DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon

HEALTHCARE INSPECTION | REPORT #21-01682-25 | NOVEMBER 9, 2021

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation of inadequate care coordination for a veteran (resident 1) seen at the Southern Oregon Rehabilitation Center and Clinics in White City (White City facility) and the Roseburg VA Health Care System (Roseburg HCS) in Oregon. It was alleged resident 1 was admitted to the White City facility's Mental Health Residential Rehabilitation Treatment Program (MH RRTP) despite not meeting admission criteria, was later transported to the Roseburg HCS for admission to its acute psychiatric unit but was not accepted, and then was discharged to the community in an unsafe manner. The OIG received additional allegations that a second resident (resident 2) was admitted to the MH RRTP without meeting admission criteria, and that another resident was injured after slipping and falling while getting out of the shower. During the inspection, the OIG learned about three additional residents who may not have met admission criteria, and two who fell in the shower area.

The OIG did not substantiate that resident 1 was inappropriately admitted to the MH RRTP, but found that resident 1's discharge was not adequately coordinated. The OIG determined that the MH RRTP's transport of resident 1 to the Roseburg HCS for admission to its acute psychiatric unit did not comply with Veterans Health Administration (VHA) policy in that facility staff transported a resident with a behavioral flag. The OIG further found that after arriving at the Roseburg HCS Urgent Care Center, the resident was assessed by a provider, determined to not meet admission criteria, and was discharged to the community.

During treatment at the MH RRTP, resident 1 showed increasingly concerning behaviors, including threatening bodily harm to staff and residents. As a result of these behaviors, staff documented nine entries in the Disruptive Behavior Reporting System and a behavioral flag was entered into the electronic health record (EHR) on the day of discharge.[1] Service line and MH RRTP leaders and staff agreed that resident 1 did not have suicidal ideation; however, service line and MH RRTP leaders interpreted the threats of bodily harm to staff and residents as homicidal ideation that warranted admission to a higher level of care than was available at the MH RRTP. The leaders made a plan to discharge resident 1 from the MH RRTP and pursue admission to the acute psychiatric unit at the Roseburg HCS. They stated that after speaking with a Roseburg HCS acute psychiatric provider, the plan was to transport resident 1 to the Roseburg HCS Urgent Care Center where the resident would be medically evaluated and directly admitted to the acute psychiatric unit. In contrast, the Roseburg HCS acute psychiatric provider stated the resident had not been accepted to the unit and reported advising a MH RRTP leader to transport

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

the resident to a local emergency department in White City, Oregon, for medical clearance prior to traveling to Roseburg.

When asked by the OIG, service line and MH RRTP leaders reported limited options available for transport after business hours, and as such, decided to transport resident 1 in a White City facility vehicle accompanied by two non-clinical staff, noting it was the only option available for safe transport and a mode of transport that staff from White City had previously used. Service line and MH RRTP leaders also denied awareness of a VHA policy prohibiting residents with behavioral flags from using VHA transportation services.[2]

On the day of discharge, documentation of resident 1's discharge plan was lacking in the resident's EHR. Although the OIG found a care coordination note discussing discharge plans in the resident's EHR, the note was entered three days after the discharge and was not in alignment with VHA policy that outlines elements that should be included in the discharge checklist.[3]

Resident 1 checked in to the Roseburg HCS Urgent Care Center 13 minutes before it closed. The OIG found conflicting reports regarding the hand-off that occurred. Urgent Care Center staff reported that the resident stated being unaware of the reason for the visit to the Urgent Care Center and had no accompanying paperwork from the MH RRTP in White City. The Urgent Care Center provider determined the resident did not meet criteria for inpatient psychiatric admission and discharged the resident to the community. Five days later, the resident was brought back to the Urgent Care Center by family members; was again determined to not meet criteria for acute psychiatric admission; and was discharged to a community homeless shelter. Two and a half months later, the resident called a VA call center and reported being admitted to a state mental health hospital.

The OIG reviewed the records of five MH RRTP residents (residents 1–5) and found that four of the five residents reviewed met admission criteria.[4] Due to a lack of documentation and the departure of two staff from whom the OIG team may have gained clarification regarding the resident's change in medical status and admission, the OIG was unable to determine if resident 5 had disqualifying conditions that would have precluded admission.[5] However, the OIG determined resident 5 should have been re-evaluated after a change in medical status prior to admission.

[2] VHA Directive 1695, *Veterans Transportation Services*, September 18, 2019.

[3] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

[4] For this report, the OIG considers an admission appropriate when criteria were met with no reasons for denial based upon VHA Directive 1162.02. An inappropriate admission was when admission criteria were not met or a reason for denial was found but the resident was still admitted.

[5] The OIG does not have testimonial subpoena authority to compel former federal employees to provide testimony in support of OIG oversight activities.

The OIG substantiated that a resident (resident 6) of MH RRTP was injured after slipping and falling while getting out of the shower. The OIG found two additional residents fell in the shower on the MH RRTP in the preceding 10 months. The OIG determined that White City facility leaders and facility-wide committees were aware of the falls but found they missed an opportunity to identify and acquire solutions in a timely manner to prevent future falls. The OIG identified the lack of an MH RRTP Safety Committee as a factor contributing to the lack of service-specific focus on the falls.

The OIG made five recommendations to the White City Facility Director related to the discharge template, discharges during regular business hours, transport of residents with behavioral flags, conducting medical evaluations, and a review of falls in the shower area.

Comments

The Veterans Integrated Service Network and the White City Facility and Roseburg HCS Directors reviewed the report (see appendixes A, B, and C for the Directors' comments). The Veterans Integrated Service Network and the White City Facility Directors concurred with the findings and recommendations and provided acceptable action plans. The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

EHR	electronic health record
HFMEA	Healthcare Failure Mode and Effect Analysis
OIG	Office of Inspector General
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation of inadequate care coordination for a veteran seen at the Southern Oregon Rehabilitation Center and Clinics in White City (White City facility) and the Roseburg VA Health Care System (Roseburg HCS) in Oregon. Specifically, the OIG assessed the veteran's admission to the White City facility's Mental Health Residential Rehabilitation Treatment Program (MH RRTP), discharge coordination, and transport to Roseburg HCS. The OIG reviewed additional allegations related to the appropriateness of another veteran's admission to the MH RRTP and a third veteran's fall.

Southern Oregon Rehabilitation Center and Clinics

The White City facility, part of Veterans Integrated Service Network (VISN) 20, has an MH RRTP as well as outpatient primary care and mental health clinics. The MH RRTP has an 180-bed general domiciliary that provides residential treatment level of care for a veteran population with co-morbid conditions including medical, psychiatric, substance use disorders, and posttraumatic stress disorders, and a 50-bed homeless domiciliary that provides residential treatment for homeless veterans.[1] The White City facility is designated as level 3, low complexity, and does not have an acute hospital, acute psychiatric unit, urgent care center, or emergency department.[2]

Roseburg VA Health Care System

Roseburg HCS, part of VISN 20, consists of a 94-bed facility that includes an acute care hospital, posttraumatic stress disorder and substance use disorder residential rehabilitation treatment programs, an acute psychiatric unit, and a community living center; as well as outpatient primary, specialty, and mental health clinics. Roseburg HCS is designated as level 3, low complexity, and has an urgent care center.[3]

Mental Health Residential Rehabilitation Treatment Programs

MH RRTPs, which evolved from a domiciliary care program that was established in the 1860s, offer a residential therapeutic setting for veterans with mental health and addictive disorders.[4]

---

[1] Underlined terms are hyperlinks to a glossary. To return from the glossary to the point of origin, press alt and left arrow together.

[2] VHA Office of Productivity, Efficiency, and Staffing. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b,1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex.

[3] VHA Office of Productivity, Efficiency, and Staffing.

[4] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program,* July 15, 2019.

Professional staff and non-licensed peer support staff provide treatment and sub-acute care to residents.[5] Non-licensed staff provide 24-hour supervision of the units seven days a week.[6] The Veterans Health Administration (VHA) requires that treatment at MH RRTPs is patient-centered to meet the individual needs of each resident. Residents identify and address goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration. VHA also specifies guidelines and requirements for staffing levels at MH RRTPs, including "core staffing requirements."[7]

Allegations and Related Concerns

On January 28, 2021, the OIG received a complaint alleging that a resident was admitted to the White City facility MH RRTP despite requiring a higher level of care than was provided by the MH RRTP and therefore, did not meet admission criteria. Further, the complaint stated that the resident was later transported to Roseburg HCS for admission to its acute psychiatric unit but was not accepted and was instead discharged to the community in an unsafe manner. In March 2021, the OIG received additional allegations that (1) a second resident was admitted to the MH RRTP without meeting admission criteria, and (2) another resident was injured after falling while getting out of the shower. During the inspection, the OIG learned about three additional residents who may not have met admission criteria, and two more residents who fell in the shower area.

Scope and Methodology

The OIG initiated the inspection on March 9, 2021, and conducted an unannounced site visit at the White City facility on April 15, 2021, to assess the environment of care where residents showered. Interviews at the White City facility and Roseburg HCS were conducted virtually from April 19–23, 2021.

The OIG interviewed the National MH RRTP Director and White City facility staff including the Associate Chief of Staff for Behavioral Health, Chief and Deputy Chief of the MH RRTP, Patient Safety Manager, and MH RRTP staff familiar with the care of the residents included in this inspection. Roseburg HCS staff interviewed included physicians, a nursing staff member, an administrative officer of the day, and social workers.

[5] Within the context of this report, residents are veterans who live in the MH RRTP and participate in rehabilitation and treatment services. Residents suitable for sub-acute care have needs greater than can be addressed as outpatients but are not in need of the level of bedside care provided on inpatient units. MH RRTP residents are expected to be independent in self-care.

[6] VHA Directive 1162.02. Non-licensed staff are "responsible for monitoring the unit's safety and security, including health and welfare inspections, rounds, contraband prevention, monitoring the whereabouts of Veterans, and maintaining staff situational awareness throughout the unit in conformance with requirements."

[7] VHA Directive 1162.02.

The OIG team reviewed relevant VHA and White City facility policies and procedures, Commission on Accreditation of Rehabilitation Facilities standards and reports, committee agendas and minutes, and select joint patient safety reports. The OIG reviewed the electronic health records (EHRs) of residents identified in the complaint and through the course of the inspection.

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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

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

Patient Case Summary

The veteran (resident 1) was in their early 70's when initially referred by a Roseburg HCS outpatient provider to the White City facility's MH RRTP in summer 2020.[8] Resident 1's past mental health history was significant for paranoid schizophrenia, polysubstance abuse, and chronic homelessness.[9] Approximately two weeks later, an MH RRTP provider completed a medical review and noted no medical concerns for admission. MH RRTP admissions staff attempted, unsuccessfully, to contact the resident multiple times to conduct a screening interview. Therefore, resident 1 was not admitted at that time.

A Roseburg HCS provider submitted another MH RRTP admission referral for resident 1 in fall 2020, again noting the reason for referral as homelessness and treatment for stimulant dependence. A psychiatric assessment was also requested. The referring provider noted that resident 1 had legal issues with a court date scheduled in late 2020. After a preadmission screening and phone contact with the resident and a family member by an MH RRTP social worker, admission to the MH RRTP was scheduled prior to the start of the new year (day 1).

A psychiatric nurse practitioner evaluated the resident on day 1 and documented a long history of polysubstance abuse, schizophrenia, and homelessness. Resident 1 acknowledged auditory hallucinations; however, the psychiatric nurse practitioner felt the patient was safe for admission. The psychiatric nurse practitioner expressed doubt that the resident would be able to participate in the substance abuse program and documented the focus of the admission would be on housing and disposition after discharge. Consistent with White City facility's COVID-19 protocol, resident 1 was placed in quarantine for seven days. The admissions pharmacist documented that the resident was not capable of independent medication administration and would require medication supervision.

On day 5, resident 1 informed the MH RRTP case manager of wanting to speak to a psychiatrist regarding the resident's diagnosis. The case manager documented notifying the psychiatrist of the resident's request.

On day 12, a staff member reported the resident was noted playing music out loud on a phone speaker and that the resident responded to staff's attempts at education about the policy with hand gestures and foul language. In response, a disruptive behavior incident report was made to the Disruptive Behavior Committee. On day 13, an MH RRTP case manager and addiction therapist discussed the inappropriate behavior with the resident and the consequences if similar behavior recurred.

[8] The OIG uses the singular form of they (their) in this instance for the purpose of patient privacy.

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

On day 14, a case manager documented a recovery plan note with a projected discharge date (three months from the day of admission). The plan addressed treatment objectives as well as the resident's homelessness, legal issues, and discharge criteria. The case manager discussed the plan with the resident.

On day 21, a psychiatrist evaluated the resident for initiation of antipsychotic medication. The psychiatrist documented identified risk factors that were discussed with the resident. The psychiatrist completed a suicide risk assessment, which was negative. Follow-up was planned for within one month.

On day 22, a staff member asked to search the resident's bags per MH RRTP guidelines. The staff documented that resident 1 became hostile, responding with statements such as "you won't be alive much longer" and "you are a dead man walking." The following day, the MH RRTP case manager called a meeting to discuss the resident's argumentative behavior and threatening language towards the staff. The resident was notified that any further violation of the facility policy by the resident would result in recommendation for discharge. The event was entered into the Disruptive Behavior Reporting System.

On day 26, a case manager and the program manager met with the resident to discuss alleged inappropriate comments the resident made towards a female veteran. The resident was informed that this behavior could not continue and that the staff would work on finding the resident housing and discharge planning. On day 28, the case manager had another team meeting with the resident to discuss the behavior.

The psychiatrist re-evaluated the resident on day 29 and reviewed the treatment plan with the interim MH RRTP Chief. The resident denied suicidal ideation in the preceding month and the psychiatrist screened resident 1 as low imminent risk of harm to self or others. The psychiatrist adjusted the medication dosage, discussed the side effects, and provided supportive psychotherapy.

On day 30, the case manager spoke to a family member to try to secure housing for the resident, however, was unsuccessful. On day 33, a staff member overheard the resident stating that the resident "cheeks" medications and then spits them out. On day 34, the case manager spoke to another member of the resident's family about the resident's home situation who stated multiple family members would be unable to take the resident into their homes. The family member reported a court hearing occurred and the resident was to go to a state hospital to be assessed and medicated; however, because of COVID-19, the hospital would not admit the resident.

On day 35, resident 1 failed to present for an appointment with the psychiatrist. In the preceding four weeks, the resident missed several appointments—nine for medical and group visits, and three for medication administration.

On day 36, resident 1 presented for an unscheduled visit with the psychiatrist. The psychiatrist made further medication adjustments and planned on meeting with the resident twice weekly, checking medication levels, and optimizing the resident's medication management.

On day 37, the MH RRTP Deputy Chief documented the decision to discharge and transport the resident to the Roseburg HCS Urgent Care Center for evaluation prior to admission to its acute psychiatry unit.[10] The documentation stated the belief that the resident would benefit from a higher level of care for further stabilization and monitoring than could be provided in the MH RRTP. Resident 1 had no known history of self-harm or suicidality observed or recorded.

Nine disruptive behavior entries were reported during resident 1's MH RRTP admission culminating in a behavioral flag and Order of Behavioral Restriction.

In the evening of day 37, approximately 15 minutes after the Urgent Care Center had closed, a Roseburg HCS Urgent Care Center provider evaluated resident 1 who had arrived shortly before closing time. The resident reported being driven there by a worker from the White City facility. The Urgent Care Center provider stated no report had been provided by White City facility staff, and that the resident did not know the reason for being there. The Urgent Care Center provider documented the resident denied suicidal or homicidal ideation and was oriented to person, place, and time with normal judgment. The resident also denied pain and wanted to leave. The Urgent Care Center provider reported resident 1's physical exam did not reveal abnormal findings. The Urgent Care Center provider documented that the administrative officer of the day reported receiving a call from Roseburg HCS's staff psychiatrist who indicated that the resident should go to the "nearest ED [emergency department]" although "no reason was given." The Urgent Care Center staff permitted resident 1 to use the phone to call friends and then discharged resident 1.

The discharge summary from the White City facility was dictated on day 40, three days after discharge. On the same day, the Roseburg HCS Workplace Violence Prevention Program Manager documented awareness of the resident's disruptive behavioral patient record flag and Order of Behavioral Restriction. The Program Manager's note indicated that the White City facility Disruptive Behavior Committee concluded the resident represented a significant risk for future disruptive behavior and initiated an Order of Behavioral Restriction requiring the veteran to check in with VA Police upon arrival to VA medical centers.

On day 42, resident 1's family members brought resident 1 to the Roseburg HCS Urgent Care Center because of reported difficulty managing resident 1's behavior. Resident 1 was assessed and determined to not meet criteria for an acute psychiatric admission. Urgent Care Center staff provided resident 1 with a meal, medications, and offered resident 1 a ride to the community homeless shelter.

[10] The MH RRTP Deputy Chief initiated a note on day 37, but did not sign the note until three days after discharge. Notes are not visible in the EHR until signed by the author.

On day 77, resident 1 presented to a Roseburg HCS Homeless Program case manager and discussed being "kicked out" of the community homeless shelter for refusing to complete a urinalysis and having contacted a cousin for a ride.

On day 119, resident 1 called a VA call center and reported being admitted to the state mental health hospital and needed clarification regarding current medications.

Inspection Results

During the inspection, the OIG found the allegation related to the discharge of resident 1 significant and identified opportunities for improvement of care coordination and discharge planning. Therefore, this report first describes the inspection findings related to the discharge planning of resident 1. The allegation related to whether admission criteria was met is discussed second, followed by the OIG's analysis of the resident who allegedly fell in the shower area.

1. Inadequate Discharge Planning of a Resident

The OIG substantiated that White City facility staff transported resident 1 to Roseburg HCS for admission to its acute psychiatric unit, that the resident was not admitted, and was discharged to the community. The OIG found that the White City facility did not adequately coordinate and plan the discharge and transport of resident 1 to Roseburg HCS. When discharging resident 1 from the MH RRTP, White City facility staff did not use a discharge checklist, conducted the discharge after normal regular business hours, and provided transportation for the resident despite a documented behavioral flag.

Adequate discharge planning ensures a smooth transition when a resident is transferred to another level of care or is discharged from an MH RRTP.[11] VHA requires discharge planning to begin at the time of admission and include residents and facility interdisciplinary recovery team members in the discharge planning process.[12] The resident must be provided clear information about the discharge including continuity of VA and non-VA services. The use of a discharge planning checklist should include the following—outpatient follow-up plans, verified appropriate safe housing, verified travel arrangements, review of medications, and update of the suicide risk safety plan, when appropriate.[13] VHA requires MH RRTP discharges to occur during regular business hours and facilities must have procedures and resources in place to ensure the safety of residents and staff until discharge can occur during regular business hours.[14] Per VHA policy, "individuals with a disruptive behavior flag are not eligible for transport until and unless the Flag is removed."[15]

[11] Commission on Accreditation of Rehabilitation Facilities International, *2020 Behavioral Health Standards Manual,* July 1, 2020–June 30, 2021.

[12] VHA Directive 1162.02. The Interdisciplinary Recovery Team is composed of multiple disciplines "that are responsible for participating in the assessment, planning and/or implementation of a Veteran's care." Members of the team typically include a case manager, chaplain, psychiatric provider, psychologist, admissions/transitions coordinator, social worker, medical provider, registered nurse, clinical pharmacist or clinical pharmacy specialist, employment and vocational staff, peer support specialist, dietician, and recreation therapist.

[13] VHA Directive 1162.02.

[14] VHA Directive 1162.02. The White City facility's normal business hours are Monday through Friday 8:00 a.m.-4:30 p.m.

[15] VHA Directive 1695, *Veterans Transportation Services*, September 18, 2019.

Consistent with VHA policy, staff at the White City facility created a discharge planning checklist template. The facility discharge plan, referred to as a continuing care plan, is to be developed with the resident, and includes provisions to address post-discharge treatment needs. White City facility's standard operating procedure states that on discharge, the continuing care plan is to include a summary of the reason for the resident's admission, services provided, condition at discharge, reason for discharge, and any specific instructions provided to the resident.[16]

Admission to Roseburg HCS's acute psychiatric unit requires medical clearance by a hospitalist or urgent care provider and acceptance by an acute psychiatric provider. Roseburg HCS's acute psychiatric unit admission criteria include acute or imminent risk of harming self or others, severe psychosis, extreme anxiety, severe mania, catatonia, and inability to complete activities of daily living due to severe depression or other mental health conditions.[17]

Through an EHR review, the OIG confirmed that discharge planning for resident 1 began on the day of admission (day 1) and included both the resident and staff during interdisciplinary recovery team meetings. According to both facilities' staff, communication regarding the potential discharge from the White City facility and admission to the Roseburg HCS's acute psychiatric unit started around day 33, and due to an escalation in the resident's disruptive behavior, intensified on a Friday, day 37.

Through a review of resident 1's EHR and interviews with MH RRTP staff, the OIG learned resident 1 had cognitive issues and difficulty participating in treatment groups. Documentation in the EHR indicated resident 1 showed increasingly concerning behaviors: used profanity, kept unsanitary room conditions, threatened arson, threw a cup of urine at staff, and threatened bodily harm to staff and residents. As a result of these behaviors, staff documented nine entries in the Disruptive Behavior Reporting System. In response to the entries, the Disruptive Behavior Committee conducted a meeting via email on days 36 and 37, and entered a category 1 disruptive behavior flag into the EHR on the day of discharge at 6:14 p.m.[18] Service line and MH RRTP leaders and staff agreed that resident 1 did not have suicidal ideation; however, the resident's threats of bodily harm to staff and residents were interpreted by service line and MH RRTP leaders as homicidal ideation that warranted admission to Roseburg HCS's acute psychiatric unit.

After determining a higher level of care was needed, service line and MH RRTP leaders made a plan to discharge resident 1 from the MH RRTP and pursue admission to the Roseburg HCS

[16] White City Facility Standard Operating Procedure Chief of Staff-014, *Treatment Management*, August 27, 2015.

[17] Roseburg HCS Standard Operating Procedure 653-116-008, *Admission Policies and Procedures for the Inpatient Psychiatric Unit*, June 22, 2020.

[18] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, defines patients with category 1 as those "who present an immediate safety risk for seriously disruptive, threatening, or violent behavior and may be safely treated within VHA wherever they are registered and seek care."

acute psychiatric unit. White City facility service line and MH RRTP leaders stated that after speaking with a Roseburg HCS acute psychiatric provider, the discharge plan was to transport resident 1 to the Roseburg HCS Urgent Care Center where the resident would be medically evaluated and directly admitted to the acute psychiatric unit. The plan, while clear to MH RRTP leaders, was not conveyed to all staff on the resident's interdisciplinary recovery team as some staff understood the discharge would occur the following week. In contrast, the Roseburg HCS acute psychiatric provider told the OIG that resident 1 had not been accepted to the acute psychiatric unit and reported having advised an MH RRTP leader to transport resident 1 to a local emergency department for medical clearance prior to traveling to Roseburg HCS. According to the Roseburg HCS acute psychiatric provider, staff should call 911 or arrange for transport by ambulance to an emergency department for residents with homicidal ideation. The acute psychiatric provider also reported having notified the Roseburg HCS administrative officer of the day that the resident might be arriving from the White City facility.

Service line and MH RRTP leaders and staff reported the inconsistent use of a discharge planning checklist; the White City facility checklist was not completed for resident 1. On the day of discharge, documentation of the discharge plan was lacking in the resident's EHR. Although the OIG found a care coordination note authored by the MH RRTP Deputy Chief discussing discharge plans in resident 1's EHR, the note was entered into the EHR three days after the discharge and was not in alignment with VHA policy, which outlines elements that should be included in the discharge checklist.[19] Specifically, the OIG found the note did not include verified appropriate safe housing, travel arrangements, or a review of medications.

An MH RRTP leader stated that discharges do not typically take place after regular business hours or on weekends unless there is a concern for the safety of staff, residents, or the physical building. Resident 1 was discharged at 5:48 p.m., after business hours. Service line and MH RRTP leaders reported that there were limited options available for transport after business hours. As such, the service line and MH RRTP leaders decided to transport resident 1 in a White City facility vehicle accompanied by two non-clinical staff, noting it was the only option available for safe transport and a mode of transport that had been previously used. Service line and MH RRTP leaders determined this method of transport to be safe as there were two VHA employees in attendance and, while resident 1 had exhibited homicidal ideations earlier in the day, resident 1 was not in an escalated state at the time of transport and had not previously threatened these employees. When asked by the OIG, service line and MH RRTP leaders denied awareness of the VHA policy prohibiting residents with behavioral flags from using VHA transportation services.[20]

[19] VHA Directive 1162.02.

[20] VHA Directive 1695.

The early evening departure time left two hours and 12 minutes to arrive at the Roseburg HCS Urgent Care Center prior to closure; a trip that, at minimum, requires one hour and 37 minutes. An MH RRTP staff member reported it was snowing at the time of transport, and service line and MH RRTP leaders acknowledged there was no contingency plan in place had the resident arrived after the Urgent Care Center was closed.

Resident 1 checked in to the Roseburg HCS Urgent Care Center at 7:47 p.m., 13 minutes before it closed. There were conflicting reports regarding the hand-off that occurred. According to a White City facility staff member who transported the resident, the resident was escorted with belongings into Roseburg HCS and a Roseburg HCS staff member was notified of the arrival. However, Roseburg HCS Urgent Care Center staff reported not being aware of resident 1's transfer and not having contact with White City facility staff, the administrative officer of the day, or the acute psychiatric provider. Roseburg HCS Urgent Care Center staff reported that resident 1 stated being unaware of the reason for the visit to the Urgent Care Center and had no accompanying paperwork from the White City facility. Resident 1 was well-known to the Urgent Care Center provider who conducted the evaluation. The Urgent Care Center provider acknowledged not reviewing the resident's White City facility EHR notes at the time of the Urgent Care Center visit at issue. Had the Urgent Care Center provider reviewed the notes, other than the behavioral flag, specific discharge information was not available in the EHR. The Urgent Care Center provider determined the resident did not meet admission criteria for inpatient admission and was discharged to the community.

White City facility service line and MH RRTP leaders reported active engagement with Roseburg HCS leaders to improve the process to transfer residents to the Roseburg HCS acute psychiatric unit. On a regional level, a White City facility service line leader reported participating in a VISN 20 workgroup focused on developing a standardized process for admissions into acute psychiatric units.

Although the intent of White City facility service line and MH RRTP leaders was to discharge resident 1 for admission to an acute psychiatric unit, the OIG found that White City facility staff did not adhere to processes outlined in VHA directives that contribute to a smooth transition of care. Specifically, White City facility staff did not use a discharge checklist, conducted the discharge after regular business hours, and transported a resident with a behavioral flag.[21] Communication failures between the facilities and lack of clear processes for the transfer of MH

[21] The OIG recognizes the close relationship of the time between the departure of the resident from the White City facility and the placement of the behavioral flag in the EHR. While the note indicating the resident was administratively discharged was entered approximately 30 minutes prior to the entry of the flag into the EHR, the flag was in place while the resident was being transported. The OIG is concerned that (1) MH RRTP leaders knew a flag was being placed on the day of discharge but did not notify the staff transporting the resident of the flag's placement, and (2) they were unaware of VHA policy prohibiting the transport of a resident with a behavioral flag.

RRTP residents to a higher level of care led to confusion over the discharge plan and resulted in the resident being discharged to the community.

2. Admission of Residents to the White City Facility MH RRTP

The OIG did not substantiate that the White City facility inappropriately admitted two residents (resident 1 and resident 2) to the MH RRTP.[22] During the course of the inspection, the OIG learned of concerns regarding the appropriateness of three additional residents (residents 3, 4, and 5) for admission. The OIG found that two of the three additional residents met admission criteria. Due to a lack of EHR documentation and the departure of two staff from whom the OIG team may have gained clarification regarding the resident's admission and change in medical status, the OIG was unable to determine if the third additional resident had disqualifying conditions that would have precluded admission.[23]

VHA requires that MH RRTPs reduce barriers to treatment and consider each veteran's circumstances and individualized needs when screened for admission.[24] VHA admission criteria requires the veteran to be capable of self-preservation and self-care; to have a mental health, addiction, psychosocial, or medical rehabilitation need requiring the services, structure, and support that an MH RRTP can provide; not be an imminent risk of harm to self or others; and require a level of care higher than outpatient services but does not meet the need for acute inpatient mental health or medical admission.[25] VHA requires that "Veterans may be denied admission to residential care only when they do not meet admission criteria as defined by this directive."[26]

Further, VHA requires that veterans cannot be denied admission solely based upon current abstinence or length of current abstinence from alcohol or non-prescribed controlled substances; previous number of treatment episodes; time since last residential admission; use of prescribed controlled substances; legal history; medical co-occurring conditions not requiring a higher level of care or common medical needs; recent acute inpatient mental health treatment, recent thoughts of suicide, or attempt, or elevated chronic risk of self-harm; pregnancy; or the need for initiation or continuation of therapy for opioid use disorders.[27]

---

[22] For this report, the OIG considered an admission appropriate when criteria were met with no reasons for denial based upon VHA Directive 1162.02. An admission was considered inappropriate when admission criteria were not met or a reason for denial was found but the resident was still admitted.

[23] The OIG does not have testimonial subpoena authority to compel former federal employees to provide testimony in support of OIG oversight activities.

[24] VHA Directive 1162.02.

[25] VHA Directive 1162.02.

[26] VHA Directive 1162.02.

[27] VHA Directive 1162.02.

White City facility's admission screening guidelines align with VHA policy and state that veterans must not require more intensive treatment such as acute psychiatric or medical hospitalization, have tried less restrictive alternatives if available, not present an imminent risk of harm to themselves or others, ambulate and move without help, and independently complete activities of daily living.[28]

White City facility guidelines state the MH RRTP admission process begins with a veteran either self-referring to the program or being referred by a clinical staff member through an EHR consult. An admissions staff member and medical provider screen all referrals and consults, after which an interdisciplinary admission team meets and reviews each case to make an admission or denial decision. Veterans are admitted at the soonest possible date and an MH RRTP staff member stays in contact with the veteran while awaiting admission.[29] Upon admission, each resident receives medical, nursing, and mental health assessments. The resident is assigned to an interdisciplinary recovery team whose members work directly with the resident during the treatment program with the goal of completing the resident's individualized treatment plan.[30]

Review of Resident Admissions

Resident 1

The OIG did not substantiate that resident 1 was inappropriately admitted to the MH RRTP. The OIG found that resident 1 met admission criteria to the MH RRTP due to diagnoses of homelessness, schizophrenia, posttraumatic stress disorder, and substance use disorder.

Resident 1 was referred to the MH RRTP for consideration for admission in late 2020, by U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program staff at the Roseburg HCS. Preadmission screening was completed two days later.[31] On the referring consult, it was noted that resident 1 was unable to independently perform activities of daily living. Electronic communication between the admissions staff member and the referring provider clarified the resident's ability to perform activities of daily living. The referring provider acknowledged an error on the original consult and stated the resident could independently complete self-care activities. Through interviews, the OIG learned this information was relayed to the MH RRTP Medical Director, who completed the medical review, and the Admissions Supervisor; however, it was not documented in the EHR. The

[28] White City Facility Medical Center Memorandum 11-013, *Admission Screening Guidelines*, October 30, 2019; VHA Directive 1162.02.

[29] VHA Directive 1162.02; White City Facility Medical Center Memorandum 11-013. The interdisciplinary admission team consists of the admissions supervisor, admissions medical director, and program support assistant (or designees).

[30] VHA Directive 1162.02; White City Facility Standard Operating Procedure Chief of Staff-014.

[31] According to a Roseburg HCS acute psychiatric provider, Roseburg HCS's RRTP was closed at this time due to COVID-19 so a consult for admission was submitted to the White City facility RRTP.

interdisciplinary admission team, which consisted of the MH RRTP Medical Director and Admissions Supervisor, approved resident 1 for admission five days after receiving the referral with a tentative date of approximately two weeks later.

The OIG learned through interviews with MH RRTP leaders and staff of differing opinions regarding resident 1's appropriateness for admission and ability to engage in treatment. Some stated the resident was appropriate for admission while others were concerned that the resident's care needs were too complex, precluding engagement in treatment. The OIG found the resident met admission criteria per VHA guidelines and did not have disqualifying conditions that would preclude admission to the program.[32]

Resident 2

The OIG did not substantiate that resident 2 was inappropriately admitted to the MH RRTP. The OIG found the resident met admission criteria due to diagnoses of homelessness, traumatic brain injury, posttraumatic stress disorder, and substance use disorder. Resident 2 was referred from the community to the MH RRTP in late 2020, screened for acceptance five days later, medically cleared for admission the next day, and admitted approximately three weeks after referral. Shortly after admission, Resident 2 was irregularly discharged from the program, for disruptive behaviors related to COVID-19 quarantine restriction violations. Resident 2 self-referred for readmission within 14 days of discharge and was readmitted to the program seven days later.

Similar to concerns related to resident 1, MH RRTP leaders and staff had varying opinions on resident 2's appropriateness for admission and ability to engage in treatment. However, the OIG found the resident met admission criteria per VHA guidelines and did not have disqualifying conditions that would preclude admission to the program. The resident was discharged in spring 2021.

Additional Resident Cases

During interviews with the OIG, MH RRTP staff expressed concerns about the appropriateness of admission of three additional residents, residents 3, 4, and 5. In response to the concerns, the OIG reviewed the residents' EHRs and determined that two (residents 3 and 4) of the three residents met admission criteria with no disqualifying conditions that would preclude admission to the MH RRTP.

The OIG was unable to determine if the third resident (resident 5) met admission criteria due to the lack of documentation of communication alerting a White City facility medical provider to the resident's change in medical status and the lack of a medical reassessment documented in the EHR. The OIG learned through an EHR review that resident 5 was accepted into the MH RRTP

[32] VHA Directive 1162.02.

in 2021, with a scheduled admission date five days later. Two days before admission, a White City facility nursing staff member entered a note in the EHR documenting the resident was an inpatient at a community hospital being treated for a myocardial infarction. The OIG did not find evidence that a White City facility medical provider was notified of this change in medical status or conducted a re-evaluation of medical appropriateness prior to the resident's planned day of admission. Additionally, two staff from whom the OIG team may have gained clarification regarding the resident's change in medical status and admission were unavailable for interview as they were no longer employed at the facility at the time of the OIG inspection. Once admitted to the MH RRTP, resident 5 was seen twice at a non-VA emergency department for chest pain and each time was released back to the care of the MH RRTP. Resident 5 completed the treatment program and was discharged in early summer 2021.

The OIG determined that residents 1, 2, 3, and 4 met admission criteria. The OIG was unable to determine if resident 5 met admission criteria due to a lack of documentation and availability of staff for interview. However, the OIG determined that resident 5 should have been re-evaluated after a change in medical status prior to admission.

3. Resident Fall in Shower Area Resulting in Injury

The OIG substantiated that a resident (resident 6) was injured after slipping and falling while getting out of the shower. The OIG determined that there were missed opportunities to identify and acquire solutions in a timely manner to prevent future falls.

VHA requires that facilities provide MH RRTP residents a safe physical environment.[33] The Commission on Accreditation of Rehabilitation Facilities states that facilities must maintain a safe environment that minimizes risk of harm to individuals receiving care.[34] VHA requires that when events such as patient falls occur, the event is reviewed to identify the cause and implement changes to reduce the likelihood of it occurring again.[35]

In early 2021, resident 6 was admitted to the MH RRTP. At admission, it was noted in the EHR that the resident used a walker and the resident was assessed to be at moderate risk of falls. The following day, the resident slipped and fell in the shower area and was sent to a community emergency department where 14 staples were placed in the resident's head. The EHR shows that resident 6 told the MH RRTP staff member who found the resident after the fall of slipping on water that was on the floor outside of the shower.

[33] VHA Directive 1162.02.

[34] Commission on Accreditation of Rehabilitation Facilities International, *2020 Behavioral Health Standards Manual 2020,* July 1, 2020–June 30, 2021.

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

During its unannounced site visit, the OIG viewed a resident bathroom and shower identical to the one that resident 6 used.[36] The shower had an adjustable hand-held shower head, two grab bars, and a pull-down shower bench. The OIG observed a continuous slope in the floor angled towards the drain. During the visit, the OIG was told of two additional resident falls (residents 7 and 8) in the shower area during the previous year. The OIG verified the two falls and discovered the first fall occurred in spring 2020, when resident 7 stepped out of the shower and the second in fall 2020, while resident 8 was in the shower. The OIG found that at the time of each of the two falls, no actions were taken to prevent future falls.

Records show that the falls of residents 6, 7, and 8 were submitted in the Joint Patient Safety Reporting system and reviewed by the Patient Safety Manager. In response to resident 7's fall in spring 2020, the Patient Safety Manager reported proposing to the previous MH RRTP Director that a bathmat or extra towel be placed outside the shower but this request was not approved. The Patient Safety Manager believed the request was denied due to there having been only one fall to date, but could not remember the specific details. The Patient Safety Manager recalled multiple conversations following the 2020 falls discussing options to improve safety in the shower area; however, none were implemented prior to the third fall in early 2021. While on-site, the OIG met with facility leaders who stated awareness of the three falls on the MH RRTP and that after the most recent fall, the third in a ten-month period, a decision was made to place a towel outside of each resident's shower to prevent falls and to monitor the success of this intervention.

Prior to resident 6's fall in 2021, facility leaders completed a facility-wide aggregated falls patient safety assessment tool and identified two areas for improvement and two action items.[37] One action item was to conduct a Healthcare Failure Mode and Effect Analysis (HFMEA) in the MH RRTP focusing on falls and fall-related injury prevention.[38] The OIG found that after multiple residents fell in the shower area, an evaluation of the shower area and related falls was to be incorporated into the HFMEA to identify potential areas for improvement. The Patient Safety Manager said as of April 29, 2021, three months after identifying the need, the HFMEA had not started.

After resident 6's fall and injury in early 2021, the White City facility Associate Director requested a staff member in the safety section look into steps facility staff could take to prevent slips and falls in the shower area. Following the review, the Associate Director emailed and received approval from the Chief of Staff to pursue the purchase of bath shoes and longer shower

[36] The OIG did not enter resident 6's bathroom as it was on a COVID-19 quarantined floor.

[37] The two areas of improvement related to (1) communication of the falls program data, analysis, and improvement actions to front line staff and (2) the use of a valid and reliable instrument to screen for patient fall risk factors upon admission and a change with a condition.

[38] Another action item was for the Patient Safety Manager to provide a fall report at RRTP safety meetings that occurred monthly with the ultimate goal being to reduce the fall rate by at least 10 percent in the RRTP compared to the previous year.

curtains and to lower the shower curtains already there. These staff, along with leaders from the MH RRTP, infection control, and patient safety, corresponded via email to discuss implementation of these solutions but were not able to come to a consensus as individuals on the email correspondence expressed concerns about infection control, compliance standards, and product availability for some of the options suggested.

A multidisciplinary group met to discuss the solutions to prevent residents' falls in detail for the shower area. A variety of options were reviewed and discussed including the shower curtain lengths and bath shoes as well as bathmats and non-skid strips. The Patient Safety Manager stated the multidisciplinary group decided that each resident would receive a bathmat to place outside the shower. However, Roseburg HCS, which provided linens to the White City facility, did not stock bathmats so bath towels were ordered instead. Beginning early spring 2021, each resident was issued an extra towel to serve as a bathmat. In the meantime, facility leaders were able to find bathmats through another entity and approximately one month later, ordered a bathmat for each resident to use in lieu of the extra towel.

The OIG learned that in March 2017, VHA's Deputy Under Secretary for Health for Operations and Management sent a memorandum to the field focusing on safety in MH RRTPs.[39] The memorandum was accompanied by a document, "Ten Steps to Improving Safety, Security, and 24/7 Supervision" that encouraged VA medical centers to develop an MH RRTP Safety Committee. A request to the White City facility for meeting minutes from the committee revealed that the White City facility did not have an MH RRTP Safety Committee prior to February 2021 when the then–interim MH RRTP Chief requested approval of a charter to initiate one. The charter was submitted to, and approved by, the White City facility's Safety and Health Leadership Committee. The first meeting of the committee was held in April 2021, and included falls as a reoccurring discussion topic.

The OIG found that three residents fell in the shower on the MH RRTP over the course of 10 months with one incurring injury. The OIG determined that White City facility leaders and facility-wide committees were aware of the falls but found a missed opportunity to identify and acquire solutions timely to prevent future falls. The OIG identified the lack of an MH RRTP Safety Committee as a factor contributing to the lack of service-specific focus on the falls.

[39] VHA Deputy Under Secretary for Health for Operations and Management Memorandum, *Ensuring Safety and Quality of Care in the Mental Health Residential Rehabilitation Treatment Programs: Surge on Safety (VAIQ 7777978*), March 15, 2017.

Conclusion

The OIG substantiated that White City facility staff transported resident 1 to Roseburg HCS for admission to its acute psychiatric unit; however, the resident was not admitted and was discharged to the community. The OIG found that the White City facility did not adequately coordinate and plan the discharge and transport of resident 1 to Roseburg HCS. When discharging resident 1 from the MH RRTP, inconsistent with VHA policy, White City facility staff did not use a discharge checklist, conducted the discharge after regular business hours, and provided transportation for the resident despite a documented behavioral flag.

Although the intent of White City facility service line and MH RRTP leaders was to discharge resident 1 for admission to an acute psychiatric unit, the OIG found that the White City facility did not adhere to processes outlined in VHA directives that likely would have contributed to a smoother transition of care. Communication failures between the facilities and lack of clear processes for the transfer of MH RRTP residents to a higher level of care led to confusion over the discharge plan and resulted in the resident being discharged to the community.

The OIG did not substantiate that the White City facility inappropriately admitted two residents (residents 1 and resident 2) to the MH RRTP. The OIG found that resident 1 met admission criteria to the MH RRTP due to diagnoses of homelessness, schizophrenia, posttraumatic stress disorder, and substance use disorder. The OIG found that resident 2 met admission criteria due to diagnoses of homelessness, traumatic brain injury, posttraumatic stress disorder, and substance use disorder.

During the course of the inspection, the OIG learned of concerns regarding the appropriateness of three additional residents (residents 3, 4, and 5) for admission. The OIG found that two of the three additional residents met admission criteria (residents 3 and 4). Due to a lack of EHR documentation and the departure of two staff from whom the OIG team may have gained clarification regarding the resident's admission and change in medical status, the OIG was unable to determine if the third additional resident (resident 5) had disqualifying conditions that would have precluded admission. However, the OIG determined that resident 5 should have been re-evaluated after a change in medical status prior to admission.

The OIG substantiated that a resident (resident 6) was injured after slipping and falling while getting out of the shower. During an unannounced site visit, the OIG was told of two additional resident falls (residents 7 and 8) in the shower area during the previous year. The OIG determined that facility leaders and facility-wide committees were aware of the falls but missed an opportunity to identify and acquire solutions timely to prevent future falls. The OIG identified the lack of an MH RRTP Safety Committee as a factor contributing to the lack of service-specific focus on the falls.

Recommendations 1–5

1. The Southern Oregon Rehabilitation Center and Clinics Director conducts an assessment to ensure all applicable elements of the Southern Oregon Rehabilitation Center and Clinics continuing care plan template are addressed when discharging residents from the Mental Health Residential Rehabilitation Treatment Program and takes action as warranted.

2. The Southern Oregon Rehabilitation Center and Clinics Director ensures discharges of residents from the Mental Health Residential Rehabilitation Treatment Program occur during regular business hours in accordance with Veterans Health Administration Directive 1162.02.

3. The Southern Oregon Rehabilitation Center and Clinics Director reviews Southern Oregon Rehabilitation Center and Clinics transportation policies to ensure alignment with Veterans Health Administration transportation directives, including management of the transport of residents with behavioral flags.

4. The Southern Oregon Rehabilitation Center and Clinics Director develops a process to ensure an updated medical evaluation is conducted should the admission team be notified of a change in medical status that occurs after a veteran's initial admission screening medical evaluation but prior to admission to the Mental Health Residential Treatment Program.

5. The Southern Oregon Rehabilitation Center and Clinics Director completes a systematic review of residents' falls in the shower area on the Mental Health Rehabilitation Residential Program units and takes action as warranted.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 6, 2021

From: Director, VA Northwest Network (10N20)

Subj: Healthcare Inspection—Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon

To: Director, Office of Healthcare Inspections (54HL05)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review the findings from the Healthcare Inspection—Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon.
2. I concur with your findings and recommendations, as well as Southern Oregon Rehabilitation Center and Clinics' proposed actions.

(*Original signed by*:)

John A Mendoza, Deputy Network Director
On behalf of Teresa Boyd

Appendix B: Southern Oregon Rehabilitation Center and Clinics Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 29, 2021

From: Director, Southern Oregon Rehabilitation Center and Clinics (692)

Subj: Healthcare Inspection—Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon

To: Director, VA Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the Healthcare Inspection—Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon.

2. The Southern Oregon Rehabilitation Center and Clinics concurs with the findings and recommendations and will ensure that actions to correct these findings are completed as described in the responses.

3. If you have any questions, please contact me.

(*Original signed by*:)

David L. Holt, MBA, FACHE

Facility Director Response

Recommendation 1

The Southern Oregon Rehabilitation Center and Clinics Director conducts an assessment to ensure all applicable elements of the Southern Oregon Rehabilitation Center and Clinics continuing care plan template are addressed when discharging residents from the Mental Health Residential Rehabilitation Treatment Program and takes action as warranted.

Concur.

Target date for completion: 5/1/2022

Director Comments

The Southern Oregon Rehabilitation Center and Clinics Director developed a Standard Operating Procedure (SOP) for Residential Rehabilitation Treatment Program (RRTP) which contains the template for Continuing Care Plan. The Continuing Care Plan template will be updated in Computerized Patient Record System (CPRS). The Chief of RRTP or designee will provide education to RRTP staff regarding the updated Continuing Care Plan template. Monthly chart reviews of up to 10 discharges will occur to ensure all elements are completed within the Continuing Care Plan for a series of six consecutive months at 90% compliance or greater. Review data will be reported to Behavioral Health Oversight Council (BHOC) monthly.

Recommendation 2

The Southern Oregon Rehabilitation Center and Clinics Director ensures discharges of residents from the Mental Health Residential Rehabilitation Treatment Program occur during regular business hours in accordance with VHA Directive 1162.02.

Concur.

Target date for completion: 5/1/2022

Director Comments

The Southern Oregon Rehabilitation Center and Clinics Director updated the Residential Rehabilitation Treatment Program Discharges Standard Operating Procedures (SOP) and the Resident Handbook to remove immediate discharge language and reflect that discharges will occur during regular business hours. In accordance with VHA Directive 1162.02, if there are irregular discharges, a plan to notify RRTP leadership will be in place. The Chief of RRTP or designee will provide education on the updated discharge process to the RRTP staff. Monthly chart reviews of up to 10 discharges will be performed to verify discharges occur during business hours or if an irregular discharge is indicated, that a leadership plan is in place in accordance

with VHA Directive 1162.02. Monthly Chart reviews will be reported to BHOC meeting until six consecutive months of 90% compliance or greater is reached.

Recommendation 3

The Southern Oregon Rehabilitation Center and Clinics Director reviews Southern Oregon Rehabilitation Center and Clinics transportation policies to ensure alignment with VHA transportation directives, including management of the transport of residents with behavioral flags.

Concur.

Target date for completion: 12/2/2021

Director Comments

The Southern Oregon Rehabilitation Center and Clinics Director has reviewed the transportation policies and has assigned revision of the local Voluntary Transport Services (VTS) policy regarding Mental Health and Disruptive Behavior Transport. This revision will reflect VTS Directive for travelling Veterans with Orders of Behavioral Restriction (Flags) as well as the Workplace Violence Prevention Program Directive regarding how Veterans with Behavioral Flags and High Risk for Suicide Flags will be transported. The Chief of Business office or designee will send out an email to all VA SORCC staff regarding the transportation of Veterans with Behavioral and High-Risk Suicide flags.

Recommendation 4

The Southern Oregon Rehabilitation Center and Clinics Director develops a process to ensure an updated medical evaluation is conducted should the admission team be notified of a change in medical status that occurs after a veteran's initial admission screening medical evaluation but prior to admission to the Mental Health Residential Treatment Program.

Concur.

Target date for completion: 5/1/2022

Director Comments

The Southern Oregon Rehabilitation Center and Clinics Director has revised the RRTP Admission SOP to include language that medical clearance will be re-evaluated at any time between when the admission date is provided and when the Veteran presents for admission. The RRTP Admission team will be provided with the updated SOP. Chart Audits of up to 10 admission will be reviewed monthly for verification of compliance with the revised SOP to determine whether updated medical information was provided to the admission team and determine if an updated medical evaluation occurred following the provision of updated medical

information. Audit data will be reported to the BHOC meeting and will continue until 90% compliance or greater is met for six consecutive months.

Recommendation 5

The Southern Oregon Rehabilitation Center and Clinics Director completes a systematic review of residents' falls in the shower area on the Mental Health Rehabilitation Residential Program units and takes action as warranted

Concur.

Target date for completion: 1/31/2022

Director Comments

The Southern Oregon Rehabilitation Center and Clinics Director will charter a formal aggregate Root Cause Analysis (RCA) to address the three incidences of falls in RRTP in the ten month period outlined in the report. Upon completion of the RCA, the VA SORCC Director will ensure corrective actions are implemented until completed.

Appendix C: Roseburg VA Health Care System Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 1, 2021

From: Director, Roseburg VA Health Care System (653)

Subj: Healthcare Inspection—Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon

To: Director, VA Northwest Network (10N20)

1. Thank you for the opportunity to review the findings from the Healthcare Inspection—Inadequate Care Coordination for a Mental Health Residential Rehabilitation Treatment Program Resident in VISN 20, Oregon.

(*Original signed by*:)

Keith M. Allen

Glossary

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

activities of daily living. "Functions or tasks for self-care usually performed in the normal course of a day, i.e., mobility, bathing, dressing, grooming, toileting, transferring, and eating."[45]

anxiety. An abnormal and overwhelming sense of apprehension and fear often marked by physical signs (such as tension, sweating, and increased pulse rate), by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it.[46]

behavioral flag. A category one patient record flag for violent or disruptive behavior that is shared across all VHA facilities for a given patient. The flag is for those patients who present an immediate risk for seriously disruptive, threatening, or violent behavior and allows patients to be safely treated within VHA wherever they are registered and seek care.[47]

catatonia. A psychomotor disturbance that may involve muscle rigidity, stupor or mutism, purposeless movements, negativism, echolalia, and inappropriate or unusual posturing and is associated with various medical conditions (such as schizophrenia and mood disorders).[48]

COVID-19. A viral infection "caused by a new coronavirus first identified in Wuhan, China, in December 2019. Because it is a new virus, scientists are learning more each day. Although most people who have COVID-19 have mild symptoms, COVID-19 can also cause severe illness and even death. Some groups, including older adults and people who have certain underlying medical conditions, are at increased risk of severe illness."[49]

depression. A mood disorder that is marked by varying degrees of sadness, despair, and loneliness and that is typically accompanied by inactivity, guilt, loss of concentration, social withdrawal, sleep disturbances, and sometimes suicidal tendencies.[50]

---

[45] Electronic Code of Federal Regulations, CFR Title 38: Pensions, Bonuses and Veterans Relief, Part 52—*Per Diem for Adult Day Health Care of Veterans in State Homes*, §52.2 Definitions, accessed June 10, 2021, https://www.ecfr.gov/cgi-bin/text-idx?SID=cdaebfb60e82252b2117dccaefadddfa&pitd=20180101&node=sp38.2.52.a&rgn=div6.

[46] *Merriam-Webster.com Dictionary,* "anxiety," accessed June 22, 2021, https://www.merriam-webster.com/dictionary/anxiety.

[47] VHA Directive 2010-053, *Patient Record Flags,* December 3, 2010.

[48] *Merriam-Webster.com Dictionary*, "catatonia," accessed June 22, 2021, https://www.merriam-webster.com/dictionary/catatonia.

[49] *"*About COVID-19*,"* Centers for Disease Control and Prevention, accessed April 29, 2021, https://www.cdc.gov/coronavirus/2019-ncov/cdcresponse/about-COVID-19.html.

[50] *Merriam-Webster.com Dictionary*, "depression," accessed June 22, 2021, https://www.merriam-webster.com/dictionary/depression.

Disruptive Behavior Reporting System. A secure, web-based program "that allows all employees to have a voice regarding any concerns they may have about safety."[51]

Healthcare Failure Mode and Effect Analysis. A proactive risk assessment model used to evaluate "a product or process to identify systems vulnerabilities, and their associated corrective actions, before an adverse event occurs."[52]

Housing and Urban Development-VA Supportive Housing. "A collaborative program between HUD [Housing and Urban Development] and VA that combines HUD housing vouchers with VA supportive services to help Veterans who are homeless, and their families find and sustain permanent housing."[53]

irregular discharge. "The release of a competent patient from a VA or VA-authorized hospital, nursing home, or domiciliary care due to: refusal, neglect or obstruction of examination or treatment; leaving without the approval of the treating health care clinician; or disorderly conduct and discharge is the appropriate disciplinary action."[54]

mania. Excitement manifested by mental and physical hyperactivity, disorganization of behavior, and elevation of mood.[55]

myocardial infarction. Also known as a heart attack. Permanent damage to the heart muscle occurs as a result of death of tissue due to lack of blood supply.[56]

posttraumatic stress disorder. A psychological reaction occurring after experiencing a highly stressing event (such as wartime combat, physical violence, or a natural disaster) that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event.[57]

psychosis. A serious mental illness (such as schizophrenia) characterized by defective or lost contact with reality often with hallucinations or delusions.[58]

---

[51] "VHA's Workplace Violence Prevention Program," VA, accessed June 17, 2021, VHA's Workplace Violence Prevention Program (WVPP) - Public Health (va.gov).

[52] VHA Directive 1050.01.

[53] "U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program," VA, accessed June 3, 2021, https://www.va.gov/homeless/hud-vash.asp.

[54] VHA Handbook 1601B.05, *Beneficiary Travel*, July 21, 2010, corrected copy July 23, 2010.

[55] *Merriam-Webster.com Dictionary*, "mania," accessed June 22, 2021, https://www.merriam-webster.com/dictionary/mania.

[56] "Heart Attack (Myocardial Infarction)," Cleveland Clinic, accessed June 10, 2021, https://my.clevelandclinic.org/health/diseases/16818-heart-attack-myocardial-infarction.

[57] *Merriam-Webster.com Dictionary*, "post-traumatic stress disorder," accessed June 22, 2021, https://www.merriam-webster.com/dictionary/post-traumatic%20stress%20disorder.

[58] *Merriam-Webster.com Dictionary*, "psychosis," accessed June 22, 2021, https://www.merriam-webster.com/dictionary/psychosis.

root cause analysis. A process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls.[59]

schizophrenia. A mental illness characterized by disturbances in thought (such as delusions), perception (such as hallucinations), and behavior (such as disorganized speech or catatonic behavior), by a loss of emotional responsiveness and extreme apathy, and by noticeable deterioration in the level of functioning in everyday life.[60]

substance use disorder. "A disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication."[61]

traumatic brain injury. An acquired brain injury caused by external force (such as a blow to the head sustained in a motor vehicle accident or fall or shrapnel or a bullet entering through the skull).[62]

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

[60] *Merriam-Webster.com Dictionary*, "schizophrenia," accessed June 22, 2021, https://www.merriam-webster.com/dictionary/schizophrenia.

[61] "Drug addiction (substance use disorder)," Mayo Clinic, accessed June 22, 2021, https://www.mayoclinic.org/diseases-conditions/drug-addiction/symptoms-causes/syc-20365112.

[62] *Merriam-Webster.com Dictionary* "traumatic brain injury," accessed June 22 2021, https://www.merriam-webster.com/dictionary/traumatic%20brain%20injury.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Susan Tostenrude, MS, Director Kevin Arnhold, FACHE Sami Cave, MA Marlene DeMaio, MD Seema Maroo, MD Nancy Short, LCSW Patrice Marcarelli, MD
Other Contributors	Alicia Castillo-Flores, MBA, MPH Kathy Gudgell, JD, RN Dawn Rubin, JD, MSN Natalie Sadow, MBA Robert Wallace, MPH, ScD

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Northwest Network (10N20)
Director, Roseburg VA Health Care System (653)
Director, VA Southern Oregon Rehabilitation Center (692)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Merkley, Ron Wyden
U.S. House of Representatives: Cliff Bentz, Earl Blumenauer, Suzanne Bonamici, Peter DeFazio, Kurt Schrader

OIG reports are available at www.va.gov/oig.