapproved because the patient did not meet criteria for CLC placement and the CLC Medical Director documented having recommended an ALF, Medical Foster Home or H/HHA for the patient in the June 2020 Consult Note. A month later, the CLC Medical Director documented having spoken with the family member and explained the CLC placement disapproval decision by the CLC screening committee. During the call, the family member alleged that the ALF director reported the patient's functional status incorrectly and requested that the CLC screening committee re-evaluate the patient for CLC placement. The CLC Medical Director documented having explained to the family member that any further assessments of the patient's functional status should be submitted to a PACT social worker for additional CLC placement consideration.

The family member arranged for a community physician's medical assessment, which was completed that same month, and sent the assessment to the PACT social work supervisor in fall 2020. The PACT social work supervisor submitted a CLC LTC consult later that month and uploaded the community physician's medical assessment in the EHR, which indicated that the patient was incontinent and needed ADL assistance. The following day, the CLC screening committee reviewed the consult and approved the patient for a 30-day short stay CNH placement. A PACT social worker told the OIG of having difficulty finding placement because of restricted CNH admissions due to COVID-19.¹⁶ In fall 2020, while awaiting nursing home placement, the ALF discharged the patient and the patient returned home. Eventually the patient was placed in a CNH a month after having returned home.

The OIG concluded that the CLC screening committee received, reviewed, and dispositioned consults in accordance with VHA and facility policy. The CLC screening committee determined that the patient's level of functional status did not warrant CLC placement until fall 2020, at which time the patient was approved for a 30-day short stay CNH placement.

¹⁶ VHA Operational Memorandum, *Coronavirus (COVID-19) Community Living Centers*, March 17, 2020. In response to the COVID-19 pandemic, VHA CLC's limited admissions to patients already admitted to a VHA medical facility and temporarily paused admissions from outpatient or non-VA settings.

Respite Care and H/HHA Consults

The OIG substantiated that facility staff failed to coordinate respite services for the patient. The community health nurse supervisor and community health nurse did not properly determine the patient's eligibility for H/HHA services.

VHA policy states that respite care is provided to eligible patients who have a diagnosed chronic disabling illness or condition, live at home and require substantial assistance with ADLs in order to continue to reside safely in the home, have a caregiver in need of temporary or intermittent relief from daily care tasks, meet eligibility and clinical criteria for nursing home and long-term care, are dependent in three or more ADLs or have significant cognitive impairment, and have two or more of the following conditions

- Is dependent in three or more [Instrumental Activities of Daily Living](#)
- Was recently discharged from a nursing home
- Is 75 years or older
- Has had three or more hospitalizations or has utilized outpatient clinics or had emergency evaluations 12 or more times in the past year
- Is clinically depressed¹⁷

VHA policy states that patients are eligible for H/HHA services if they are in need of nursing home care.¹⁸ “The following criteria identify the target population of eligible veterans who are in most need of H/HHA services as an alternative to nursing home care: (1) through an interdisciplinary assessment, the veteran has been determined to have the following clinical conditions: (a) three or more ADL dependencies, or (b) significant cognitive impairment, or (c) require H/HHA services as adjunct care to hospice services, or (d) two ADL dependencies, and two or more of the following conditions:

1. Has dependency in three or more Instrumental ADLs;
2. Has been recently discharged from a nursing facility, or has an upcoming nurse home discharge plan contingent on receipt of home and community-based care services;
3. Is 75 years, or older;

¹⁷ VHA Handbook 1140.02.

¹⁸ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006. “The phrase ‘in need of nursing home care’ means that an interdisciplinary team has made a clinical judgement that the veteran, would, in the absence of home and community-based care services, need nursing home care.”

4. Has had high use of medical services defined as three or more hospitalizations in the past year or has utilized outpatient clinics or emergency evaluation units 12 or more times in the past year;
5. Has been diagnosed with clinical depression;
6. Lives alone in the community.”¹⁹

The OIG reviewed the patient’s EHR and found that between spring 2018 and fall 2020, the psychiatrist and PACT members submitted six consults for evaluation of the patient for respite care or H/HHA (see table 2).

Table 2. Respite Care and H/HHA Consult Evaluations

Consults Between Spring 2018 – Fall 2020	Type of Consult	Reason for Request	Consult Disposition	Comments by Community Health Nurse
1	Respite care	Assistance needed to care for the patient; spouse undergoing surgery	Canceled	Does not meet criteria
2	H/HHA	Assistance needed with bathing, toileting, and dressing	Discontinued	Does not meet eligibility requirements
3	Respite care	Spouse/family member unable to care for patient	Discontinued	Does not meet criteria
4	H/HHA	Patient’s vascular dementia affecting ADLs	Discontinued	Reconsult after medical and mental health stability is evaluated
5	H/HHA	Assistance needed with ADLs and Instrumental ADLs	Approved	Scheduled 16 hours per week
6	Respite care	Assistance needed with ADLs and Instrumental ADLs	Approved	Scheduled 6 hours per day

Source: OIG review of documentation related to Respite Care and H/HHA consult evaluations of a patient.

In an interview with the OIG, a community health nurse described using the same steps for processing respite care and H/HHA consults, which included contacting a patient, patient’s family member, or caregiver for information on the patient’s functional status, completing a functional assessment of the patient and documenting the assessment in the EHR, and entering

¹⁹ VHA Handbook 1140.6.

the eligibility decision in the consult.²⁰ The OIG reviewed the facility's Home Health Aide and Home Respite Consult Process and Daily Procedures and did not find that the document included information on determining a patient's eligibility for respite care or H/HHA, or assessing a patient's functional status.²¹

The OIG reviewed the respite care consults from spring 2018 and fall 2020 and determined that the community health nurse and community health nurse supervisor evaluated the consults and determined that the patient's level of functional status did not warrant respite care until fall 2020, at which time the patient was approved for up to 16 hours of respite care per day.

The community health nurse reported understanding that patients met criteria for H/HHA if they needed nursing home level of care and required assistance with at least two to three ADLs, but indicated making an eligibility determination based on whether a patient was able to bathe and feed themselves. The community health nurse did not indicate cognitive impairment was a criteria for determining eligibility, as specified in VHA policy.

The OIG found that in winter 2018, the community health nurse completed an H/HHA consult and H/HHA assessment and noted that the patient was independent with bathing, dressing, and ambulating short distances, and needed assistance for toileting, hygiene, and feeding, and safe chair and bed transfers. There was no documented evidence in either the H/HHA assessment or the completed consult that the community health nurse factored the patient's vascular dementia, a cognitive impairment criterion, into the determination of eligibility.

Additionally, the community health nurse did not document a score for the patient's ADL needs or complete the additional areas of dependency for the patient on the H/HHA assessment.²² When a patient has additional dependencies, they are eligible to receive increased hours of care.

Consistent with VHA GEC guidance for determination of H/HHA services for eligible patients, the community health nurse reported a practice of calculating a total score of ADL dependence and considering other dependency areas only when a patient qualified for H/HHA services.²³ The OIG calculated the total for ADL dependence on the H/HHA assessment to equal 72, which would have qualified the patient to receive up to six hours of H/HHA services per week.

²⁰ The H/HHA assessment includes functional ability categories ranging from independence to total dependence with corresponding scores and is used to determine a patient's level of ADL dependency. The total of each scored ADL category and other dependency considerations determines the number of H/HHA hours the patient is eligible to receive.

²¹ Facility Guideline, *Home Health Aide and Home Respite Consult Process and Daily Procedures*, October 22, 2019.

²² Additional areas of dependency include: debilitating disease including progressive neurological disorders, recent discharge from a nursing home or residing in a nursing home and desires to return home, advanced age, chronic medical conditions, cognitive impairment, caregiver availability, legal blindness, under hospice care, uses oxygen, history of a fall, and frequent use of medical services including hospitalizations, emergency department and outpatient visits.

²³ VHA Office of Geriatrics and Extended Care PowerPoint, *Use of VHA Case Mix Tool*, September 21, 2017.

However, the community health nurse documented that the patient did not meet eligibility requirements because the patient was independent in bathing and dressing and discontinued the December 2018 H/HHA consult. The community health nurse also documented that the patient's spouse reported the patient had verbal and physical aggression, and explained to the spouse that a home health agency would not accept the patient because of the reported aggression.

In spring 2019, after a PACT nurse entered a consult for H/HHA services, the community health nurse supervisor discontinued the consult and documented in the EHR that the patient was physically abusive and unsafe. The community health nurse supervisor requested that another consult be placed after the completion of an evaluation of the patient's medical and mental stability determining that staff who provide home care could safely enter the patient's home. The OIG was unable to find documentation that hostile behavior is considered an exclusionary criteria for H/HHA services under VHA policy.²⁴

During an interview with the OIG, the community health supervisor stated that patients need to have a deficiency in three ADLs to be eligible for H/HHA services. When asked how having a significant cognitive impairment would be considered when determining eligibility, the supervisor stated that it would be one of several dependency considerations when determining a total score from the H/HHA assessment but did not indicate that having a significant impairment was considered when determining a patient's eligibility for H/HHA services.

The OIG did not find documented evidence of any interdisciplinary assessments of the patient to determine the patient's eligibility for H/HHA services. The community health nurse and community health nurse supervisor told the OIG that an interdisciplinary assessment only occurs if there are questions about a patient. However, this is inconsistent with VHA policy, which states H/HHA eligibility is determined by an interdisciplinary assessment.²⁵

In fall 2020, the patient was found to meet the criteria for H/HHA, and the community health nurse approved a consult for the patient to receive 16 hours of H/HHA services per day.

The OIG determined that the community health nurse supervisor and community health nurse did not adequately evaluate the patient for H/HHA services in winter 2018 and spring 2019. The nurses did not consider the patient's diagnosis of vascular dementia when determining the patient's eligibility for services. In addition, the OIG did not find that an interdisciplinary assessment was completed to determine the patient's eligibility for H/HHA services. As a result, the patient was not afforded the opportunity to receive H/HHA services until fall 2020.

²⁴ VHA Handbook 1140.6.

²⁵ VHA Handbook 1140.6.

2. Medication Management of the Patient

The OIG did not substantiate that facility staff failed to provide medications for the patient while at a community ALF. However, the OIG found that when the patient needed to be seen by a community optometrist to obtain glaucoma medications, primary care provider 2 did not initiate a community care optometry consult for the patient.

VHA policy states that patients who are admitted to a community facility, or obtaining non-VA treatment in the community that VHA is not providing payment for, are eligible to receive medications prescribed by a non-VA provider from a VA pharmacy.²⁶ While VA providers are responsible for managing VA care and services for a patient receiving [dual care](#), they are not required to follow the treatment plans or medication recommendations by a non-VA provider. If a VA provider decides to not prescribe a recommended medication, they must communicate to the patient and document the rationale for the decision in the EHR.²⁷ Facility policy requires “knowledgeable concurrence and appropriate VA follow up” by a provider when prescribing medications started by a non-VA provider.²⁸

The patient was discharged from a community hospital in summer 2019 and admitted to a community ALF, then transferred to another community ALF for continued care in winter 2019. The OIG reviewed the patient’s prescribed medications between summer 2019 and fall 2020 and found that prescriptions requested were appropriately ordered, renewed, and dispensed. During interviews with the OIG, both primary care provider 2 and the psychiatrist stated that they did not recall declining any medication refill requests for the patient.

The family member told the OIG that the psychiatrist declined to fill the patient’s [quetiapine](#) order. The OIG reviewed the EHR and found that in summer 2019, community ALF staff contacted a WHCC PACT nurse and reported that the patient was exhibiting aggression and requested a dose increase of quetiapine or the addition of another medication for the aggression. A few days later, the family member made the same request to the facility psychiatrist through a secure message. In response, the psychiatrist informed the family member that the community ALF nurse had been contacted and confirmed that the patient had only one incident of aggression, which was likely due to the patient adjusting to the new environment. The psychiatrist documented having told the ALF nurse of wanting to keep the medications unchanged at the time, ordered the quetiapine, and the VHA pharmacy filled the prescription.

The family member told the OIG that the patient’s eye drops for glaucoma were not refilled and the patient was without this medication for one year. During an interview with the OIG, primary care provider 2 stated that prescribing medications for glaucoma would be outside the

²⁶ VHA Handbook 1108.05, *Outpatient Pharmacy Services*, June 16, 2016.

²⁷ VHA Directive 2009-038, *VHA National Dual Care Policy*, August 25, 2009.

²⁸ Facility Memorandum No. 119-19, *Pharmacy Operations*, October 10, 2017.

physician's scope of practice and instead, would generally offer patients optometry or ophthalmology community care consults for specialty prescriptions. The OIG noted that a one-time, 30-day supply of eye drops for glaucoma was dispensed by the facility pharmacy in summer 2019 when the patient was discharged from a community hospital and admitted to a community ALF.

That same month, a CITC provider placed a community care optometry consult and the patient was approved for CITC. The patient was scheduled for an appointment with the community optometrist in fall 2019; however, the patient did not show up to the appointment. In winter 2019, the family member was advised through secure messaging that the glaucoma eye drop prescription was not managed by primary care, and that the prescription needed to be written by a community optometrist. The OIG was unable to find documented evidence that primary care provider 2 placed a community care optometry consult for the patient.

3. Improper Care Provided by the Psychiatrist

Use of IVC for the Patient

During the course of the review, the OIG identified that the psychiatrist used the IVC process in a manner that was inconsistent with the state's established parameters during the patient's spring 2019 appointment.

VHA and the facility require that patients are provided with the most effective treatment in the least restrictive environment.²⁹ VHA requires facilities to follow IVC state law.³⁰ Under North Carolina law, no individual shall be involuntarily committed to a 24-hour facility unless that individual is mentally ill or a substance abuser and dangerous to self or others. North Carolina law also states that anyone who has knowledge of an individual who has a mental health illness and is either dangerous to self or dangerous to others, or in need of treatment to prevent further disability or deterioration, may petition the court to issue a custody order for the individual to have a mental health examination by a [commitment examiner](#).³¹

Facility policy requires that "when the next of kin is present or readily available and has firsthand knowledge of the Veteran's action or intent to harm himself/herself or others, they will be encouraged to file a Petition for Commitment at the county magistrate's office."³²

During the spring 2019 appointment, the psychiatrist completed and signed an affidavit for IVC for a behavioral health admission indicating that the patient was "mentally ill and dangerous to

²⁹ VHA Handbook 1160.06.

³⁰ VHA Handbook 1160.06; North Carolina General Statutes, Ch. 122C, Article 5 (2019).

³¹ North Carolina General Statutes, Ch. 122C, Article 5 (2019).

³² Facility policy 116-1, *Commitment Procedures for Psychiatric Patients Under Involuntary Commitment*, January 24, 2019.

self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.”

The psychiatrist told the OIG that the family member reported that the patient needed to be hospitalized for medication management and changes in behavior, and agreed to assist the family member with the patient’s hospitalization. However, the psychiatrist did not think that a “behavioral health admission was necessarily warranted” and believed that the patient would not harm the family member, spouse, or themselves. During an interview with the OIG, the psychiatrist reported knowing that the family member and the patient did not get along, and that “it [hospitalization] would give everyone a brief respite;” but realized “[I] should not have assented to [the family member’s] demands that [the patient] be hospitalized when medically...[the patient] probably didn’t need to be.”

The psychiatrist reported having received secure messages from the family member, which were demanding and insistent, and that the family member reported intent to take concerns to others above the psychiatrist.

The OIG reviewed the EHR and found several instances from fall 2016 through spring 2019 when the family member made calls or sent secure messages to WHCC clinic staff to report the patient’s uncontrolled and abusive behavior and request that the psychiatrist assess the patient’s [competency](#) and functional status. The family member also requested hospitalization for the patient. On two occasions the psychiatrist requested that a facility mental health nurse educate the family member on steps to seek emergency assistance or have the patient hospitalized involuntarily. A facility mental health nurse documented providing IVC information to the family member on both occasions. The family member often requested immediate attention by facility staff on requests and contacted the psychiatrist’s supervisor to request follow up on a matter discussed with the psychiatrist.

The supervisory psychiatrist reported to the OIG of having a discussion with the psychiatrist and that the psychiatrist felt pressured by the family member. The supervisory psychiatrist reported having reviewed the EHR and did not find documentation that supported the psychiatrist having been pressured by the family member. Rather, the supervisor described the EHR documentation as similar to other cases in which family members report feeling overwhelmed and request admission for patients, and wondered whether a voluntary admission had been considered. The supervisor also stated that “decisions as a psychiatrist would not be based solely on the pressure.”

The psychiatrist told the OIG of having felt pressure from the family member to pursue the patient’s hospitalization and indicated that without this pressure, would not have initiated the IVC.

Failure to Adequately Assess and Document Decision-Making Capacity of the Patient

The OIG determined that the psychiatrist failed to determine the [decision-making capacity](#) of the patient. Patients receiving health care from VA have the right to accept or refuse any medical treatment or procedure recommended to them.³³ No medical treatment or procedure may be performed without the prior, voluntary [informed consent](#) of the patient.³⁴

Patients are presumed to have decision-making capacity unless a clinician completes an assessment stating otherwise or a court has determined the patient to be [incompetent](#). The clinician's assessment will determine the patient's ability to comprehend and appreciate information about the situation and treatment options, and to communicate a healthcare decision.³⁵ A provider must also document a decision-making assessment for any patient who lacks capacity for medical decision-making.³⁶

During the interview with the OIG, the psychiatrist reported having a concern about the patient's ability to manage medications in 2019 and that in spring 2019, the family member indicated the patient needed to be hospitalized for medication management. The psychiatrist indicated having determined that due to the patient's vascular dementia, "[the patient] did not have the capacity to consent to a voluntary admission." The psychiatrist reported not having assessed the patient's cognition at the spring 2019 appointment but believed "an assessment of [the patient's] cognition should have been done." When asked about documenting a patient's decision-making capacity, the psychiatrist reported a practice of asking questions to assess a patient's understanding of their psychiatric condition and treatment including consequences of consenting to or refusing treatment; however, did not generally document a patient's decision-making capacity.

The OIG found that despite having determined that the patient lacked decision-making capacity, the psychiatrist failed to document the assessment of the patient's decision-making capacity.

³³ 38 C.F.R. § 17.32 and 17.33; Facility Memorandum 116-1, *Commitment Procedures for Psychiatric Patients Under Involuntary Commitment*, January 24, 2019; VHA Handbook 1004.01(2), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009. This handbook was in effect at the time of the events discussed in this report. The handbook was amended April 4, 2019, June 25, 2020, and January 4, 2021. All versions of the handbook contain the same or similar language related to a patient's rights to accept or refuse medical treatments or procedures.

³⁴ 38 C.F.R. § 17.32 and 17.33.

³⁵ VHA Handbook 1004.01(2). This handbook was in effect at the time of the events discussed in this report. The handbook was amended April 4, 2019, June 25, 2020, and January 4, 2021. All versions of the handbook contain the same or similar language related to a patient's decision making capacity.

³⁶ VHA Handbook 1004.01(2).

Failure to Determine the Availability of a Healthcare Agent

The OIG found that the psychiatrist failed to determine whether there was a [healthcare agent](#) who was authorized to make medical decisions. If a patient lacks decision-making capacity, the patient's authorized [surrogate](#) may provide informed consent.³⁷ When it is determined that a patient lacks decision-making capacity, the practitioner must make a reasonable inquiry as to the availability of an [advance directive](#) naming a healthcare agent.³⁸

The OIG found that the patient had executed a [Health Care Power of Attorney](#) and designated the patient's spouse as the healthcare agent and the family member to take the responsibility if the spouse was unable to fulfill the duties.³⁹ The psychiatrist was unable to remember if the patient's spouse was present at the spring 2019 appointment and was unsure whether the spouse was the Health Care Power of Attorney.

The OIG found that the psychiatrist reported being concerned about the patient's decision-making capacity but failed to adequately assess and document the patient's capacity to make informed decisions and to determine whether the patient had a healthcare agent who was authorized to make medical decisions. The psychiatrist ultimately advised the patient that an emergency department visit was necessary to assess whether the current medications were appropriately prescribed, but did not discuss the necessity of a behavioral health admission with the patient because the psychiatrist did not believe the patient would agree to hospitalization. The psychiatrist subsequently initiated IVC based on pressure from the family member although they did not believe the patient met the criteria at the time.

After a second interview with the psychiatrist in early January 2021, the OIG expressed concerns to the Facility Director and Chief of Staff about the psychiatrist's actions to initiate an IVC at the spring 2019 appointment, despite indicating that "behavioral health admission was not necessarily warranted." The OIG also reported that the psychiatrist failed to communicate the treatment options with the patient and the patient's healthcare agent. Leaders were informed that they could proceed with a review of the psychiatrist's actions in accordance with VHA policy after having been made aware of the OIG team's concerns.

³⁷ VHA Handbook 1160.06; VHA Handbook 1004.01(2). This handbook was in effect at the time of the events discussed in this report. The handbook was amended April 4, 2019, June 25, 2020, and January 4, 2021. All versions of the handbook contain the same or similar language related to a patient's surrogate.

³⁸ VHA Handbook 1004.01(2). This handbook was in effect at the time of the events discussed in this report. The handbook was amended April 4, 2019, June 25, 2020, and January 4, 2021. All versions of the handbook contain the same or similar language related to a practitioner's inquiry as to the availability of an advance directive.

³⁹ The OIG recognizes that there may be limitations on the authority of surrogates to make decisions regarding mental health treatment.

4. Specialty Care Coordination

The OIG identified a missed opportunity when primary care provider 1, primary care provider 2, and the psychiatrist did not coordinate or follow up on specialty care consults for the patient in response to the patient’s progressive functional decline and the family member’s requests for evaluation and treatment. VHA policy states that “[t]o provide patients with comprehensive care, PACTs routinely partner with specialty care to ensure patients receive care that is informed by the knowledge and expertise needed to manage and treat uncommon or complex health conditions” and that “PACT staff consult with providers of specialty care when:

- (1) The patient requests clinically appropriate consultation;
- (2) PACT staff is not clinically privileged or resourced to provide the clinically indicated and desired care;
- (3) Appropriate PACT staff seek the opinion, advice, or expertise of the specialty care provider to evaluate or manage a patient’s health condition(s); or
- (4) VHA clinical guidelines or professionally accepted practice standards recommend consultation with a provider of specialty care.”⁴⁰

Neurology

The OIG reviewed the EHR and found that during spring and summer 2018 the family member requested a neurology appointment for the patient, but an appointment was not scheduled. In spring 2018, primary care provider 1 ordered a neurology consult to evaluate the patient’s headaches. Neurology services were unavailable at WHCC and during attempts to schedule the patient for an appointment, a facility scheduler documented that the patient would not be able to travel to the facility for an appointment and the family member planned to contact primary care provider 1 for a community care consult.⁴¹ The neurology consult was discontinued due to multiple failed scheduling efforts and there was no documented evidence that the family member contacted primary care provider 1 or that a community care consult for neurology was initiated.⁴²

During a scheduled mental health appointment later that month, the psychiatrist reviewed results of the most recent computed tomography scan showing prior stroke, documented that the family

⁴⁰ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, May 26, 2017.

⁴¹ “Veteran Community Care – General Information (VA MISSION Act),” Community Care National Portal, accessed March 7, 2021, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000089111/VA-MISSION-Act-of-2018. (This is an internal VA website not publicly accessible.) The Fayetteville VA Medical Center is 98 miles from the WHCC. In accordance with the Mission Act, this distance qualified the patient for CITC.

⁴² VHA Directive 1232(1), *Consult Processes and Procedures*, August 23, 2016, amended on September 23, 2016. “Minimum scheduling effort” is defined as two attempts to contact the patient, including at least one phone attempt and one letter, and a 14 day period to allow the patient to contact the facility to schedule an appointment.

member reported that the patient's headaches had resolved, but noted a decline in the patient's cognition. The family member requested a consult for the patient to see a geriatric neurologist in the community. When the OIG inquired about the availability of geriatrics and neurology specialty services, the psychiatrist reported that in 2018, geriatrics and neurology services were available at the facility but not at WHCC. The psychiatrist also reported that as a board certified geriatric psychiatrist it was within their scope of practice to treat the patient's dementia without a specialty referral. The OIG found that the psychiatrist acknowledged the patient's impairments due to the major neurocognitive disorder, the psychiatrist documented providing minimal supportive psychotherapy and a plan to place a community care consult for neuropsychological testing, but there was no documented evidence that the psychiatrist entered community care consults for neuropsychological testing, geriatrics, or neurology.

The patient was then assigned to primary care provider 2 and attended an appointment with primary care provider 2 in summer 2018. The family member again requested a neurology consult due to concern with the patient's dementia medication, donepezil. Primary care provider 2 told the OIG of having had a discussion with the family or recommending a referral for the patient's dementia; however, the OIG could not find documented evidence that primary care provider 2 initiated a neurology consult.

Optometry

The OIG found that the patient was scheduled to see a community optometrist in fall 2019; however, the patient did not attend the appointment. The following month, primary care provider 2 documented in the patient's EHR that the prescription eye drops were not managed through primary care and offered to place a consult for the patient to be seen by optometry. In late 2019, a PACT nurse responded to the family member's secure message indicating that the patient needed to have medications, including glaucoma eye drops, refilled by the facility. The nurse documented explaining to the family member that the patient's medications would be refilled, with the exception of the glaucoma eye drops, which needed to be ordered by an optometrist. The OIG found that the PACT nurse relayed this information to primary care provider 2. During an interview with the OIG, primary care provider 2 indicated that treatment for glaucoma was beyond their area of expertise and usually offered care in the community for patients to be followed by an eye specialist. The OIG found no documented evidence that primary care provider 2 entered an optometry consult to the facility or for care in the community. According to the family member, the patient went one year without receiving the glaucoma eye drops.

Geriatrics

The OIG found that the psychiatrist and primary care providers did not initiate a [geriatric consultation](#) for the patient. Geriatric consultation supports providers by assessing a patient's clinical presentation of symptoms within a defined geriatric population and assists patients by

providing the most appropriate care based on those symptoms.⁴³ The psychiatrist told the OIG of being board certified in geriatric psychiatry and feeling confident to provide care for the patient without the need for geriatric consultation. Based on the patient's age, complexity and number of medications, primary care provider 1 told the OIG of having "probably" offered the patient a geriatric consult. The OIG reviewed the patient's EHR and was unable to find documented evidence that primary care provider 1 referred the patient for a geriatrics evaluation or that the patient had received care from the Geriatrics Consult Clinic. Although primary care provider 2, in interviews, recalled that the patient was receiving care in the Geriatrics Consult Clinic, the OIG found no documented evidence to support this recollection. The OIG determined that the patient's family and patient needed more support as evidenced by the frequent family member's requests for evaluation, specialty consultation, placement, and respite care. Geriatric services could have provided additional services to support the patient and family.

The OIG determined that primary care provider 1, primary care provider 2, and the psychiatrist missed an opportunity to coordinate specialty care needs for the patient. Primary care provider 1 did not order a geriatrics consult; primary care provider 2 did not enter a geriatrics, neurology, or optometry consult; and the psychiatrist did not enter a geriatrics or neurology consult. These missed opportunities denied the patient the chance to be evaluated and possibly receive needed or additional treatment and care by specialty providers.

Conclusion

The OIG did not substantiate that facility staff failed to coordinate the care of a patient seeking CLC placement. The CLC screening committee received, reviewed, and dispositioned consults in accordance with facility policy to determine the patient's eligibility for CLC care. The CLC screening committee determined that the patient's level of functional status did not warrant CLC placement until fall 2020, at which time the patient was approved for a 30-day short stay CNH placement.

The OIG substantiated that facility staff failed to coordinate respite services for the patient. The community health nurse supervisor and community health nurse did not properly determine the patient's eligibility for H/HHA services between spring 2018 and spring 2019 when they did not consider the patient's diagnosis of vascular dementia. In addition, the OIG did not find that an interdisciplinary team review was completed to determine the patient's eligibility for H/HHA services, as required by VHA policy.

The OIG did not substantiate that facility staff failed to provide medications for the patient while at a community ALF. However, the OIG found that when the patient needed to be seen by a community optometrist to obtain glaucoma medications, and after the patient did not attend the

⁴³ VHA Directive 1140.09, *Geriatrics Consultation*, June 28, 2017.

initial community care optometry appointment, another community care optometry consult was not initiated.

During the course of the review, the OIG determined that the psychiatrist used the IVC process in a manner that was inconsistent with the state's established parameters during the patient's spring 2019 appointment. The psychiatrist reported being concerned about the patient's decision-making capacity but failed to adequately assess and document the patient's capacity to make informed decisions and to determine whether the patient had a healthcare agent who was authorized to make medical decisions. The psychiatrist ultimately advised the patient that an emergency department visit was necessary to assess whether the current medications were appropriately prescribed, but did not discuss the necessity of a behavioral health admission with the patient because the psychiatrist did not believe the patient would agree to hospitalization. The psychiatrist subsequently initiated IVC based on pressure from the family member although they did not believe the patient met the criteria at the time. The patient was transported to a community hospital emergency department by the sheriff's office where a community physician completed a commitment exam and the patient was admitted pursuant to North Carolina state law.

The OIG determined that primary care provider 1, primary care provider 2, and the psychiatrist missed an opportunity to coordinate specialty care needs for the patient. These missed opportunities denied the patient the chance to be evaluated and possibly receive needed or additional treatment and care by specialty providers.

The OIG made seven recommendations.

Recommendations 1–7

1. The Fayetteville VA Medical Center Director ensures that community health nurses evaluate patients referred for homemaker and/or home health aide services in accordance with Veterans Health Administration policy when determining patient eligibility.
2. The Fayetteville VA Medical Center Director verifies that interdisciplinary assessments of homemaker and/or home health aide referrals are completed to determine patient eligibility for services.
3. The Fayetteville VA Medical Center Director ensures that community health staff are trained on the eligibility criteria for homemaker and/or home health aide services.
4. The Fayetteville VA Medical Center Director evaluates staff compliance with Veterans Health Administration and state of North Carolina commitment requirements, confirms staff understanding of required processes, and consults with the Office of General Counsel regarding state law, as warranted.

5. The Fayetteville VA Medical Center Director ensures that providers consistently assess and document when patients lack decision-making capacity.
6. The Fayetteville VA Medical Center Director ensures that providers consistently determine whether a patient has an identified healthcare agent when patients lack decision-making capacity.
7. The Fayetteville VA Medical Center Director makes certain that patient aligned care team providers and outpatient psychiatrists are educated about initiating specialty care consults for patients.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 19, 2021

From: Acting VA Mid-Atlantic Health Care Network Director, VISN 6 (10N6)

Subj: Healthcare Inspection—Deficiencies in the Assessment and Care of a Patient Seeking Geriatric Services at the Fayetteville VA Medical Center in North Carolina

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

1. The attached response is forwarded for your review and further action. I reviewed and concur with the response of the Fayetteville VA Medical Center (VAMC), Fayetteville, North Carolina.
2. If you have further questions, please contact the QMO, VISN 6.

(Original signed by:)

Stephanie Young
Acting VA Mid-Atlantic Health Care Network Director, VISN 6 (10N6)

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 16, 2021

From: Director, Fayetteville VA Medical Center (565)

Subj: Healthcare Inspection—Deficiencies in the Assessment and Care of a Patient Seeking Geriatric Services at the Fayetteville VA Medical Center in North Carolina

To: Director, Mid-Atlantic Healthcare Network (10N6)

1. The Executive Director of the Fayetteville VA Coastal Health Care System has reviewed the draft report and concurs with the findings.
2. A plan for corrective actions to include timeline for completion and sustainment of improvements has been completed.

(Original signed by:)

Daniel L. Dücker, MSS, M Ed
Executive Director
Fayetteville North Carolina VA Coastal Health Care System

Facility Director Response

Recommendation 1

The Fayetteville VA Medical Center Director ensures that community health nurses evaluate patients referred for homemaker and/or home health aide services in accordance with Veterans Health Administration policy when determining patient eligibility.

Concur.

Target date for completion: January 31, 2022

Director Comments

All Community Health Staff Physicians and Mid-Level Providers will be educated on Home Health Aide eligibility criteria within VHA Handbook 1140.6 Purchased Home Health Care. All referrals will be reviewed for compliance in accordance to established criteria. Data will be reported to the Medical Executive Board and monitored until 90% compliance has been achieved for three consecutive months. This education will also be added to service line new employee orientation.

Recommendation 2

The Fayetteville VA Medical Center Director verifies that interdisciplinary assessments of homemaker and/or home health aide referrals are completed to determine patient eligibility for services.

Concur.

Target date for completion: January 31, 2022

Director Comments

A template will be created to capture all eligibility criteria and interdisciplinary assessment requirements from the VHA Handbook 1140.6 Purchased Care that will determine patient eligibility for services. This will be added to the Community Care-GEC Home Health Aide Consult. Validation and adherence to the criteria, assessment and template will be established by reviewing all Community Care GEC Community Care Consults entered by providers. Compliance data will be reported to the Medical Executive Board Data and monitored until 90% compliance has been achieved for three consecutive months.

Recommendation 3

The Fayetteville VA Medical Center Director ensures that community health staff are trained on the eligibility criteria for homemaker and/or home health aide services.

Concur.

Target date for completion: January 31, 2022

Director Comments

All Community Health Staff will be educated on the Home Health Aide eligibility criteria in accordance with VHA Handbook 1140.6 Purchased Home Health Care. Compliance with training will be reported to the Medical Executive Board. This education will also be added to service line new employee orientation.

Recommendation 4

The Fayetteville VA Medical Center Director evaluates staff compliance with Veterans Health Administration and state of North Carolina 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: January 31, 2022

Director Comments

Fayetteville VA will audit all instances of staff initiating involuntary commitment orders to ensure full compliance with the Veterans Health Administration and the State of North Carolina commitment requirements. Language outlining commitment and documentation requirements will be added to a new standardized note title for involuntary commitments. All providers will be educated about the involuntary commitment requirements and documentation, as well as the new note title utilization. Compliance data will be reported to the Medical Executive Board. This education will also be added to service line new employee orientation.

Recommendation 5

The Fayetteville VA Medical Center Director ensures that providers consistently assess and document when patients lack decision-making capacity.

Concur.

Target date for completion: January 31, 2022

Director Comments

Fayetteville VA providers will be educated on requirements on determining decision-making capacity in accordance with VHA Handbook 1004.01. Documentation criteria will be added to current documentation template in relation to assessment and determination of patient's capacity

to consent to treatment being offered. Data will be reported to the Medical Executive Board and monitored until 90% compliance has been achieved for education and appropriate use of template for three consecutive months. This education will also be added to service line new employee orientation.

Recommendation 6

The Fayetteville VA Medical Center Director ensures that providers consistently determine whether a patient has an identified healthcare agent when patients lack decision-making capacity.

Concur.

Target date for completion: January 31, 2022

Director Comments

Standardized language regarding patient status relating to identifying healthcare agents when patients lack decision-making capacity will be added to existing medical record template. Providers will be educated on the use of the template. Data will be reported to the Medical Executive Board and monitored until 90% compliance with education and appropriate use of template has been achieved for three consecutive months. This education will also be added to service line new employee orientation.

Recommendation 7

The Fayetteville VA Medical Center Director makes certain that patient aligned care team providers and outpatient psychiatrists are educated about initiating specialty care consults for patients.

Concur.

Target date for completion: January 31, 2022

Director Comments

All patient aligned care team providers and outpatient psychiatrists will be educated on the consultation process to include initiating specialty care consults for patient. Data will be reported to the Medical Executive Board and monitored until 90% compliance has been achieved for three consecutive months. This education will also be added to service line new employee orientation.

Glossary

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

activities of daily living. Specific household tasks needed to maintain a safe environment in the home for the patient. These tasks may include bathing, toileting, eating, dressing, ambulation, medical equipment, or routine health monitoring.⁴⁴

adult day health care. An option for patients to participate in recreation and socialization in a non-institutional care environment that includes therapeutic interventions from an interdisciplinary team consisting of nursing, rehabilitation, and social work.⁴⁵

advance directive. A written statement outlining future health care decisions in the event that an individual is no longer able to make decisions.⁴⁶

antidepressant. A drug class used to treat depression.⁴⁷

assisted living facility. Housing for patients who need assistance with ADLs, but do not require nursing home care. The facility also provides limited care.⁴⁸

atrophy. A decrease in size of a body part or tissue.⁴⁹

behavioral health. “A category of medicine and rehabilitation that combines the areas of alcohol and other drug services, mental health and psychosocial rehabilitation.”⁵⁰

care in the community. Also known as community care, medically necessary care services provided from a non-VA facility, such as a community hospital, that are not feasibly available within the VA system.⁵¹

cognition. Mental activities such as thinking, understanding, learning, and remembering of a person’s conscious.⁵²

⁴⁴ VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006.

⁴⁵ VHA Directive 1141.03, *VA Operated Adult Day Health Care*, November 9, 2020.

⁴⁶ VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.

⁴⁷ Merriam-Webster, “antidepressant,” accessed March 1, 2021, <https://www.merriam-webster.com/dictionary/antidepressant#medicalDictionary>.

⁴⁸ Merriam-Webster, “assisted living facility,” accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/assisted%20living>.

⁴⁹ Merriam-Webster, “atrophy,” accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/atrophy>.

⁵⁰ CARF International, 2020 Behavioral Health Standards Manual, accessed May 16, 2021, <https://vaww.qps.med.va.gov/divisions/qm/ea/carfManuals2020.aspx>.

⁵¹ “VA Care in the Community,” Benefits.gov, accessed March 5, 2021, <https://www.benefits.gov/benefit/322>.

⁵² Merriam-Webster, “cognition,” accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/cognition>.

commitment examiner. Any certified health professional, including mental health, who conducts an examination of a patient for involuntary commitment.⁵³

community living center. A VA-owned skilled nursing environment on or near a VA medical facility that provides short and long stay treatment.⁵⁴

competency. A legal determination made by a court of law that a patient has the requisite capacities to make a medical decision.⁵⁵

computed tomography scan. A series of x-rays used to create cross-sectional images of the body that can be used to diagnose disease or injury.⁵⁶

consult. An electronic request submitted through the EHR, on behalf of a patient, for clinical services and often used as a source to communicate requests and/or results between services.⁵⁷

coronary artery disease. A heart condition that involves damage to or narrowing of the blood vessels of the heart, causing a decrease in blood flow to the heart. The decrease in blood flow may cause chest pain, shortness of breath, or a heart attack.⁵⁸

coronavirus (COVID-19). A newly discovered infectious disease. It can be spread from person to person through droplet secretions, such as a cough or sneeze.⁵⁹

decision-making capacity. A clinical determination of patients' ability to make decisions on their own health care plans.⁶⁰

donepezil (Aricept®). A medication that may improve cognition in patients with dementia.⁶¹

dual care. Veterans receiving health care within the VA as well as in the community.⁶²

⁵³ "What is a commitment examiner?" North Carolina General Statutes, accessed March 11, 2021, <https://files.nc.gov/ncdhhs/documents/files/IVC-FAQ-final-August-2019.pdf>.

⁵⁴ VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.

⁵⁵ VHA Handbook 1004.01(4), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009 (amended January 4, 2021).

⁵⁶ Mayo Clinic, "CT scan," accessed November 20, 2020, <https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675>.

⁵⁷ VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

⁵⁸ Mayo Clinic, "coronary artery disease," accessed January 29, 2021, <https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes/syc-20350613>.

⁵⁹ World Health Organization, "coronavirus disease (COVID-19)," accessed August 4, 2020, https://www.who.int/health-topics/coronavirus#tab=tab_1.

⁶⁰ VHA Handbook 1004.01(4).

⁶¹ Physician Desk Reference, "Donepezil," accessed January 26, 2021, <https://www.pdr.net/drug-summary/Aricept-donepezil-hydrochloride-138>.

⁶² VHA Directive 2009-038, *VHA National Dual Care Policy*, August 25, 2009.

extended care. Both residential and community-based programs, independent of age, offered to patients with chronic conditions that have compromised their ability to self-care.⁶³

geriatric. The patient population of older adults, advanced age, and typically defined as 65 years of age and older.⁶⁴

geriatric consultation. An interdisciplinary team approach to address interactions of a variety of biopsychosocial issues within the geriatric population.⁶⁵

geriatric evaluation. A comprehensive assessment and plan of care developed by a multidisciplinary team with specific goals for the elderly population or patients with complex medical and psychosocial conditions that would benefit from the service.⁶⁶

glaucoma. A condition of increased pressure in the eyeball that may lead to damage to the optic disk and ultimately loss of vision.⁶⁷

healthcare agent. An individual named by the patient to be the power of attorney and make health care decisions for the patient when the patient is not able to make a decision for themselves.⁶⁸

health care power of attorney. A legal document “authorizing one to act as the attorney or agent of the grantor” as it relates to health care planning.⁶⁹

homemaker and/or home health aide. “Personal care and related support services that enable frail or disabled Veterans to live at home.”⁷⁰

hospice. The last phase of palliative care in a patient diagnosed with advanced disease or terminal illness and a prognosis of less than six months. The goal of treatment is comfort care.⁷¹

hypertension. Also known as high blood pressure, a common condition that is determined by the amount of blood the heart pumps and the amount of resistance to blood flow in the arteries. High

⁶³ VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

⁶⁴ VHA Directive 1140.11.

⁶⁵ VHA Directive 1140.09, *Geriatrics Consultation*, June 28, 2017.

⁶⁶ VHA Directive 1140.04, *Geriatrics Evaluation*, November 28, 2017.

⁶⁷ Merriam-Webster, “glaucoma,” accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/glaucoma#medicalDictionary>.

⁶⁸ VHA Handbook 1004.01(4).

⁶⁹ Merriam-Webster, “power of attorney,” accessed March 11, 2021, <https://www.merriam-webster.com/dictionary/power%20of%20attorney>.

⁷⁰ VHA Handbook 1140.6.

⁷¹ VHA Handbook 1140.6; VHA Directive 1140.11.

blood pressure may not present with any signs and symptoms, however the long-term force of the blood against the artery may lead to serious health problems.⁷²

incompetent. Lacking necessary ability or skills. A determination of competence includes the presence of medical or psychiatric conditions limiting the ability to be legally qualified as competent.⁷³

informed consent A patient's right to informed participation in healthcare decisions and to agree to or decline any medical treatment or procedures.⁷⁴

instrumental activities of daily living. Light housekeeping tasks needed to ensure a safe and clean living condition at home; tasks include laundering, meal preparation, grocery shopping, and assisting with attendance of patient appointments.⁷⁵

involuntary commitment. A legal process, in which those who are considered a danger to themselves or others may be admitted for mental health evaluation and treatment.⁷⁶

long-term care. Medical and non-medical services to meet a person's health or personal care needs when they are no longer able to perform basic activities of daily living.⁷⁷

medical foster home. A residential home where a patient may reside and receive care provided by a resident of the home.⁷⁸

neurology. The study of the structure, function, and disease process of the nervous system.⁷⁹

neuropsychological testing. A comprehensive battery of tests to evaluate mental functions such as intellect, memory, attention, reasoning, and mood. Neuropsychological testing may be used to diagnose cognitive disorders and plan treatment.⁸⁰

palliative care. Clinical care focused on comfort and symptom control in patients with "advanced life-limiting disease."⁸¹

⁷² Mayo Clinic, "hypertension," access February 22, 2021, <https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410>.

⁷³ Merriam-Webster, "incompetent," March 11, 2021, <https://www.merriam-webster.com/dictionary/incompetent>.

⁷⁴ VHA Handbook 1004.01(4).

⁷⁵ VHA Handbook 1140.6.

⁷⁶ Merriam-Webster, "involuntary admission," accessed March 11, 2021, <https://www.merriam-webster.com/dictionary/involuntary%20admission>.

⁷⁷ HealthCare.gov, "long-term care," accessed March 5, 2021, <https://www.healthcare.gov/glossary/long-term-care/>.

⁷⁸ VHA Directive 1141.02(1), *Medical Foster Home Program Procedures*, August 9, 2017.

⁷⁹ Merriam-Webster, "neurology," accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/neurology>.

⁸⁰ Cleveland Clinic, "neuropsychological testing and assessment," accessed January 29, 2021, <https://my.clevelandclinic.org/health/diagnostics/4893-neuropsychological-testing--assessment>.

⁸¹ VHA Directive 1140.11.

patient aligned care team. A multidisciplinary team that provides a comprehensive primary care service in partnership with the patient and/or caregivers to ensure a complete and consistent health care.⁸²

peripheral artery disease. A decrease in blood flow to the limbs caused by narrowing of arteries. Peripheral artery disease increases risk of stroke and heart attack.⁸³

pneumonia. An acute disease of the lungs with accompanied symptoms of fever, chills, cough, breathing difficulties, fatigue, and chest pain.⁸⁴

posttraumatic stress disorder. A mental health condition caused by a traumatic event and causes symptoms of anxiety, flashbacks, and nightmares.⁸⁵

psychiatrist. A medical doctor who specializes in mental health disorders diagnosing and treating psychiatric disorders including emotional and behavioral.⁸⁶

psychologist. A healthcare professional who specializes in the study of psychology which includes treatment of emotional and behavioral disorders.⁸⁷

quetiapine. A medication used to treat mental health disorders such as schizophrenia, bipolar disorder, and major depressive disorder.⁸⁸

respite care. Supportive services provided for the purpose of relieving caregivers from the duties of caregiving.⁸⁹

secure message. An authorized, encrypted, and secure communication tool utilized by VA staff and patients to exchange non-urgent information related to their health care.⁹⁰

stroke. A medical emergency in which blood supply to the brain is interrupted or reduced, and the brain tissue is not getting oxygen and nutrients.⁹¹

⁸² VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, May 26, 2017.

⁸³ Mayo Clinic, “peripheral artery disease,” accessed January 29, 2021, <https://www.mayoclinic.org/diseases-conditions/peripheral-artery-disease/symptoms-causes/syc-20350557>.

⁸⁴ Merriam-Webster, “pneumonia,” accessed March 12, 2021, <https://www.merriam-webster.com/dictionary/pneumonia>.

⁸⁵ Mayo Clinic, “post-traumatic stress disorder (PTSD),” accessed January 29, 2021, <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>.

⁸⁶ Merriam-Webster, “psychiatrist,” accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/psychiatrist>.

⁸⁷ Merriam-Webster, “psychologist,” accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/psychologist>.

⁸⁸ Physician Desk Reference, “Quetiapine,” accessed March 5, 2021, <https://www.pdr.net/drug-summary/Seroquel-quetiapine-fumarate-2185>.

⁸⁹ VHA Handbook 1140.6.

⁹⁰ VHA Handbook 1101.10(1).

⁹¹ Merriam-Webster, “stroke,” accessed March 5, 2021, <https://www.merriam-webster.com/dictionary/stroke>.

surrogate. An individual who is authorized to make medical care decisions for a patient without decision-making capacity.⁹²

vascular dementia. A type of memory loss caused by impaired blood flow to the brain. Conditions that increase risk of vascular dementia are heart disease, stroke, high blood pressure, and high cholesterol.⁹³

⁹² VHA Handbook 1004.01(4).

⁹³ Mayo Clinic, “vascular dementia,” accessed January 29, 2021, <https://www.mayoclinic.org/diseases-conditions/vascular-dementia/symptoms-causes/syc-20378793>.

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