



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Failure of Leaders to  
Address Safety, Staffing, and  
Environment of Care  
Concerns at the Tuscaloosa  
VA Medical Center in  
Alabama



## 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.*

FOR MORE  
VA OIG REPORTS  
**CLICK HERE**



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

[www.va.gov/oig/hotline](http://www.va.gov/oig/hotline)

**1-800-488-8244**



## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Tuscaloosa VA Medical Center (facility) in Alabama to assess allegations regarding the failure of facility leaders, including community living center (CLC) leaders, to address CLC security and safety issues known to them. This alleged failure by facility leaders resulted in a resident's elopement.

The OIG also assessed allegations that facility leaders failed to fill key vacant positions, utilize unused space for the provision of patient care, and ensure the environment of care and maintenance of grounds provided a safe setting. To ensure that oversight of the facility was occurring, the OIG also reviewed findings and recommendations outlined by Veterans Integrated Service Network (VISN) 7 staff resultant from their visit to the facility to assess concerns reported to them in the OIG team briefing.

The OIG substantiated that facility leaders failed to address CLC safety and security issues that resulted in a resident's elopement. The OIG found that while an alert system was in place to notify staff whenever an exterior door was opened, facility leaders did not implement a 2018 Healthcare Failure Mode and Effect Analysis recommendation to install an electronic alarm system to prevent resident elopement until November 2021, when a contract to purchase the system was awarded.<sup>1</sup> The OIG learned that five residents eloped from a locked CLC cottage since the recommendation was made to facility leaders.<sup>2</sup> The residents were found safe. There were various reasons why these recommendations were not implemented, including confusion on the need for an alarm system on a locked unit, failure of key stakeholders to respond to Equipment Committee requests for discussion of the topic, and changes in facility leadership.

During the inspection, the OIG identified concerns regarding the operability of security cameras located in the CLCs, the security of outdoor areas surrounding the CLC cottages, and use of elopement risk alerts in residents' electronic health records. The OIG determined that these security and safety concerns likely contributed to, or failed to mitigate, resident elopements. Timely follow-through on the resolution of these concerns, along with implementation of the recommended electronic alarm system, were imperative to the safety of CLC residents at the facility.

---

<sup>1</sup> The alert is a single chime that sounds when an exterior door is opened and does not remain on until someone takes action to turn it off. An example of an electronic alarm system used to prevent elopement on a locked unit is a global positioning system (GPS-style tracking device worn by residents that sounds an alert if a resident leaves the unit, providing staff with the resident's location. VA National Center for Patient Safety, *Healthcare Failure Modes and Affects Analysis (HFMEA) Guidebook*, January 2021. Healthcare Failure Mode and Effect Analysis is a tool used for proactive risk assessment; it is specifically focused on healthcare and considers risks before an event occurs.

<sup>2</sup> Units where CLC residents live are referred to as neighborhoods. Cottages are freestanding buildings on the facility campus that each house a CLC neighborhood.

The OIG substantiated that facility leaders failed to fill several key positions specified in the original complaint.<sup>3</sup> The OIG reviewed administrative, physician, and engineering vacancies and found that all administrative vacancies, two of five physician vacancies, and seven of 14 engineering vacancies were filled. Eight of the reviewed positions remained unfilled for more than a year. The OIG found facility leaders took action to assign, when available, interim staff to cover the vacant positions until the hiring of permanent staff. The OIG identified factors contributing to the vacancies, such as difficulty in recruiting candidates for certain positions, lower salary levels associated with the facility's low-complexity level and rural location, and challenging human resource processes.

The OIG did not substantiate that facility leaders failed to use available space to provide care for patients. Veterans Health Administration (VHA) requires that each facility use a facility master plan, which includes areas of space, to review existing resources and project healthcare needs and demands of the facility.<sup>4</sup> The OIG confirmed that facility leaders utilized several long-range planning tools and an internal space request process when considering their designs for space management and construction projects. Facility leaders and staff explained to the OIG that the facility's Space and Moves Planning Committee, in accordance with their internal space request process and policy, is responsible for "reviewing changing space requirements of all Services based on Medical Center priorities, program needs, workload, personnel, and other influencing factors."<sup>5</sup> This committee is also responsible for assigning space and managing moves within the facility. During the on-site visit, the OIG team did not observe any areas in which patient care was negatively impacted due to space limitations or constraints. Some areas observed by the OIG appeared crowded, but without any negative impact noted on patients receiving care. Interviews with staff confirmed this. The OIG team found that although the facility had unused space, a lack of assigned space was not a limiting factor when providing patient care.

VHA requires managers to conduct Comprehensive Environment of Care (CEOC) rounds and to resolve issues timely. The goal of the CEOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients,

---

<sup>3</sup> For this report, the complainant identified the following as key positions: physicians, Chief of Quality Management, Public Affairs Officer, Chief of Police, Industrial Hygienist, Safety Officer, engineers, Clinic Profiler, Chief of Supply Chain, and Contract Liaison. The OIG placed these positions into the following three categories: administrative, physician, and engineering.

<sup>4</sup> VHA Directive 1002.1, *Non-Recurring Maintenance Program*, May 6, 2020. VHA Capital Asset Management Guidebook, December 5, 2019.

<sup>5</sup> Facility MCM 138-21, *Space and Moves Planning Committee*, August 17, 2018.

visitors, and staff.<sup>6</sup> The OIG did not substantiate that facility leaders failed to ensure the environment of care and maintenance of grounds provided a safe setting for patients, visitors, and staff. However, the OIG determined that the facility leaders did not follow VHA and facility requirements to inspect inpatient care areas twice per fiscal year and did not complete inspections of the grounds during fiscal years 2020 and 2021.<sup>7</sup> Due to numerous instances of discolored or damaged ceiling tiles, issues involving facility cleanliness, and finding various discarded equipment, including equipment waiting for turn-in, the OIG determined the facility's CEOC rounds were ineffective.

VHA emphasizes the importance of maintaining facility grounds and parking as it impacts patients' experience.<sup>8</sup> Through interviews with facility leaders, the OIG learned of challenges faced by the facility in the maintenance of the grounds due to the large size of the campus.<sup>9</sup> Facility and service leaders reported that low staffing levels were exacerbated by the Grounds Department staff's collateral duties that effectively removed them from grounds duties. Such collateral duties included driving to provide transportation for veterans and laundry services to other VA facilities. Despite these challenges, the OIG found that the facility's grounds were generally maintained, did not observe safety concerns that impacted patient care, and that facility leaders prioritized patient care at the forefront while managing the challenges of staffing and its large campus.

Following an OIG briefing to VISN and facility leaders, VISN 7 staff visited the facility and identified many of the same areas of concern addressed in this report including cleanliness, housekeeping and engineering staffing shortages, inadequate rounding of the grounds, and storage of equipment pending disposal. In late October 2021, VISN 7 staff made multiple findings and had 12 recommendations. As of December 22, 2021, the facility had completed seven of the VISN's 12 recommendations.

The OIG inspection resulted in one recommendation to the VISN 7 Director related to ensuring that the facility completes all VISN recommendations made as a result of the October 2021 VISN 7 site visit.

---

<sup>6</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. This directive was in effect during the time of some events discussed in this report; it was rescinded and replaced by VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, June 21, 2021. The two policies have the same or similar language related to the goal of the CEOC Program.

<sup>7</sup> "FEMA Recovery Support Function Leadership Group," accessed November 2, 2021, <https://recovery.fema.gov/glossary/FY#>. "The fiscal year is an accounting period that spans 12 months. For the Federal government, it runs from October 1 to September 30. For example, Fiscal Year 2017 (FY2017) starts October 1, 2016, and ends September 30, 2017."

<sup>8</sup> VHA Healthcare Engineering Guidebook, January 8, 2020.

<sup>9</sup> The facility is located on a 125-acre campus with 42 buildings totaling 1,135,711 gross square footage.

Additionally, the OIG made nine recommendations to the Facility Director related to providing oversight of the purchase and installation of an electronic alarm system for the CLC; completing a risk analysis to determine suitability of the Azalea House<sup>10</sup> for the patient population residing there; ensuring all security cameras are operable and labeled; assessing the effectiveness of the outdoor fencing and gates surrounding the Azalea House as a security measure to prevent resident elopement; establishing a review process to ensure that CLC residents determined to be high risk for elopement have documentation in their electronic health record identifying their risk status; collaborating with VISN 7 staff to develop a plan for coverage, recruitment, and retention of difficult to fill positions; confirming that patient care areas are properly classified and inspected as required as part of the facility's CEOC program; developing a plan to effectively identify areas in need of attention to provide a clean and safe environment of care; and confirming that Engineering Service staff conduct inspections of the grounds according to facility policy.

## **VA Comments and OIG Response**

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes D and E). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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

---

<sup>10</sup> The Azalea House is a locked freestanding cottage that is part of the facility's community living center and houses residents with dementia-related diagnoses.

## Contents

Executive Summary .....	i
Abbreviations .....	vii
Introduction.....	1
Scope and Methodology .....	2
Inspection Results .....	3
1. CLC Security and Safety.....	3
2. Staffing of Key Positions .....	9
3. Unused Space .....	15
4. Environment of Care and Grounds .....	17
5. VISN Oversight.....	24
Conclusion .....	24
Recommendations 1–10.....	26
Appendix A: Facility Map .....	27
Appendix B: Facility Building List.....	28
Appendix C: October 2021 VISN 7 Facility Review Results.....	30
Appendix D: VISN Director Memorandum .....	31
Appendix E: Facility Director Memorandum .....	33
OIG Addendum to the Facility Director Memo.....	34

OIG Contact and Staff Acknowledgments .....41

Report Distribution .....42



## Abbreviations

CLC	community living center
CEOC	Comprehensive Environment of Care
EHR	electronic health record
GEC	Geriatrics and Extended Care
GPS	Global Positioning System
HFMEA	Healthcare Failure Mode and Effect Analysis
JPSR	Joint Patient Safety Reports
MISSION	VA Maintaining Internal Systems and Strengthening Integrated Outside Networks
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Tuscaloosa VA Medical Center (facility) in Alabama to assess allegations regarding the failure of facility leaders, including community living center (CLC) leaders, to address CLC security and safety issues known to them; this alleged failure resulted in a resident's elopement. The OIG also assessed allegations that facility leaders failed to fill key vacant positions, utilize unused space for the provision of patient care, and ensure the environment of care and maintenance of grounds provided a safe setting.<sup>1</sup>

## Background

The facility, part of Veterans Integrated Service Network (VISN) 7, is located on a 125-acre campus with 42 buildings totaling 1,135,711 gross square footage.<sup>2</sup> In 2012, approximately 60 acres and 21 buildings, constructed in the 1930s and 1940s, were listed on the National Register of Historic Places. (See appendixes A and B for a facility map and building list.) The facility operates one community-based outpatient clinic located in Selma, Alabama. The facility is designated as level 3, low complexity, and provides primary care, mental health, specialty care, and long-term and rehabilitative care.<sup>3</sup> From October 1, 2019, through September 30, 2020, the facility served 15,450 patients and had 317 operating beds consisting of 134 CLC, 128 domiciliary, 43 inpatient mental health, and 12 compensated work therapy transitional residence beds. The CLC has seven neighborhoods located in five buildings; three of the neighborhoods are in freestanding cottages built between 2012 and 2018.<sup>4</sup>

---

<sup>1</sup> For this report, the terms *elopement*, *wandering*, and *missing* are individually defined, and not used interchangeably. Agency for Healthcare Research and Quality, Patient Safety Network, *Elopement*, accessed February 22, 2022, <https://psnet.ahrq.gov/web-mm/elopement>. "Elopement is defined as a patient that is aware that he/she is not permitted to leave, but does so with intent." VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. The handbook announced VHA's decision to replace the term *nursing home care unit* with *community living center*. For this report, the OIG refers to CLC patients as residents.

<sup>2</sup> VA Standards Alert, "Standardization of Square Footage Space Definitions and Measurements for VA Facilities," April 1, 2012, accessed February 15, 2022, <https://www.cfm.va.gov/til/sAlert/sAlert002a.pdf>. "Gross Square Feet (GSF) is defined as the area that includes all enclosed space as measured from the exterior face of the building walls."

<sup>3</sup> 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." A level 3 facility has low-volume, low-risk patients; few, or no complex clinical programs; and small or no research and teaching programs.

<sup>4</sup> Units where CLC residents live are referred to as *neighborhoods*. *Cottages* are freestanding buildings on the facility campus that each house a CLC *neighborhood*.

## Allegations and Related Concerns

On July 7, 2021, the OIG received an anonymous complaint alleging facility leaders failed to

- address known CLC security and safety issues, which resulted in a resident elopement,
- fill several key positions,<sup>5</sup>
- use available space to provide care to patients, and
- ensure the environment of care and maintenance of grounds provided a safe setting for patients, visitors, and staff.<sup>6</sup>

To ensure that oversight of the facility was occurring at the VISN level, the OIG reviewed findings and recommendations outlined by VISN staff in response to their visit to the facility to assess concerns reported to them during a briefing by the OIG team.

During the inspection, the OIG discovered concerns related to the facility's Patient Safety Program. Given the significance of these concerns, the OIG team consulted with OIG Office of Healthcare Inspections leaders who decided to initiate a separate healthcare inspection to assess those matters. The findings of that inspection will be discussed in a separate report.

## Scope and Methodology

The OIG initiated the inspection on July 29, 2021. Telephonic interviews were conducted September 27–October 2, 2021. A site visit was conducted October 5–6, 2021, to assess security in the CLC, environment of care in areas used to directly support or provide patient care, and the condition of the facility's grounds. Additional telephonic interviews were conducted October 14–21, 2021.

The OIG interviewed VISN 7 and facility leaders and facility staff familiar with processes related to CLC security and safety, staffing, space utilization, environment of care, maintenance of grounds, and their oversight of the facility.

---

<sup>5</sup> The complainant identified the following as key positions: physicians, Chief of Quality Management, Public Affairs Officer, Chief of Police, Industrial Hygienist, Safety Officer, engineers, Clinic Profiler, Chief of Supply Chain, and Contract Liaison. For this report, the OIG placed these positions into the following three categories: administrative, physician, and engineering.

<sup>6</sup> For the purposes of this report, the OIG focused the inspection of the grounds to the exterior property providing ingress and egress to the healthcare facilities used by veterans, visitors, and staff. This included vehicle parking, pedestrian walkways, sidewalks, curb cuts and ramps, stairs, patient drop-off zones, shuttle and bus stops, exterior lighting, signage, as well as entrances and exits from buildings. The OIG focused the inspection of the facility's environment of care to buildings or spaces used to directly support or provide patient care. Elements of review were identified to ensure that these environments adhered to infection control standards and supported the privacy, safety, and security of patients, visitors, and staff.

The OIG reviewed relevant Veterans Health Administration (VHA) directives, handbooks, guidebooks, and memorandums as well as facility policies, and organizational charts. The OIG also reviewed the facility's committee meeting minutes, staff hiring data, space management documents, construction project reports, and external accreditation survey results.

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.

## Inspection Results

### 1. CLC Security and Safety

The OIG substantiated that facility leaders failed to address CLC security and safety issues that resulted in a resident's elopement. The OIG found that facility leaders did not implement a 2018 Healthcare Failure Mode and Effect Analysis (HFMEA) recommendation to install an electronic alarm system to prevent resident elopement.<sup>7</sup> The OIG learned that five resident elopements occurred from a locked CLC cottage since the HFMEA recommendation was made. During the inspection, the OIG identified additional CLC security and safety concerns that likely contributed to or failed to mitigate resident elopements.

---

<sup>7</sup> VHA National Center for Patient Safety, *Healthcare Failure Modes and Affects Analysis (HFMEA) Guidebook*, January 2021. HFMEA is a tool used for proactive risk assessment. Specifically focused on health care, HFMEA considers risks before an event occurs. Alarm systems used to prevent elopement on a locked unit may include door alarms that notify staff when they are opened, and Global Positioning System (GPS) style tracking devices worn by residents that sound an alert if the resident leaves the unit.

VHA recognizes that “patients straying beyond the normal view or control of employees may be at-risk for injury or death.” While VHA is responsible “for all patients under its care, physically, mentally, or cognitively-impaired patients require a distinctly higher degree of monitoring and protection.”<sup>8</sup> VHA requires staff to provide this monitoring and protection through various forms, such as

- facility-specific policies for prevention and effective management of wandering or missing patients,
- wandering prevention and management awareness training for staff,
- prescribed assessment and documentation of patients’ cognitive impairment status, and
- a systematic process to ensure location of at-risk patients by staff, which may be enhanced by use of electronic technology.<sup>9</sup>

To identify residents as being high risk for elopement or wandering, the facility requires specific documentation to be in the resident’s electronic health record (EHR). Specifically, the facility policy states that “The computerized record of any Veteran identified as an elopement/wandering risk will be flagged by the RN [registered nurse] or provide[provider] *and* added as a clinical warning.” (The OIG added italics for emphasis.)<sup>10</sup>

## Failure to Implement an HFMEA Recommendation

The Azalea House, one of seven neighborhoods of the facility’s CLC, is a cottage. The cottage has a capacity for 20 residents and provides specialized dementia care on a secure (locked) unit for residents who have been identified as being at high risk for wandering.<sup>11</sup> In written correspondence to the OIG, the Chief of Engineering reported that since opening in 2018, the Azalea House has had a system in place that alerts staff whenever an exterior door is opened.<sup>12</sup> In July 2018, the Facility Director identified a team to conduct an HFMEA focused on wandering incidents and elopements. This HFMEA resulted in recommendations that included

---

<sup>8</sup> VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.

<sup>9</sup> Agency for Healthcare Research and Quality, Patient Safety Network, *Elopement*, accessed September 24, 2021, <https://psnet.ahrq.gov/web-mm/elopement>. A wandering patient is defined as a person who “strays beyond the view or control of staff without the intent of leaving (cognitive impairment).” VHA Directive 2010-052 defines a missing patient as “an at-risk patient who disappears from the patient care areas (on VA property), or while under control of VHA, such as during transport.” VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Standards (CLC)*, August 13, 2008.

<sup>10</sup> Facility MCM GEC-07, *Management of Wandering Community Living Center (CLC) Veteran*, August 20, 2019.

<sup>11</sup> The facility CLC has two locked neighborhoods: Azalea House, a freestanding cottage that houses residents with dementia-related diagnoses; and Patriots Point, a neighborhood within a building on campus that houses residents with mental health diagnoses.

<sup>12</sup>The alert is a single chime that sounds when an exterior door is opened and does not remain on until someone takes action to turn it off.

implementation of two specific types of electronic alarm systems to alert CLC staff when residents crossed a secure threshold to the outdoors, unsecured units or open cottages, and the provision of Global Positioning System (GPS) tracking of residents' locations within the secured cottages and units.<sup>13</sup>

The topic of an alarm system was included on the facility's Equipment Committee agenda in January 2019. Committee minutes reflected a discussion on the alarm system and noted that the type of alarm system, recommended by the HFMEA team, was not needed; no further resolution or action was planned. An electronic alarm system was on the committee's agenda again seven months later in August 2019 identified as a Geriatrics and Extended Care (GEC) equipment priority for fiscal year 2020.<sup>14</sup> The OIG learned through interviews and review of Equipment Committee minutes that multiple barriers to the purchase of an electronic alarm system occurred over the following year that included

- confusion as to why a system was needed on a locked unit,
- failure of key stakeholders to respond to Equipment Committee requests to discuss the topic,
- appointment of an interim Associate Chief Nurse of GEC who did not have background knowledge of the HFMEA and recommended waiting for permanent leaders to be in place to make a decision regarding the equipment, and
- delays associated with the coronavirus (COVID-19) pandemic.<sup>15</sup>

In July 2020, GEC, Safety, Patient Safety, and Biomedical Service staff determined that a new electronic alarm system for the CLC was not necessary and shared this information with the Equipment Committee members.

In November 2020, the Equipment Committee discussed an electronic alarm system as a GEC fiscal year 2021 equipment need. Further discussion led to a decision to purchase the same type of electronic alarm system for all CLC units and cottages. Per the Equipment Committee meeting minutes, the selected alarm system does not have a tracking feature to show the specific location of a resident, but it can be programmed to alert staff before a resident passes through an exit. The purchase was approved by the Equipment Committee in February 2021. However, through

---

<sup>13</sup> One type of an electronic alarm system used to prevent elopement on a locked unit is a GPS-style tracking device worn by residents that sounds an alert if a resident leaves the unit, providing staff with the resident's location. Wander Alert and WanderGuard® are examples of electronic alarm systems available on the market.

<sup>14</sup> "FEMA Recovery Support Function Leadership Group," accessed November 2, 2021, <https://recovery.fema.gov/glossary/FY#>. "The fiscal year is an accounting period that spans 12 months. For the Federal government, it runs from October 1 to September 30. For example, Fiscal Year 2017 (FY 2017) starts October 1, 2016, and ends September 30, 2017."

<sup>15</sup> World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it*, accessed November 2, 2021, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it).

interviews with facility and service leaders, the OIG learned the purchase was not completed in fiscal year 2021 because submission of the purchase order was delayed due to lack of ownership, coordination, and follow-through by the GEC Administrative Officer. The Chief of Quality Management shared with the OIG that the contract for an electronic alarm system for all CLC units and cottages was awarded on November 10, 2021.

A review of Joint Patient Safety Reports (JPSRs) from October 2019 through August 2021, the time between the 2018 HFMEA and this OIG inspection, showed five CLC resident elopements had occurred from the Azalea House.<sup>16</sup> These elopements involved residents leaving through unlocked windows, unsecured outdoor areas, doors with failed locking mechanisms, and doors where staff used improper processes to secure those doors. All five elopements concluded with the Azalea House residents being found unharmed. Staff identified four of the five elopements immediately after the residents left the building and while still in the immediate vicinity of the cottage. The fifth, and most recent elopement, occurred in early summer 2021; this resident left the Azalea House unwitnessed and was subsequently located by a homeowner who found the resident in the homeowner's yard approximately one mile away from the facility campus. The VA Police responded to this elopement and filed a report of the incident. In written correspondence with the OIG, the Facility Director reported that a fact finding was initiated immediately after the incident (on the same day) and completed in late summer. In addition, a risk assessment of the egress doors and exterior gate was conducted at the end of August 2021.

### **Additional CLC Security and Safety Concerns**

During the inspection, the OIG identified additional CLC safety concerns which likely contributed to or failed to mitigate resident elopements. The concerns identified by the OIG aligned with results of the facility's fact finding and risk assessment.

### ***Challenging Physical Environment***

When interviewed by the OIG, the Facility Director reported that the CLC cottages were originally built to house long-term care residents with higher cognitive function than the residents housed there during this inspection's time frame. The Facility Director also reported that the decision to use the Azalea House for the dementia care population occurred as a result of a VISN request to meet an *extreme need* for space to care for CLC residents with mental health needs, especially given the difficult challenges with community placement. Facility and CLC leaders shared with the OIG that the physical layout of the Azalea House was not conducive to caring for this population. Reasons given included the large square footage of the cottage itself,

---

<sup>16</sup> VHA National Center for Patient Safety, *JPSR Business Rules and Guidebook*, July 2020. The JPSR system is a database used nationally by VHA to capture real-time safety incident data. JPSR data was pulled from October 1, 2019, through August 13, 2021.

the inability to closely observe multiple residents at one time due to design, and nursing stations being located separately from resident care areas. The facility-initiated risk assessment team recommended a risk analysis be conducted to determine if the Azalea House is suitable for housing residents with dementia. The Chief of Quality Management reported that, as of December 2021, the risk analysis was not complete.

### *Inoperable Security Cameras*

The OIG learned through interviews with CLC staff and leaders and a review of the facility-initiated fact finding that, at the time of the early summer 2021 elopement, the security cameras located in the CLC were not functional; the security cameras were the original ones installed when the Azalea House was built in 2018. This became apparent when a GEC nurse manager requested to see camera footage of the summer 2021 elopement and discovered the cameras were not operational. The Associate Chief of Staff of GEC and Associate Chief Nurse of GEC stated the cameras had not functioned since the Azalea House was built. The facility fact-finding review included a recommendation to ensure security cameras in and around the Azalea House were operational. The Associate Chief Nurse of GEC stated the cameras were functional as of September 22, 2021. OIG staff confirmed the presence of many security cameras throughout the CLC and observed the police control room where the cameras were live-streamed, and recordings were made. At the time of the OIG visit, facility police were in the process of labeling the location of cameras to make them more readily identifiable.

### *Unsecured Exits*

#### *Window Locks*

In reviewing elopement related JPSRs, the OIG learned of a resident who eloped from the Azalea House through an unsecured window. Through interviews with the OIG, CLC leaders reported that since this elopement, windows in areas accessible to residents have been secured. During the on-site visit, the OIG team checked a sampling of windows accessible to residents and found them locked.

#### *Malfunctioning Doors*

Facility and CLC leaders shared with the OIG reports of malfunctioning doors in the Azalea House and that plans were in place to remedy the problem. The facility-initiated risk assessment found one of the wood egress doors had warped, which prevented the door's magnetic lock from properly engaging. Facility and Engineering Service leaders and a staff member reported that staff disabled the magnetic locks on the wood doors and transitioned to using locks that required a key. Plans for a long-term solution included replacing the existing doors with metal doors; however, at the time of the inspection, the metal doors had not been received by the facility. A



CLC leader reported to OIG that a newly implemented safety precaution was to conduct staff rounds every shift to check and confirm doors were secured. During the site visit, the OIG found that all Azalea House egress doors were secured. However, during a subsequent VISN 7 site visit in October 2021, they identified an issue that was preventing CLC exterior doors from self-closing and latching properly. The VISN inspectors made a formal recommendation to the facility to investigate the issue and adjust the door closure devices for proper closure.

### *Gaps in Outdoor Security*

The Azalea House has outdoor spaces including screened-in porches and courtyards immediately outside the cottage. CLC leaders and a staff member reported that residents need to be accompanied by staff members to utilize these areas. However, two residents breached the perimeter of the courtyard in the time between the 2018 HFMEA and this OIG inspection. One resident eloped from a screened-in porch, and the other resident eloped from the building and courtyard. The OIG observed a fence around the courtyard with an open gate. In interviews with the OIG, an Engineering Service leader and staff member acknowledged that one courtyard gate remained open at all times to facilitate the ease with which staff accessed the area. While at the Azalea House, the OIG team was able to easily open a patio screen door and exit into the courtyard, which was surrounded by a four-foot fence with three gates; two were locked, and the one referenced above was not closed or locked. The need for stronger security in the outdoor areas surrounding the Azalea House was evident and also identified in the facility fact-finding review and risk assessment. As a result, an engineering leader and staff member reported to OIG that a custom gate for the courtyard was ordered to replace the gate that remained open.

### *Inconsistent Elopement Risk Documentation*

The facility policy for the management of wandering residents in the CLC states, “The computerized record of any Veteran identified as an elopement/wandering risk will be flagged by the RN [registered nurse] or provide[provider] *and* added as a clinical warning.” (The OIG added italics for emphasis.)<sup>17</sup> The facility-initiated fact finding identified that an elopement risk clinical warning was missing in the EHR of the resident who eloped in early summer 2021, and recommended the clinical warning be entered in the resident’s EHR no later than the end of August 2021. On September 2, 2021, the OIG reviewed the EHRs of residents with documented elopements from the Azalea House, including the resident who eloped in early summer 2021, and found no elopement risk flags or clinical warnings. A subsequent OIG review of the EHRs found that a CLC registered nurse added elopement risk flags to the EHRs for these residents on September 16, 2021.

---

<sup>17</sup> Facility MCM GEC-07.

### *Incomplete Joint Patient Safety Reports*

The VHA Patient Safety Program is charged with being the steward of data collected in the JPSR system and ensuring its accuracy so that data may be used to identify trends and risks.<sup>18</sup> Each incident entered in the JPSR system has multiple fields that when completed, provide a full picture of the incident, the review of the event, and the time frame in which it was reviewed. Assessment and evaluation of adverse events and close calls entered in the JPSR system assists VA staff in determining what contributed to the incident and what can be done to help prevent it from happening again. Reviewing these incidents can help VHA staff learn from them in an environment based on mutual trust rather than punitive actions. An OIG review of the JPSRs related to the five Azalea House resident elopements revealed the investigation and action plan fields of the JPSR were not completed, rendering these JPSRs a simple record of each occurrence. As noted earlier in this report, the facility's Patient Safety Program, including review of JPSRs, is the subject of a separate OIG healthcare inspection. Therefore, the OIG will not be issuing a recommendation regarding JPSRs in this report.

The OIG substantiated that facility leaders failed to adequately address known CLC security and safety issues, which resulted in a resident elopement. A contract has been awarded to install an electronic alarm system for all of the facility's CLC neighborhoods in response to the HFMEA team's 2018 recommendations to improve safety and security. The concerns identified by the OIG team regarding the operability of security cameras in the CLCs, the security of the outdoor areas surrounding the CLC cottages, and use of elopement risk alerts in the EHR are in alignment with recommendations made by the facility through the fact finding and risk assessments conducted after the most recent resident elopement. Timely follow-through on the resolution of these concerns along with implementation of the recommended electronic alarm system are imperative to the safety of CLC residents at the facility.

## **2. Staffing of Key Positions**

The OIG substantiated that facility leaders failed to fill 27 key positions and found eight key positions remained unfilled for more than a year. The OIG found facility leaders took action to assign, when available, interim staff to cover the vacant positions until the hiring of permanent staff. Through interviews, the OIG identified factors contributing to the vacancies, such as difficulty in recruiting candidates for certain positions, lower salary levels associated with the facility's low-complexity level and rural location, and challenging human resource processes as barriers to filling the positions.

VA policy on staffing states that "VA staffing programs and practices will be administered and used to support the Department's efforts to create and maintain a high-performing workforce to

---

<sup>18</sup> VHA National Center for Patient Safety, *JPSR Business Rules and Guidebook*, July 2020.

serve veterans and their families.”<sup>19</sup> According to VA, “The workforce and succession planning process is not a product or activity with a specific or arbitrary end date; rather, it is an ongoing activity intended to keep VA’s workforce aligned with the critical needs of the Department’s mission.”<sup>20</sup>

In reviewing documents and interviewing facility leaders and staff, the OIG learned the facility operated a Position Management Committee (committee) to review service chiefs’ requests to fill vacancies or create new positions. The committee makes recommendations to the committee chair (Facility Director) regarding approval or disapproval of position requests based on an analysis of cost and benefits.

Through interviews with VISN 7 and facility leaders, the OIG learned of two pathways to submit committee requests. When a position has been vacant for less than 30 days or will become vacant due to a staff member’s upcoming resignation, retirement, or transfer, the requestor will email the committee requesting an out-of-committee position management approval. For new positions, or positions that will be changed in some way, facility guidance outlines the following process for submitting requests

- complete a request form, to include a current position description or functional statement, a current organizational chart, and efficiency data if available,
- route the completed form to the originating service chief and quad member for signature, and
- place the request on the meeting agenda.<sup>21</sup>

Committee actions are documented in committee minutes and signed by the Facility Director, indicating approval. The Facility Director reported that in most instances, he renders a decision on the position request before the conclusion of each meeting. The Facility Director and VISN 7 Senior Strategic Business Partner noted that following the formal approval, Human Resource Service staff are then responsible for executing the recruitment actions.

## **Administrative Positions**

In the complaint to the OIG, eight administrative positions were identified by position title. The OIG found that as of October 2021, all eight positions were filled. However, the OIG determined that three were open longer than a year. Additionally, the OIG found that one position, the Chief

---

<sup>19</sup> VA Directive 5005, *Staffing*, April 15, 2002.

<sup>20</sup> VA Directive 5002, *Workforce and Succession Planning*, January 15, 2003.

<sup>21</sup> For this report, based on the facility organizational chart, quad members included the Facility Director, Associate Director, Chief of Staff, and Associate Director of Patient Care Services.

of Supply Chain Management, was a newly created position. Table 1 is an analysis of position status and length of vacancy for the eight administrative positions as of October 2021.

**Table 1. Administrative Positions and Length of Vacancies**

Position Name	Status of Vacancy	Length of Vacancy (As of 10/2021)	Date Vacancy Approved for Hire	Date of Hire
Industrial Hygienist	Filled	81 Months*	December 2020	August 2021
Chief of Police	Filled	14 Months	September 2021	September 2021
Public Affairs Officer	Filled	21 Months	January 2021	October 2021
Chief of Quality Management	Filled	9 Months	January 2021	September 2021
Safety Officer	Filled	9 Months	December 2020	May 2021
Clinic Profiler	Filled	8 Months	October 2020	June 2021
Contract Liaison	Filled	7 Months	January 2021	June 2021
Chief of Supply Chain	Filled	New Position	April 2021	October 2021

*Source: OIG analysis of facility documents, information provided by the facility related to vacancies, and interviews with facility leaders.*

*\* 81 months is equal to 6 years 9 months*

The Facility Director and the Facility Planner stated that the inability to recruit a qualified candidate for the Industrial Hygienist vacancy was a key reason for the position remaining unfilled for an extended period. The Facility Director reported that Human Resource Service staff continuously pursued recruitment for an Industrial Hygienist; it just took longer to successfully recruit and hire into the position. Other factors which also contributed to the hiring delay included the time required to draft, redraft, and announce the position on multiple occasions, the inability to offer a competitive (higher) salary because of the lower job complexity associated with a level 3 facility, and the difficulty finding a candidate with adequate experience to perform the job and accept the salary offered. This position was vacant for over six years until August 2021 when an Industrial Hygienist was hired.

The OIG learned from facility leaders and the VISN 7 Senior Strategic Business Partner that processing position re-classification requests was a barrier to timely hiring into the Public Affairs Officer and Chief of Police positions. The Facility Director and the VISN 7 Senior Strategic Business Partner reported the Public Affairs Officer position was reclassified to obtain a higher grade following the inclusion of more supervisory responsibilities and changes in duties, and the Associate Director described the same for the Chief of Police. Additionally, staffing and process

changes in the VISN 7 Human Resource Service during this time slowed the hiring process. In addition to waiting for the reclassification, the Facility Director explained that a pending personnel action prevented the facility from moving forward with hiring a Public Affairs Officer. Both the Chief of Police and Public Affairs Officer positions were covered by interim staff until October 2021, when permanent staff were hired.

The OIG also reviewed four vacancies open less than one year: Chief of Quality Management, Contract Liaison, Clinic Profiler, and the Safety Officer. The OIG found all four vacancies were covered by acting staff until permanent staff were hired.

During a review of committee minutes, the OIG found the Chief of Supply Chain position was approved as a newly created position in April 2021, and a candidate was hired in October 2021. The Facility Director and Associate Director reported the facility’s Logistics Department was previously managed by the Birmingham VA Health Care System with employees located at the Tuscaloosa VA Medical Center, but after assessing facility needs, facility leaders determined it was best to hire their own staff. In the summer of 2021, the facility hired the first logistics staff.

The OIG found the Industrial Hygienist, Public Affairs Officer, and Chief of Police positions were open for greater than one year and that factors, such as salary, reclassification of the positions, and personnel actions, impacted the lengths of vacancy. The OIG determined that when qualified staff were available, those staff members were assigned to cover the vacant positions until permanent personnel were hired, thereby providing continuity in operations.

## Physician Positions

In response to an OIG request for information on vacant physician positions, the facility reported five unfilled physician positions: Associate Chief of Staff of GEC, Mental Health Chief Psychiatrist, Mental Health Staff Psychiatrist, CLC Long Stay Geri-Psychiatrist, and a Pain Management Specialist. Through a review of documentation specific to the positions, the OIG determined two positions were filled, the Geri-Psychiatrist was hired in August 2021, and the Pain Management Specialist has been selected and is pending transfer. The OIG found three physician positions vacant greater than one year at the facility. Table 2 is an analysis of position status and length of vacancy for the five physician positions as of October 2021.

**Table 2. Physician Positions and Length of Vacancies**

Service	Position Name	Status of Vacancy	Length of Vacancy (As of 10/2021)	Date Vacancy Approved for Hire	Announcement Type	Date of Hire
Geriatrics and Extended	Associate Chief of Staff	Open	15 Months	July 2020	Continuous	Not Applicable

Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns  
at Tuscaloosa VA Medical Center in Alabama

Service	Position Name	Status of Vacancy	Length of Vacancy (As of 10/2021)	Date Vacancy Approved for Hire	Announcement Type	Date of Hire
Mental Health	Chief Psychiatrist	Open	4 months	April 2021	Open	Not Applicable
Mental Health	Staff Psychiatrist	Open	12 Months	September 2020	Continuous	Not Applicable
CLC Long Stay	Geri-Psychiatrist	Filled	5 Months	March 2021	Continuous	August 2021
Specialty	Pain Management Specialist	Filled	63 Months*	July 2016	Pending Direct Hire	Selection Made, Pending Internal facility Transfer

*Source: OIG analysis of facility documents, information provided by the facility related to vacancies, and interviews with facility leaders.*

*\* 63 months is equal to 5 years 3 months*

Position Management Committee minutes indicated the Associate Chief of Staff of GEC vacancy resulted from a retirement in July 2020. The Facility Director acknowledged the vacancy of 15 months and reported that the position was announced several times, but a suitable candidate for the complex role was not found. A GEC physician was appointed as the Interim Associate Chief of Staff of GEC in July 2020 and provided consistent leadership in the role. The Facility Director stated that “It’s a very difficult, high responsibility position. We want to find the right person to fill it. Again, we are not going to settle for average for that position when I have a person who is willing to fill it, who I feel is doing a great job. You know what I’m saying, why am I going to fill it with a permanent position when the interim I feel is more qualified. It is a high bar that we have to get over, we are not just going to just hire.” The Chief of Staff and Associate Director stated that psychiatrists are difficult to recruit. In the interim, according to the Chief of Staff and interim Associate Chief of Staff for GEC, the facility assigned a half-time mental health psychiatrist and mental health nurse practitioner to temporarily fill the mental health staff psychiatrist position.

With a low-complexity level designation, the facility generally has lower patient acuity, offers fewer complex medical services, and lacks academic and research program opportunities. According to the Facility Director, Chief of Staff, and VISN 7 Senior Strategic Business Partner, the low-complexity level of the facility makes recruiting physicians difficult. Specifically, the Facility Director stated the lack of inpatient services offered at the facility was a factor contributing to the challenge of recruiting physicians. The Chief of Staff reported using journal

advertisements, cash awards, student loan repayment, and relocation recruitment incentives for physician positions, noting that the inability to combine incentives was problematic at times.

The OIG found that although the facility had open physician positions, the facility was actively recruiting for the vacant positions and put plans in place to provide coverage to minimize the impact on patient care services.

## Engineering Positions

In response to an OIG request for information on vacant engineering positions, the facility provided a list of 14 engineering positions vacant as of August 2021. As of October 2021, the OIG found seven of the positions were filled, and the seven open positions had been announced for hiring purposes. The OIG determined that two of the seven open positions were open longer than one year. Table 3 is an analysis of engineering position status and length of vacancy for the 14 engineering positions as of October 2021.

**Table 3. Engineering Positions and Length of Vacancies**

Position Name	Status of Vacancy	Length of Vacancy (As of 10/2021)	Date Vacancy Approved for Hire	Date of Hire
Lead Engineer	Open	10 Months	December 2020	Not Applicable
Bio Medical Support Specialist	Open	3 Months	July 2021	Not Applicable
General Engineer	Filled	4 Months	June 2021	To Be Determined
General Engineer	Open	4 Months	June 2021	Not Applicable
General Engineer	Open	5 Months	May 2021	Not Applicable
Laundry Mechanic	Filled	9 Months	January 2021	October 2021
Carpenter	Filled	17 Months	June 2020	September 2021
Pipefitter	Open	12 Months	October 2020	Not Applicable
Air Condition Mechanic	Open	8 Months	February 2021	Not Applicable
Laborer	Filled	7 Months	March 2021	October 2021

Position Name	Status of Vacancy	Length of Vacancy (As of 10/2021)	Date Vacancy Approved for Hire	Date of Hire
Maintenance Worker	Filled	5 Months	April 2021	September 2021
Electrician	Filled	5 Months	April 2021	October 2021
Boiler Plant Operator	Filled	2 Months	May 2021	To Be Determined
Motor Vehicle Operator/ Gardener	Open	16 Months	June 2020	Not Applicable

*Source: OIG analysis of facility documents, information provided by the facility related to vacancies, and interviews with facility leaders.*

In a discussion with the OIG, the Chief of Engineering noted recent retirements, difficulty in finding qualified staff, and low salaries as factors contributing to engineering vacancies. The Associate Director affirmed the low salaries for engineers makes it difficult for the facility to maintain a sufficient workforce. The VISN 7 Senior Strategic Business Partner reported that historically, engineering positions are difficult to fill and resulted in the facility instituting a new salary scale in summer 2021, for the engineering occupational series. An October 2021, VISN 7 site visit summary identified that the Engineering Service was significantly understaffed and made a recommendation to increase and prioritize staffing as soon as possible.

While the OIG substantiated that facility leaders failed to fill several key positions, including some that remained unfilled for more than a year, the OIG found the facility had an ongoing process through the Position Management Committee to approve positions and keep staffing aligned with the organization’s critical needs. Although the facility had unfilled key administrative, physician, and engineering positions, facility leaders ensured continuity of operations by assigning temporary staff to cover vacant positions accordingly and until permanent staff was hired. Obstacles to hiring included complex Human Resource Service processes, difficult to recruit positions, and the facility’s low-complexity level, which correlates with lower overall patient acuity, fewer complex medical services, and a lack of teaching and research opportunities for new hires.

### 3. Unused Space

The OIG did not substantiate that facility leaders failed to use available space to provide care to patients. The OIG found that although the facility had unused space, there were no instances where a lack of space was the primary limitation to provide patient care.



VHA requires that each facility use a facility master plan, which includes space, to review existing resources and project healthcare needs and demand of the facility.<sup>22</sup> The master plan is expected to align with the facility, VISN, and VA Central Office strategic plans. Title II of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 requires VA to assess the capacity of each VA medical facility and identify deficiencies in furnishing care and services to veterans and forecast short and long-term demand. The following includes direct quotes from the MISSION Act of 2018:

VA would be required to consider the following factors in making recommendations regarding the modernization or realignment of VHA facilities, and the extent to which

- the real property that no longer meets the needs of the Federal Government could be reconfigured, repurposed, consolidated, realigned, exchanged, outleased, replaced, sold, or disposed,
- operating and maintenance costs are reduced through consolidating, colocating, and reconfiguring space, and through realizing other operational efficiencies,
- the real property aligns with the mission of the Department of Veterans Affairs, and
- capacity and commercial market assessments.<sup>23</sup>

Through interviews, the OIG learned that facility leaders, the Chief of Engineering, and the facility's Planner used the Comprehensive Master Plan, Facility Condition Assessment, and Market Assessment to inform decisions about construction projects, development of new healthcare units, and space management.<sup>24</sup> Upcoming space management projects included creating a new geri-psychiatric unit and relocating inpatient pharmacy services closer to the CLCs to provide additional space for specialty care services.

Facility leaders and staff explained to the OIG that the facility's Space and Moves Planning Committee, in accordance with their internal space request process and policy, is responsible for "reviewing changing space requirements of all Services based on Medical Center priorities,

---

<sup>22</sup> VHA Directive 1002.1, *Non-Recurring Maintenance Program*, May 6, 2020. VHA Capital Asset Management Guidebook, December 5, 2019.

<sup>23</sup> The VA MISSION Act of 2018 Title II, Subtitle A, Section 203, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

<sup>24</sup> VHA Directive 1002.1. The Comprehensive Master Plan is a largely capital based plan incorporating and analyzing existing plans, gap analysis, and non-capital solutions. VHA Capital Asset Management Guidebook. Facility Condition Assessments are performed every 3 years and highlight a facility's most pressing and mission critical repair and maintenance needs. The VA MISSION Act of 2018. Market Assessments are required by the MISSION Act to review many elements including forecast of demand and services, availability of VA and non-VA services and capacity, infrastructure and government property including space demands.

program needs, workload, personnel, and other influencing factors.”<sup>25</sup> The committee is also responsible for assigning space and managing moves. Committee recommendations are not official until approved by the Facility Director.<sup>26</sup>

During interviews, the OIG learned that due to the size of the campus, attempts were made to physically locate similar services together to provide better customer service. Interviewees noted the facility had a large physical footprint; additionally, the age, structure, and floorplans of the original buildings made it difficult to convert them to usable modern medical facilities. However, the Chief of Staff reported that the space configurations did not impact patient care stating, “we haven’t allowed it to affect patient care in a negative way, as I said [we have] never restricted services because of space.” The Associate Director for Patient Care Services agreed that the nursing service was able to acquire space as needed.

During the on-site visit, the OIG team did not observe any areas in which patient care was unable to occur due to space limitations. The OIG team did observe some areas which appeared to be crowded; however, the OIG team did not observe any space constraints that had a negative impact on patients receiving care. Staff reported being able to provide care to patients within the designated space. Issues with space reported during interviews with the OIG were related to administrative spaces, such as staff training rooms or office space.

The OIG found that although the facility had unused space, a lack of assigned space was not a limiting factor when providing patient care. Facility leaders utilized several long-range planning tools and an internal space request process when considering space management and construction projects.

#### **4. Environment of Care and Grounds**

The OIG did not substantiate that facility leaders failed to ensure the environment of care and maintenance of grounds provided a safe setting for patients, visitors, and staff. However, while the OIG found the facility and grounds were generally maintained, the OIG determined that facility leaders failed to follow VHA and facility policy regarding Comprehensive Environment of Care (CEOC) program requirements for rounding of patient care areas and the grounds. During the inspection, the OIG found areas of concern related to the effectiveness of the CEOC program. However, the OIG found the facility’s grounds were generally maintained and did not observe safety concerns that impacted patient care.

---

<sup>25</sup> Facility MCM 138-21, *Space and Moves Planning Committee*, August 17, 2018.

<sup>26</sup> Facility MCM 138-21.

## Comprehensive Environment of Care Program

“Any VA medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct CEOC inspection rounds and to resolve issues in a timely manner. The goal of the CEOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.”<sup>27</sup>

In 2016, VHA defined CEOC rounds as “recurring facility tours used to determine the presence of unsafe and/or untoward conditions and whether the facility’s current processes for managing the environmental [*sic*] of care are practiced correctly and effectively”; and in 2021, VHA updated the definition to “recurring facility tours [are] used to manage environmental risk through the pro-active identification of unsafe conditions or non-compliance, and addressing corrective actions while expanding interaction with facility staff.”<sup>28</sup> VHA requires that “CEOC Rounds shall be conducted a minimum of once per fiscal year in non-patient care areas, and twice per fiscal year in patient care areas (all buildings, all floors, all rooms, and all spaces, including off-campus sites of care).”<sup>29</sup>

Through interviews with facility and service leaders and a review of facility CEOC reports, the OIG learned that CEOC rounds are conducted regularly by facility leaders and staff from engineering, safety, and infection control participated. Fiscal years 2020 and 2021 reports showed the facility did not complete the two required CEOC rounds per fiscal year within all patient care areas, to include areas such as audiology, dental, laboratory, radiology, and primary care. The OIG heard differing definitions from facility and service leaders regarding what spaces were considered patient care areas; some leaders described patient care areas as those areas in which patients spend the night and another leader stated outpatient services were considered patient care areas as well and were therefore required to have semi-annual inspections.

---

<sup>27</sup> VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016. This directive was in effect during the time of some events discussed in this report; it was rescinded and replaced by VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, June 21, 2021. The two policies have the same or similar language related to the goal of the Comprehensive Environment of Care Program. VA OIG, [Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama](#), Report No. 20-00130-194, September 2, 2020.

<sup>28</sup> VHA Directive 1608, 2016; VHA Directive 1608, 2021.

<sup>29</sup> VHA Directive 1608; The 2016 and 2021 policies have the same or similar language related to the frequency requirements for CEOC rounds.

VHA policy states that “Deficiencies and areas for improvement that are identified during CEOC Rounds shall be tracked until resolved.”<sup>30</sup> VHA set a goal for fiscal year 2021 of closing or having a documented action plan to address these deficiencies within 14 days at least 90 percent of the time.<sup>31</sup> From October 2020 through June 2021, the facility closed or created an action plan for deficiencies within 14 days, 90.5 percent of the time.

Facility policy states that grounds are to be “inspected semi-annually by the Environment of Care Inspection Team.”<sup>32</sup> It was reported during interviews, and confirmed through an OIG review of environment of care documents, that the required inspection of the grounds were not completed; however, there were at least three instances: August 20, 2020; April 15, 2021; and April 22, 2021; in which CEOC inspection team members noted grounds related deficiencies while walking along the route to the area being inspected by the CEOC team. In interviews, the Safety Manager reported being unaware of the requirement to inspect the grounds twice a year and the Chief of Engineering did not know why rounds had not been done on the grounds as required.

### *Effectiveness of the CEOC Program*

During the on-site visit, the OIG team reviewed several aspects of the environment of care in the CLCs, outpatient specialty care, outpatient mental health, physical therapy, primary care, women’s health, pharmacy, laboratory, audiology, dental, and radiology that included

- general condition of patient care areas,
- lighting and temperature,
- egress and wayfinding,
- cleanliness,
- signage and controlled access of construction areas, and
- condition of the grounds including sidewalks, curbing, ramps, and entrances.

The OIG team found that the facility was generally in good condition; however, there were areas of concern related to the effectiveness of the CEOC program as evidenced by multiple missing and discolored ceiling tiles, areas in need of cleaning, and excess equipment awaiting disposal.

### *Ceiling Tiles*

According to VHA, the lack of ceiling tiles could create a condition “whereby heat from a fire would bypass sprinklers by traveling through the ceiling opening(s) and collect in the space

---

<sup>30</sup> The Joint Commission, *Standards Manual*, EC.01.01.01, July 1, 2021. Deficiencies are defined by The Joint Commission as “injuries, problems, or use errors.” VHA Directive 1608; The 2016 and 2021 policies have the same or similar language related to the tracking of CEOC deficiencies.

<sup>31</sup> VHA Memorandum, *Fiscal Year (FY) 2021 Environment of Care (EOC) Guidance*, March 10, 2021.

<sup>32</sup> Facility Policy MCP 001-25, *Environment of Care Management Plan*, February 5, 2021.

above the ceiling.”<sup>33</sup> The OIG team identified two patient care areas with missing ceiling tiles. The missing tiles were reported to engineering staff through the work order process and staff reported the tiles had been replaced. Figure 1 is a picture of broken and displaced ceiling tiles in building 1, room 12 (office in audiology).<sup>34</sup>



**Figure 1.** Broken and displaced ceiling tiles in building 1, room 12.  
*Source: VA OIG photograph taken at the facility at 9:15 a.m. on October 6, 2021.*

The OIG also found numerous discolored ceiling tiles, which is generally a sign of a potential leak and can present mold or infection control issues. Figure 2 is a picture of a discolored ceiling tile in building 2, room 113E (office in outpatient mental health) where the discoloration may indicate the presence of mold near a sprinkler head.

---

<sup>33</sup> VHA *Fire Safety Guidebook*, December 30, 2019.

<sup>34</sup> In this case, a work order was placed on September 29, 2021, prior to the OIG visit, and the work was completed on October 12, 2021, after the OIG visit.



**Figure 2.** *Discolored ceiling tile in building 2, room 113E (office in outpatient mental health). Source: VA OIG photograph taken at the facility at 10:00 a.m. on October 6, 2021.*

### ***Cleanliness***

The OIG team found the facility was generally clean; however, the team photographed seven different areas that demonstrated a lack of cleanliness, such as excessive dirt in corners of the laboratory and dried urine on the base of a toilet. During interviews, facility and environmental management services leaders acknowledged difficulties with hiring and retaining housekeeping staff requiring them to prioritize cleaning of high traffic and patient care areas. In response to the staffing shortage, facility and service leaders reported the facility is in the process of obtaining a contract for housekeeping personnel.

### ***Excess Equipment Awaiting Disposal***

The OIG team found several areas, inside buildings and on the grounds, where different types of equipment were stored while awaiting supply chain management to pick up and process for disposal. Examples included a phlebotomy chair, multiple trucks, a small passenger bus, vacuums, washers, and dryers. Included in this group were a few items that had turn-in forms dated over 15 months prior to the OIG's on-site visit. In interviews with a VISN and facility leaders, the OIG learned of a recent reorganization of the management of the facility's supply chain from the Birmingham VA Health Care System to the facility, which resulted in the onboarding of the Chief of Supply Chain and additional team members to manage facility logistics.

## *Assessment of Facility Conditions*

Due to the concerns of deteriorating infrastructure, the OIG explored how facility leaders assessed the condition of the facility and current processes used when repairs or maintenance was requested and found that leaders used data from a variety of sources, assessments, external reviews, and staff input for long-range planning and submission of capital improvement projects. The OIG determined that the facility's work order process was established by policy, and staff were able to confirm awareness of the process.

A facility director, or designee, is responsible for managing all capital assets while considering operational needs and projected fiscal circumstances. The director is also responsible for conducting an annual infrastructure risk assessment, considering data and analysis from accrediting body recommendations and a variety of VA data sources including the Facility Condition Assessment, and identifying predictable and preventable problems that may result in untoward events.<sup>35</sup>

The facility's Associate Director provided the OIG with the infrastructure risk assessment for fiscal years 2021 and 2022, and shared insight into the process of reviewing the information from different sources and how it impacts requests for funding for future construction projects. Facility and engineering leaders informed the OIG of their recent external Facility Condition Assessment that was conducted as part of the infrastructure risk assessment and used for strategic capital planning requests and long-term planning. Per the Chief of Engineering, the Facility Condition Assessment was conducted in August 2021; however, as of November 16, 2021, the final report had not been completed. During interviews with the OIG, facility leaders shared their assessment that buildings were well maintained for their age, and the Chief of Staff reported that patient care had not been impacted by the age or condition of the buildings.

The facility's work order policy states that buildings and grounds will be maintained in good condition, and all staff will help maintain the life of government property and report problems using the work order system.<sup>36</sup> The OIG heard from multiple levels of staff of a daily safety call that all staff can attend, noting the call was a way for staff to report concerns with environment of care, safety, or the grounds in addition to using the work order system.<sup>37</sup> A review of work orders placed and completed in fiscal year 2021 indicated the average days to complete a work order placed in fiscal year 2021 was 11.5 days.

---

<sup>35</sup> VHA Directive 1002.1, *Non-Recurring Maintenance Program*, May 6, 2020. Facility Condition Assessments are completed at each facility to highlight the most pressing and mission critical repair and maintenance needs.

<sup>36</sup> Facility Policy MCP 138-12, *Engineering Service Requests/Work Orders*, January 27, 2021. Facility Policy MCM 138-12, *Work Orders (Problems, Failures and/or Use Errors Reporting)*, March 24, 2017.

<sup>37</sup> Facility Policy MCP 138-12.

During the on-site inspection, the OIG found the facility in generally good condition, and the OIG team did not observe safety concerns that impacted patient care.

## Maintenance of Grounds

According to The Joint Commission, hospitals should establish and maintain safe and functional environments.<sup>38</sup> VHA emphasizes the importance of maintaining facility grounds and parking as it impacts patients' experience.<sup>39</sup> Facility policy states the Chief of Engineering Service is responsible for management of the grounds and, along with police and safety staff, makes regular rounds to observe and correct conditions to ensure safety and security of the grounds for patients, visitors, and staff.<sup>40</sup>

Through interviews with facility leaders, the OIG learned of challenges faced by the facility in the maintenance of the grounds due to the large size of the campus. Facility and service leaders reported that low staffing levels were exacerbated by the Grounds Department staff's collateral duties that effectively removed them from grounds duties; such collateral duties included driving in order to provide transportation for veterans and laundry services to other VA facilities. Despite these challenges, facility and service leaders reported no negative impact on patient care, and an engineering supervisor reported priority was given to patient related duties, such as patient transportation and laundry services. Through interviews, the OIG learned of several projects implemented for grounds maintenance, such as recently repaired sidewalks, paved parking lots, and installation of an American with Disabilities Act compliant switchback ramp at an entrance.<sup>41</sup> The OIG on-site inspection of the grounds did not identify conditions that would have increased the likelihood of accidents, injury, and environmental hazards to veterans, staff, and visitors.

Although the OIG did not substantiate that facility leaders failed to ensure the environment of care and maintenance of grounds provided a safe setting for patients, visitors, and staff, the OIG did determine that facility leaders did not follow VHA requirements to round in the patient care areas twice per fiscal year and did not complete rounds on the grounds during fiscal years 2020 and 2021. Due to multiple documented instances of discolored ceiling tiles, issues involving cleanliness, and amount of various equipment found discarded or waiting to be accessed and disposed of, the OIG determined the facility's CEOC rounds were ineffective. The OIG found the grounds were in generally good condition, the facility prioritized patient care at the forefront

---

<sup>38</sup> The Joint Commission, *Standards Manual*, EC.02.06.01, July 1, 2021.

<sup>39</sup> VHA Healthcare Engineering Guidebook, January 8, 2020.

<sup>40</sup> Facility Policy MCP 001-25. Facility Policy MCM 001-25.

<sup>41</sup> Americans With Disabilities Act of 1990. Pub. L. 101-336, 104 Stat. 328 (1990).



while managing the challenges of staffing and the large size of the campus and that facility leaders used long-range planning tools when considering future construction decisions.

## 5. VISN Oversight

Following an OIG briefing to VISN and facility leaders, three VISN 7 staff visited the facility in October 2021 and conducted a review of issues raised by the OIG. The VISN team identified many of the same areas of concern addressed in this report that included cleanliness, housekeeping and engineering staffing shortages, lack of rounding of the grounds, and equipment pending disposal. VISN 7 staff made multiple findings and 12 recommendations (see appendix C). The VISN requested a corrective action plan be developed by facility staff by November 3, 2021. The facility complied, and as of December 22, 2021, the facility reported seven of the VISN's 12 recommendations were complete.

## Conclusion

The OIG substantiated that facility leaders failed to address CLC security and safety issues that resulted in resident elopements. The OIG found that facility leaders did not implement a 2018 HFMEA recommendation to install an electronic alarm system to prevent resident elopement until November 2021 (when a contract to purchase the system was awarded). During the inspection, the OIG identified concerns regarding the operability of security cameras in the CLCs, the security of the outdoor areas surrounding the CLC cottages, and use of elopement risk alerts in the EHR. The OIG determined these security and safety concerns likely contributed to or failed to mitigate resident elopements and further noted that timely follow-through on the resolution of these concerns, along with implementation of the recommended electronic alarm system, were imperative to the safety of CLC residents at the facility.

The OIG substantiated that facility leaders failed to fill several key administrative, physician, and engineering positions. However, the OIG found that all administrative vacancies, two of five physician vacancies, and seven of 14 engineering vacancies were filled, but eight of the reviewed positions remained unfilled for more than one year. The OIG found facility leaders took action to assign, when available, interim staff to cover the vacant positions until the hiring of permanent staff. The OIG identified factors contributing to the vacancies included difficulty in recruiting candidates for certain positions, lower salary levels associated with the facility's low-complexity level and rural location, and challenging Human Resource Service processes; these were identified barriers to filling the positions.

The OIG did not substantiate that facility leaders failed to use available space to provide care to patients. The OIG confirmed that facility leaders utilized several long-range planning tools and an internal space request process when considering their designs for space management and construction projects. During the on-site visit, the OIG team did not observe any areas in which

patient care was negatively impacted due to space limitations or constraints. The OIG team did observe that some areas appeared crowded; however, the team did not observe any space constraints that had a negative effect on patients receiving care and this was confirmed by staff interviews. The OIG team found that although the facility had unused space, a lack of assigned space was not a limiting factor when providing patient care.

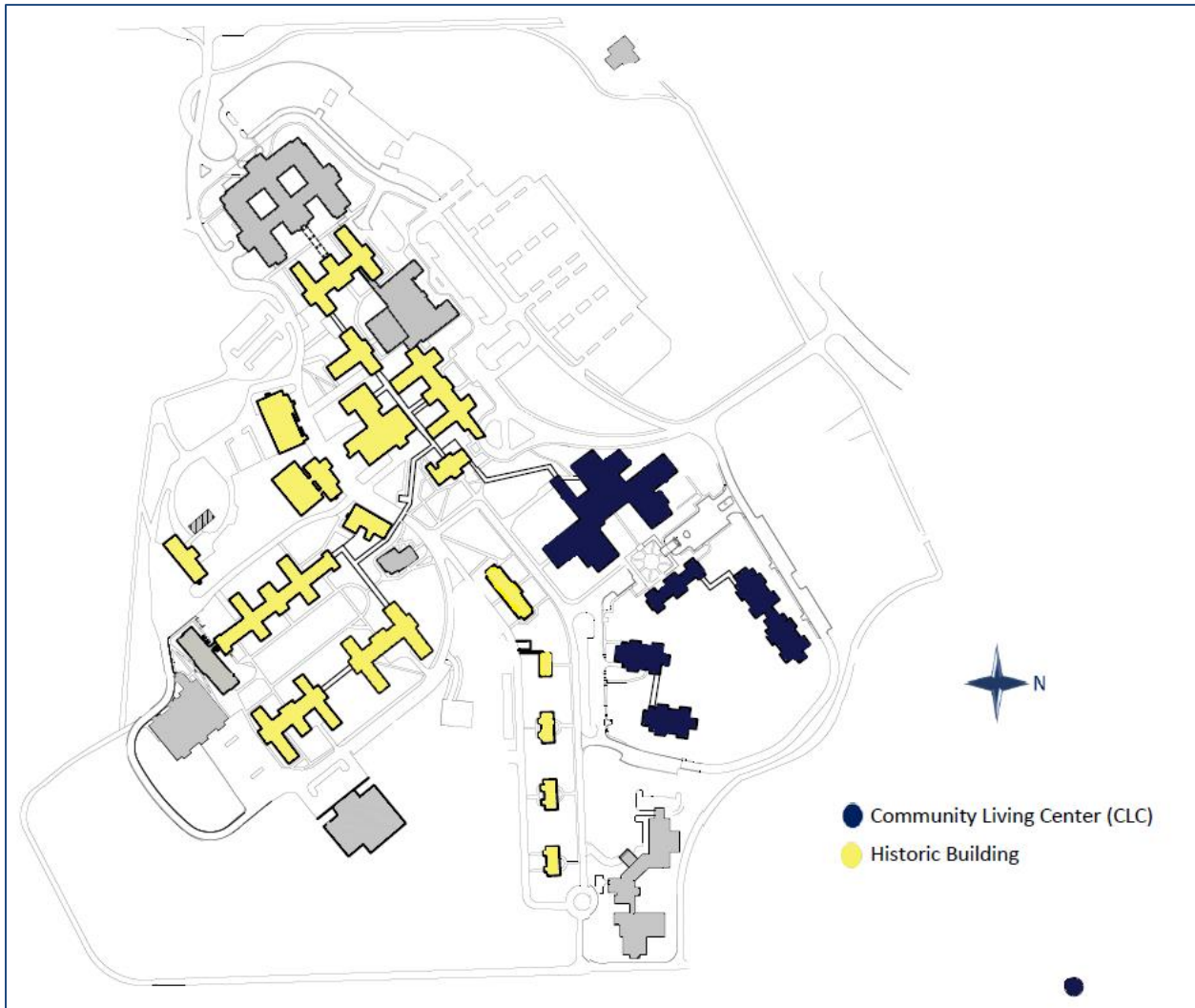
The OIG did not substantiate that facility leaders failed to ensure the environment of care and maintenance of grounds provided a safe setting for patients, visitors, and staff. However, the OIG determined that the facility did not follow VHA and facility requirements to round in the patient care areas twice per fiscal year, did not complete rounds on the grounds for the last two fiscal years, and that the facility's CEOC rounds were ineffective. Through interviews with facility leaders, the OIG learned of challenges faced by the facility in maintaining the grounds due to the large size of the campus and staffing. Despite these challenges, the OIG found that the grounds were generally maintained and did not observe safety concerns that impacted patient care.

The OIG learned that following an OIG briefing to VISN 7 and facility leaders, VISN 7 staff visited the facility and identified many of the same areas of concern addressed in this report including cleanliness, housekeeping and engineering staffing shortages, lack of rounding of the grounds, and equipment pending disposal. VISN 7 staff made multiple findings and 12 recommendations, seven of which have been addressed by the facility.

## Recommendations 1–10

1. The Tuscaloosa VA Medical Center Director provides oversight of the purchase and installation of an electronic alarm system for all Community Living Center neighborhoods and cottages and confirms ongoing monitoring of its use after installation.
2. The Tuscaloosa VA Medical Center Director confirms completion of the risk analysis recommended in the facility-initiated risk assessment to determine if the Azalea House is suitable for the patient population residing there.
3. The Tuscaloosa VA Medical Center Director ensures that all security cameras are operable and labeled appropriately and develops and monitors a plan for ongoing testing and maintenance.
4. The Tuscaloosa VA Medical Center Director directs staff to assess the effectiveness of the outdoor fencing and gates surrounding Azalea House as a security measure to prevent Community Living Center residents at-risk for elopement from leaving the facility campus.
5. The Tuscaloosa VA Medical Center Director establishes a review process to ensure that Community Living Center residents determined to be high risk for elopement have documentation consistent with Tuscaloosa VA Medical Center policy in their electronic health records identifying residents' risk status.
6. The Tuscaloosa VA Medical Center Director collaborates with the Veterans Integrated Service Network 7 Senior Strategic Business Partner to determine difficult to fill job series and develops a plan to maximize use of available tools for coverage, recruitment, and retention.
7. The Tuscaloosa VA Medical Center Director ensures completion of a review of the facility's Comprehensive Environment of Care program to confirm that patient care areas are properly classified, all areas are inspected at the required frequency, and compliance is monitored.
8. The Tuscaloosa VA Medical Center Director coordinates with subject matter experts and develops a plan to ensure that the facility's Comprehensive Environment of Care program effectively identifies areas in need of attention to provide a clean and safe environment for patients, visitors, and staff.
9. The Tuscaloosa VA Medical Center Director confirms that Engineering Service staff conduct rounds of the grounds according to Tuscaloosa VA Medical Center policy.
10. The VA Southeast Network 7 Director ensures completion of the Tuscaloosa VA Medical Center's action plan to address recommendations made as a result of the October 2021 Veterans Integrated Service Network site visit.

## Appendix A: Facility Map



**Figure A.1.** Tuscaloosa VA Medical Center Campus Map, Tuscaloosa, AL.

Source: Facility Engineering Department, August 16, 2021

Note: The OIG color coded the map provided by the facility to highlight CLC and historic buildings. Historical buildings not indicated on map: connecting corridor, 14, and 28.

## Appendix B: Facility Building List

Building Number*	Function Title	Historical Designation	Total Gross Square Footage	Total Vacant Gross Square Footage
1	Administrative/Clinics	yes	81,685	254
2	Mental Health Outpatient	yes	34,707	0
3	Boiler Plant/IT/Research/Tenant Space	yes	47,774	0
4	Auditorium	yes	11,802	0
5	Engineering/Contracting/CAM Offices/Home Based PC	yes	18,621	0
6	Vacant Building	yes	6,856	6,856
7	PRRTP-Transitional Home	yes	6,387	5,892
8	Hospice West Alabama House-Vacant	yes	4,160	4,160
12	Warehouse	yes	15,639	0
13	Pump House	no	610	0
14	Gas Meter House	yes	128	0
15	PRRTP-Transitional Home	yes	6,406	5,716
17	Engineering Shops	yes	6,685	0
18	Laundry	yes	12,750	0
28	Flammable Storage	yes	350	0
33	EUL Valor Grove	yes	40,243	0
33A	EUL Valor Grove Addition	no	36,291	0
38	Primary Care	yes	82,072	0
39	Swing Space	yes	45,902	13,958
40	OI&T Field Office/Child Care/Call Center/VISN 7 Tra [sic]	yes	66,486	0
41	MAT Shop/Grounds	yes	11,844	0
46	Chapel	no	4,228	0
61	Nursing Home Care Unit**	no	102,579	0
62	Generator Building	no	400	0
63	Administrative/Library	no	12,829	0
101	Green House	no	3,599	3,599
135	Ambulatory Care	no	62,025	0

Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns  
at Tuscaloosa VA Medical Center in Alabama

---

Building Number	Function Title	Historical Designation	Total Gross Square Footage	Total Vacant Gross Square Footage
137	Psychiatric Patient/Daycare/NHCU	no	266,159	8,393
138	Chiller Bldg.	no	4,923	0
139	Generator Bldg. 137	no	600	0
140	Generator Bldgs. 2 and 38	no	600	0
141	Generator Bldgs. 33, 39, and 40	no	600	0
142	Emergency Management/Engineering Storage	no	1,613	0
143	Dietetic facility	no	16,336	0
144	Tenant/HOWA	no	16,000	0
145	Community Center	no	14,157	1,259
146	Cottage (Magnolia House)	no	18,724	0
147	Cottage	no	18,714	0
148	Fire Pump House (Cottages)	no	220	0
149	Azalea House Cottage (CLC)	no	24,166	0
BB	Bridge Building 38, 137	no	1,861	0
CC	Connecting Corridors	yes	27,980	0

*Source: VA Heritage Assets Database compiled by facility staff from reports pulled on August 13, 2021, and August 16, 2021.*

*\* Building numbers reflect current designations and are not continuously numbered.*

*\*\* The OIG considers a CLC and the Nursing Home Care Unit to be similar terms as used in this table.*

## Appendix C: October 2021 VISN 7 Facility Review Results

1. X-RAY Room 119 out of service for extended period. Facility to determine if system still required. If so, repair and return to service. If not, decommission and remove. Estimated time to complete 120 days.
2. Wanderguard in Building 61 (Patriots Point and Eagles Cove units) non-functional with no recorded maintenance history. Ensure systems are functional, wristbands are available and required maintenance is completed/documented. Estimated time to complete 30 days.
3. Facility has a backlog of property pending disposal for over 90 days. Develop a plan and ensure final disposition and disposal of: <ul style="list-style-type: none"><li>- Unrequired vehicles located in outdoor storage areas.</li><li>- Unrequired appliances and other property located outside engineering shops area.</li><li>- Unrequired appliances and other property located outside engineering shops area.</li><li>- Unrequired property stored within logistics warehouse.</li><li>- Unrequired property stored within clinical/administrative services on pending turn-in documents.</li></ul> Estimated time to complete all turn-ins 90 days.
4. Inventory PPE [personal protective equipment] stored in building 41 to determine items procured under the current FDA [U.S. Food and Drug Administration] Emergency Use Authorization. Account for all items in a newly created GIP [generic inventory package] inventory point ##Contingency-VISN. Estimated time to complete 60 days.
5. No evidence of EOC [environment of care] rounds being conducted on the campus grounds. Include the grounds in the EOC rounding process. Estimated time to complete 30 days.
6. Exterior door to construction area in bldg. 145 Liberty Center was blocked open by contractor. Ensure construction sites are secured against unauthorized access at all times. Estimated time to complete 30 days.
7. Nurse call system in bldg. 147, rooms 7 and 69 could not be heard at the central nurse station when activated. As a result, no one responded to room 7. Ensure nurse call systems are functioning properly and initiate a response when activated. Estimated time to complete 30 days.
8. Ceiling vents were dirty in bldg. 147, central atrium. Ensure a process is put in place to routinely clean ceiling vents in areas, to include those on high ceilings. Estimated time to complete 30 days.
9. CLC resident's bathroom excessively dirty in bldg. 147, room 5. Deep clean area and increase supervisory surveillance to ensure resident rooms/bathrooms are clean and sanitary. Ensure toilet is not leaking around silicone seal. Estimated time to complete 30 days.
10. Screened-in porch on Southeast side of bldg. 147 had excessive amounts of grass clippings and dirt on the floor and top of table. Ensure the area is being cleaned often enough to prevent future accumulation clippings and dirt. Estimated time to complete 30 days.
11. Pressure differential preventing CLC exterior door(s) from self-closing and latching. Investigate the extent of the issue and adjust pressure/door closers to ensure CLC exterior doors self-close and latch at all times. Estimated time to complete 30 days.
12. Engineering and EMS [Environmental Management Service] Services are significantly understaffed per their respective organization chart and FTEE [full-time equivalent employee] ceiling. Increase/prioritize hiring/onboarding process to close the gaps as soon as possible. Estimated time to complete 120 days.

Source: Facility VISN 7 Site Visit Summary, October 26, 2021.

## Appendix D: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: April 27, 2022

From: Director, VA Southeast Network (VISN 7) (10N7)

Subj: Draft Report: Healthcare Inspection—Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns at the Tuscaloosa VA Medical Center in Alabama

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

1. I have had the opportunity to review the Draft Report: Healthcare Inspection – Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns at the Tuscaloosa VA Medical Center in Alabama.
2. I concur with the VISN 7 and Tuscaloosa VA Medical Center’s action plan and ongoing implementation for recommendations 1-10.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

*(Original signed by:)*

David M. Walker, MD, MBA  
Network Director



## VISN Director Response

### Recommendation 10

The VA Southeast Network 7 Director ensures completion of the Tuscaloosa VA Medical Center's action plan to address recommendations made as a result of the October 2021 Veterans Integrated Service Network site visit.

Concur.

Target date for completion: June 30, 2022

### Director Comments

The VA Southeast Network 7 Director will ensure completion of the Tuscaloosa VA Medical Center's action plan to address recommendations made as a result of the October 2021 Veterans Integrated Service Network site visit. The Tuscaloosa's action plan will be tracked through the Healthcare Quality Safety Value Committee. The Network Director is the co-chair and open items will be tracked until closed.

### OIG Comments

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

## Appendix E: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: May 23, 2022

From: Director, Tuscaloosa VA Medical Center (679)

Subj: Healthcare Inspection—Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns at the Tuscaloosa VA Medical Center in Alabama (VIEWS 0746221)

To: Director, VA Southeast Network (10N7)

1. On behalf of Tuscaloosa VA Medical Center, we would like to express our gratitude to the Office of Inspector General (OIG) team for the review. I reviewed the draft report and I concur with the recommendations. We appreciate the opportunity to improve the care we provide here at Tuscaloosa VA Medical Center.
2. For purposes of accuracy, the facility would like to state the following, “Since the opening of Azalea House on June 27, 2018, a door alarm system was present that notifies staff when a door is opened” to the Executive Summary on page 1, 3rd paragraph, line 3. This statement also applies throughout the report indicating there was an alarm system present.
3. For purposes of accuracy, the facility notes that research should be included in services provided at Tuscaloosa VA Medical Center. This applies to the Background section on page 1, line 4.
4. For purposes of accuracy, the facility reported issues with the Patient Safety Program through an Issue Brief to the VISN on September 20, 2021. This applies to the Allegations and Related Concerns section on page 2, line 9.
5. For purposes of clarity, the facility would like to highlight that all windows in patient bedrooms had tamper resistant locks, however, three windows in the hallway did not have this security feature. This was corrected the next morning immediately following one of the reported elopements from Azalea House. This applies to page 6, first paragraph, sentences 3.
6. For purposes of accuracy on page 6, 1st paragraph, last sentence, the facility would like to communicate that on the day of the early summer 2021 elopement, the Tuscaloosa VA Police initiated an investigation into the circumstances surrounding the elopement. Also on this same day, the Geriatrics and Extended Care leadership initiated a fact finding immediately following the incident. The next day, the Associate Director, Quality Management and Engineering conducted a walk-through of building 149 to assess doors or any other deficits. A risk assessment was completed in late August 2021 to assess the effectiveness of the outdoor fencing and gates surrounding Azalea House.
7. For purposes of clarity, the facility would like to note with respect to what is described, the issue was identified prior to OIG’s visit. The work order was not completed until October 21, 2021 because the facility had to confirm the leak was corrected and the area was dry to prevent mold. This applies to the last sentence on page 20.
8. For additional questions, contact the facility’s Chief of Quality Management.

(Original signed by:)

John F. Merkle, FACHE, VHA-CM  
Director, Tuscaloosa VA Medical Center

## **OIG Addendum to the Facility Director Memo**

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion.<sup>1</sup> For this report, VHA provided the OIG comments in the Facility Director memo during the draft phase. The OIG considered and reviewed the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to OIG findings.

---

<sup>1</sup> VA OIG GM Directive 308, *Comments to Draft Report*, April 10, 2014, amended April 24, 2019.

## Facility Director Response

### Recommendation 1

The Tuscaloosa VA Medical Center Director provides oversight of the purchase and installation of an electronic alarm system for all Community Living Center neighborhoods and cottages and confirms ongoing monitoring of its use after installation.

Concur.

Target date for completion: June 30, 2022

### Director Comments

Since the opening of Azalea House on June 27, 2018, a door alarm system was present that notifies staff when a door is opened. A more advanced electronic alarm system for all Community Living Center neighborhoods and cottages was purchased on November 9, 2021. Engineering will inventory the systems after installation and commissioning for quarterly preventative maintenance of the system. Records of the maintenance will be maintained in the work order system (Maximo). All unit installations for the cottages are expected to be completed by June 30, 2022, all remaining neighborhoods are expected to be completed August 30, 2022. GEC is currently developing a Standard Operating Procedures (SOPs) to implement system, training, and roll out. Expected completion date for SOP and training is June 30, 2022.

### OIG Comments

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

### Recommendation 2

The Tuscaloosa VA Medical Center Director confirms completion of the risk analysis recommended in the facility-initiated risk assessment to determine if the Azalea House is suitable for the patient population residing there.

Concur.

Target date for completion: Completed June 30, 2022

### Director Comments

On June 30, 2021, the Associate Director, Quality Management and Engineering conducted a walk-through of Building 149 (Azalea House) to assess doors or any other deficits. The Associate Director requested a formal facility risk-assessment be conducted by Engineering, Safety, Police, Patient Safety Manager and GEC leadership, at minimum. Five recommendations

were made: 1) Gate #1 is consistently locked with a pad lock that is accessible to all staff. 2) Gate #2 is a custom gate with a self-closing mechanism and double-sided lock accessible to all staff. 3) Wood door replaced with a metal door. 4) Limit to one method of egress using an all-accessible key until the new key system was implemented. 5) Risk analysis to be conducted to determine if the current Veteran population is suitable for Building 149 (Azalea House). All have been completed with the exception of recommendation #3 where a new metal door will be installed. Results of risk assessment including installation of new door is expected by June 30, 2022.

Based on the facility-initiated risk assessment, a risk analysis was conducted by GEC leadership, and was presented and approved by Executive Leadership on April 25, 2022. Based on the initial data, the GEC Associate Chief of Staff briefed the Strategic Planning Board on February 2, 2022 and briefed Executive Leadership Team and labor partners on February 24, 2022 regarding plans to move Azalea House residents back to Patriots Point. Patriots Point is not a standalone building, has fewer square footage, three exit doors, and two sally ports. Patriots Point was previously utilized for Veterans with dementia.

## **OIG Comments**

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

## **Recommendation 3**

The Tuscaloosa VA Medical Center Director ensures that all security cameras are operable and labeled appropriately and develops and monitors a plan for ongoing testing and maintenance.

Concur.

Target date for completion: June 30, 2022

## **Director Comments**

There are 539 cameras that are operational and properly labeled throughout the facility to include all cameras in the Community Living Centers. Additional cameras are in the process of being installed across the campus as part of a facility security camera project with the expected completion date of June 30, 2022. The facility is working to acquire an augmented service agreement prior to the expiration of the current service warranty covered under the construction project. The service agreement will cover testing and maintenance of all facility security cameras. Expected completion of June 30, 2022.

## **OIG Comments**

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

### **Recommendation 4**

The Tuscaloosa VA Medical Center Director directs staff to assess the effectiveness of the outdoor fencing and gates surrounding Azalea House as a security measure to prevent Community Living Center residents at-risk for elopement from leaving the facility campus.

Concur.

Target date for completion: Completed January 5, 2022

## **Director Comments**

On the same day as the early summer 2021 patient elopement, the Tuscaloosa VA Police initiated an investigation into the circumstances surrounding the event. That same day, GEC leadership initiated a fact finding immediately following the incident. The following day, the Associate Director, Quality Management and Engineering conducted a walk-through of Building 149 (Azalea House) to assess doors or any other deficits. A risk assessment was completed in late August 2021 to assess the effectiveness of the outdoor fencing and gates surrounding Azalea House. Two access gates were identified as possible exit points. A pad lock keyed with an all-access key was added to access gate #1, allowing entry and exit by all facility staff. Access gate #2 was replaced with a custom gate with a self-closing mechanism with a double-sided lock accessible to all staff completed January 4, 2022. In addition, Tuscaloosa VA Medical Center has installed a new 8-foot-tall perimeter fence that was completed on March 29, 2021, and cameras at all entrances to the campus were installed April 2022.

## **OIG Comments**

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

### **Recommendation 5**

The Tuscaloosa VA Medical Center Director establishes a review process to ensure that Community Living Center residents determined to be high risk for elopement have documentation consistent with Tuscaloosa VA Medical Center policy in their electronic health records identifying residents' risk status.

Concur.

Target date for completion: May 30, 2022

## **Director Comments**

GEC-07 Management of Wandering Community Living Center (CLC) Veteran provides guidance on the process for evaluating and documenting Veterans who are high risk for wandering/elopement. All efforts will be made to educate all CLC staff with at least 95% of Community Living Center staff being educated on GEC-07 Management of Wandering Community Living Center (CLC) Veteran by May 30, 2022. Compliance of appropriate documentation of Veterans at risk for elopement will be monitored through monthly Quality Management medical record audits completed by Unit Managers with an expected compliance rate of >90%, with a goal of 100%. Tuscaloosa VA Police will continue to conduct annual mock drills to address Veterans who wander and/or elope.

## **OIG Comments**

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

## **Recommendation 6**

The Tuscaloosa VA Medical Center Director collaborates with the Veterans Integrated Service Network 7 Senior Strategic Business Partner to determine difficult to fill job series and develops a plan to maximize use of available tools for coverage, recruitment, and retention.

Concur.

Target date for completion: Completed April 18, 2022

## **Director Comments**

The Tuscaloosa VA Medical Center and the Veterans Integrated Service Network (VISN) 7 Senior Strategic Business Partner will continue to use the three R's (Retention, Recruitment, and Relocation) to the fullest extent possible to fill difficult-to-fill positions at our facility. We will also continue to monitor our Local Labor Market to ensure that salaries are competitive, and we will request changes as needed to recruit the best qualified candidate. When necessary, we will also make use of the Education Debt Reduction Program and the Student Loan Repayment Program. We will continue to fill key positions with staff reassigned from other positions from the facility, VISN or VHA to ensure appropriate coverage.

## **OIG Comments**

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

## **Recommendation 7**

The Tuscaloosa VA Medical Center Director ensures completion of a review of the facility's Comprehensive Environment of Care program to confirm that patient care areas are properly classified, all areas are inspected at the required frequency, and compliance is monitored.

Concur.

Target date for completion: Completed November 2021

### **Director Comments**

A review of the facility's Comprehensive Environment of Care (EOC) program was completed in November 2021. The review included confirmation of patient care and non-patient care areas. Rounding will be performed by the EOC team at least twice a year for patient care areas and at least yearly for non-patient areas. Documentation of rounds will be entered into Performance Logic database and deficiencies tracked in EOC Board until completion.

### **OIG Comments**

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

## **Recommendation 8**

The Tuscaloosa VA Medical Center Director coordinates with subject matter experts and develops a plan to ensure that the facility's Comprehensive Environment of Care program effectively identifies areas in need of attention to provide a clean and safe environment for patients, visitors, and staff.

Concur.

Target date for completion: May 30, 2022

### **Director Comments**

Rounding to be performed by the EOC team as directed by VHA Directive, 1608 Comprehensive Environment of Care Program, dated June 21, 2021 to identify areas in need of attention. The review will include confirmation of patient care and non-patient care areas. Rounding will be performed at least twice a year for patient care areas and at least yearly for non-patient areas, to include the grounds. Staff will continue to document rounds in the Performance Logic database and deficiencies tracked in EOC Board until completion. Staff are encouraged to report environment of care concerns utilizing the work order system (Maximo), the Daily Safety Call, the Joint Patient Safety Reporting (JPSR) System, and during the Supervisors' Morning Report. For FY21, all facility staff were assigned a Talent Management System (TMS) module which



provided education on the use of Joint Patient Safety Reporting System. Eighty-three percent of facility staff completed the JPSR module. Additionally, all staff were assigned a TMS module on the use of the Maximo work order system with a completion date of May 30, 2022.

### **OIG Comments**

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

### **Recommendation 9**

The Tuscaloosa VA Medical Center Director confirms that Engineering Service staff conduct rounds of the grounds according to Tuscaloosa VA Medical Center policy.

Concur.

Target date for completion: Completed October 2021

### **Director Comments**

EOC Rounding for the grounds was conducted in October 2021 and will be conducted regularly and at least annually. A schedule for FY22 [October 1, 2021 through September 30, 2022] rounding was revised in November 2021 which includes rounding of the grounds in accordance with VHA Directive, 1608 Comprehensive Environment of Care Program, dated June 21, 2021. Rounding to be performed by the EOC team, which includes Engineering Service Staff Representative. Documentation will continue to be entered into Performance Logic database and deficiencies tracked in Environment of Care Board until completion.

### **OIG Comments**

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

## OIG Contact and Staff Acknowledgments

---

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

---

<b>Inspection Team</b>	Susan Tostenrude, MS, Director Kevin Arnhold, FACHE Leakie Bell-Wilson, MSN, RN Sheyla Desir, MSN Tabitha Eden, MSN, RN Seema Maroo, MD Nancy Short, LCSW
------------------------	---

---

<b>Other Contributors</b>	Elizabeth Bullock Debbie Davis, JD, MS, RN Christopher D. Hoffman, LCSW, MBA Carol Lukasewicz, BSN, RN Natalie Sadow, MBA April Terenzi, BA, BS Robert Wallace, MPH, ScD Dawn M. Woltemath, MSN, RN
---------------------------	--

## Report Distribution

### VA Distribution

Office of the Secretary  
Veterans Health Administration  
Assistant Secretaries  
General Counsel  
Director, VA Southeast Network (10N07)  
Director, Tuscaloosa VA Medical Center (679/00)

### 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:  
Alabama: Richard C. Shelby, Tommy Tuberville  
Mississippi: Cindy Hyde-Smith, Roger F. Wicker  
U.S. House of Representatives:  
Alabama: Robert Aderholt, Mo Brooks, Jerry Carl, Jr., Barry Moore, Gary Palmer, Mike  
Rogers, Terri A. Sewell  
Mississippi: Michael Guest, Trent Kelly, Steven Palazzo, Bennie G. Thompson

OIG reports are available at [www.va.gov/oig](http://www.va.gov/oig).