



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Failure to Communicate and
Coordinate Care for a
Community Living Center
Resident at the VA Greater
Los Angeles Health Care
System in California



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations of a suspicious death of a community living center (CLC) resident and quality of care issues at the VA Greater Los Angeles Health Care System (facility) in California.¹ Specifically, the allegations were that nursing staff failed to

- assess the resident, who was complaining of pain;
- properly document assessments of the resident (including copying and pasting of assessment notes), reassessments, and treatments or interventions; and
- follow and implement the provider's order related to transferring the resident to a higher level of care.

Additionally, the OIG identified concerns related to institutional disclosure and inadequate care coordination.

Background

The resident was in their sixties and had a history of [morbid obesity](#) and [hypertension](#) and in 2006 was diagnosed with severe [obstructive sleep apnea](#) and severe [obesity hypoventilation syndrome](#).² The facility issued a [positive airway pressure device](#) to treat the conditions.

The resident was admitted to a non-VA hospital in early 2021, and was diagnosed with presumptive [congestive heart failure](#). The resident then requested transfer to the facility. Two days later, the resident was admitted through the facility's Emergency Department and treated for [hypoxemic hypercapnic respiratory failure](#). The treatment included the use of a facility-provided [average volume-assured pressure support](#) (AVAPS) machine.

The resident was discharged from the inpatient ward thirteen days after admission and was then admitted to the CLC for rehabilitation.³ Three days after admission to the CLC, a licensed vocational nurse reported to the day charge nurse that the resident complained of increased right upper quadrant abdominal pain that was rated 9 out of 10 and said nothing made the pain better.⁴

¹ For this report, the term resident refers to a veteran admitted to the CLC. The veteran discussed in this report was also an inpatient at the facility. For readability, the OIG refers to veterans admitted to the CLC as residents throughout the report.

² The OIG uses the singular form of they (their) in this instance for privacy purposes. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

³ The CLC provides short- and long-term care in a home-like environment. If a resident suffers an acute or life-threatening event, staff must call 911 for immediate help.

⁴ Pain intensity is assessed on a 0 to 10 point scale, with 0 indicating the absence of pain and 10 representing the most severe pain.

The day charge nurse then placed a call to the on-call provider, who later documented having recommended the resident be transferred to the Emergency Department. However, the day charge nurse failed to document the order in the resident's electronic health record (EHR) and did not initiate the transfer. A licensed vocational nurse found the resident unresponsive later that evening; 911 was then called. Emergency Medical Services administered [cardiopulmonary resuscitation](#) for 24 minutes, but resuscitation efforts were not successful and the resident died.

Inspection Results

The OIG did not substantiate that all nursing staff involved in the resident's care failed to assess the resident, who was complaining of pain, and to properly document the resident's assessments, reassessments, treatments, and interventions. However, the OIG did find that a day charge nurse's assessment was delayed and more than likely incomplete, because the EHR lacked documentation of a focused physical exam. Additionally, the day charge nurse failed to properly document the resident's reassessments, treatments, and interventions. The OIG found that the day charge nurse attempted to assess the resident after learning of the resident's pain but found the resident asleep. The day charge nurse went to lunch and upon return, approximately 45 minutes later, completed an assessment of the resident's pain. The OIG reviewed the EHR and found deficiencies in the assessment documentation. The documentation did not include a description of the resident's pain, nor follow-up evaluations of pain, and since the language was identical, appeared to be copied and pasted from a previous EHR entry.

The OIG substantiated that the day charge nurse failed to document, as required by facility policy, the on-call provider's order to transfer the resident to the Emergency Department after the resident reported abdominal pain. The day charge nurse told the OIG that after receiving the transfer order, the day charge nurse informed the provider that because nursing staff was changing shifts, the order would be given to the covering charge nurse. The covering charge nurse told the OIG that the [hand-off](#) received from the day charge nurse was to send the resident to the Emergency Department only "if pain gets worse." According to the covering charge nurse, this information was relayed to the evening charge nurse within minutes of the start of the evening shift. The evening charge nurse documented an assessment of the resident within 10 minutes of starting the shift. That assessment documented the resident's pain had improved, the resident did not want to go to the Emergency Department at that time, and the resident would notify the nurse if pain increased. Approximately three hours after the on-call provider gave the telephone order, the resident was found unresponsive. Staff initiated an emergency response, efforts were unsuccessful, and the resident died.

The OIG determined that, due to a lack of coordination of care at the time of discharge from the inpatient unit, the resident did not have an AVAPS machine upon admission to the CLC. The OIG found that the discharging team had time to ensure the resident's machine was brought from home and repaired, or issue a new machine, prior to discharge. Due to the complexity of the

resident's medical condition, the OIG was unable to determine if the lack of an AVAPS machine contributed to the resident's death.

The OIG determined that following the resident's death, facility staff failed to conduct a comprehensive review of the events leading up to, and contributing to, the resident's death. Rather, the OIG found that the facility conducted an administrative factfinding over the course of six and a half months. On the next business day following the resident's death, facility staff acknowledged the death during a nursing morning call attended by nursing leaders, nurse managers, nursing off-tour supervisors, and Quality Management staff but did not confirm that a patient safety report was entered to document the event in order to begin a review of the resident's death. In interviews with the Chief Nurse of Geriatrics and Extended Care (Chief Nurse), the OIG was told that the events leading to the resident's death were considered close calls and that the death was unexpected. Therefore, the OIG determined that the event should have been entered into a [Joint Patient Safety Report](#). The OIG found the failure to do so resulted in a missed opportunity to initiate formal engagement with Quality Management staff and the patient safety process for reviewing and scoring the event including consideration of a [root cause analysis](#).

The OIG found that the events leading to the resident's unexpected death met the criteria for [peer review](#). The Chief of Quality Management and a Risk Manager told the OIG that an occurrence screen, a type of Quality Management staff review of selected cases, was incomplete.⁵ The OIG determined that the lack of a thorough occurrence screen review, as well as the failure to identify the resident's death as a peer review triggering event, led to a missed opportunity to conduct peer reviews of relevant clinical staff who provided care to the resident.

The OIG found that five days after the resident's death, the Chief Nurse, with the intention of gaining a better understanding of the facts surrounding the resident's death, asked a CLC Nurse Manager to conduct a factfinding to review the death of the resident. The Chief Nurse told the OIG that the factfinding was completed quickly and that the report was "shallow and incomplete." Nonetheless, a service level corrective action plan was developed and implemented to address deficiencies identified from this first factfinding and other conversations with nursing leaders.

The Chief Nurse chartered a second factfinding 25 days after receiving the first report to better understand the sequence of events, nurses' thought processes specific to the resident's pain management, and the condition of the resident when the on-call provider was called. The second factfinding, submitted to the Chief Nurse, included staff responses to the questions asked and made eight conclusions. A third review was conducted by the Chief Nurse six and one-half

⁵ VHA Directive 1320, Quality Management and Patient Safety Activities that can Generate Confidential Records and Documents, July 10, 2020. Occurrence screen reviews are protected under 38 USC 5705 per VHA directive; therefore this report will not include substantive findings relating to the occurrence screen.

months after the resident's death as the Chief Nurse wanted to personally interview staff to "understand the issues." The OIG found that although significant time was spent conducting three separate factfindings, the reviews focused on the event of one specific day rather than a more comprehensive analysis of system issues reflected in the resident's course of care in the CLC. Additionally, the OIG found that several items on the Corrective Action Plan were listed as ongoing or pending seven months after initiation. The OIG determined that the unresolved action items reflected a lack of urgency and oversight as the corrective actions identified should have been completed by the time of, or prior to, the OIG's inspection.

Through interviews, the OIG learned that over the course of 10 months, facility Quality Management and medical staff leaders considered the need for disclosure, eventually determining that an institutional disclosure of the failure to follow a provider's order to transfer the resident to the Emergency Department was indicated. The OIG concluded the delay in determining the need for a disclosure was excessive.

The OIG made 10 recommendations to the Facility Director related to the confirmation of CLC nursing staff knowledge of policies related to nursing practices, documentation, pain assessments, verbal orders, when to use Joint Patient Safety Report, administrative reviews, and [quality assurance reviews](#); a review of hand-off communications; the need for peer reviews specific to the resident's care and CLC admission processes related to respiratory therapy equipment; and completion of the action items identified in the Corrective Action Plan, and an institutional disclosure.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B and C). Based on information provided, the OIG considers recommendations 2, 3, and 6 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are complete.



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Contents

Executive Summary	i
Introduction.....	1
Scope and Methodology	2
Resident Case Summary	3
Inspection Results	5
1. Delayed and Incomplete Assessment and Failure to Properly Document	5
2. Failure to Follow and Document a Provider’s Telephone Order	7
3. Failure to Conduct a Comprehensive Review	9
4. Related Concern: Institutional Disclosure	14
5. Related Finding: Inadequate Care Coordination at Discharge.....	16
Conclusion	17
Recommendations 1–10.....	19
Appendix A: Detailed Resident Case Summary.....	20
Appendix B: VISN Director Memorandum.....	25
Appendix C: Facility Director Memorandum.....	26
Glossary	35
OIG Contact and Staff Acknowledgments	41
Report Distribution	42

Abbreviations

AVAPS	average volume-assured pressure support
CLC	community living center
CPR	cardiopulmonary resuscitation
EHR	electronic health record
EMS	emergency medical service
RCA	root cause analysis
JPSR	Joint Patient Safety Report
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations of a suspicious death of a community living center (CLC) resident and quality of care issues at the VA Greater Los Angeles Health Care System (facility) in California.¹

Background

The facility, part of Veterans Integrated Service Network (VISN) 22, is located in Los Angeles, California, and is designated as a Level 1a, highest complexity, facility.² From October 1, 2020, through September 30, 2021, the facility served 90,059 patients and had 372 CLC beds. The CLC is located on the West Los Angeles VA Medical Center campus and is independent of the campus' hospital.

The CLC is a homelike, nursing home setting. While the CLC provides nursing home care, it does not provide acute care and does not have an identified emergency response team that can provide resuscitative efforts during a medical emergency. As such at this facility, if a CLC resident suffers an acute medical event or life-threatening condition, staff call 911 for immediate help or transfer to the Emergency Department for evaluation and possible hospital admission.³

Allegations and Related Concerns

On May 6, 2021, the OIG received allegations forwarded from the Office of Accountability and Whistleblower Protection stating that a resident died in the CLC when nursing staff failed to

- assess the resident who was complaining of pain;
- properly document assessments of the resident (including copying and pasting of assessment notes), reassessments, and treatments or interventions; and
- follow and implement the provider's order related to the care of the resident.

¹ For this report, the term resident refers to a veteran admitted to the CLC. The veteran discussed in this report was also an inpatient at the facility. For readability, the OIG refers to the veteran as "resident" throughout the report.

² The VA Greater Los Angeles Health Care System operates two ambulatory care centers and eight community-based outpatient clinics. VHA Office of Productivity, Efficiency and Staffing, Facility Complexity Model. 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. Level 1a classification means the facility has "high volume, high risk patients, most complex clinical programs, and large research and teaching programs."

³ Facility Standard Operating Procedure 10H3-149-16, *Community Living Center Transfer Policy*, August 2012.

On May 13, 2021, after reviewing the original complaint, the OIG sent a Hotline Complaint Referral to the facility. The referral asked the facility to review the allegations and to indicate which, if any, were substantiated.

The facility responded to the hotline referral on August 17, 2021. Upon review of the facility's response, the OIG determined that the facility's review was not comprehensive as it did not adequately evaluate the care of the resident. Specifically, the OIG found that the facility's response did not identify

- the charge nurse's copying and pasting of a note,
- the charge nurse's lack of documentation regarding the resident's pain throughout the day of death, and
- the charge nurse's incomplete documentation regarding the charge nurse's telephone communication with the on-call provider.⁴

In addition, the OIG found that the timeline provided in the facility's response was not consistent with documentation in the electronic health record (EHR).

The OIG opened this inspection to review the care the resident received from CLC staff as well as the allegations made by the complainant and the facility's response to those allegations.

During this inspection, the OIG team identified additional concerns related to institutional disclosure and care coordination at the time of inpatient discharge from the facility, specifically, ensuring resident access to a functioning [average volume-assured pressure support](#) (AVAPS) machine.

Scope and Methodology

The OIG initiated the inspection on September 7, 2021. The OIG interviewed facility and CLC leaders as well as relevant providers and staff. Virtual interviews were conducted October 20–28, 2021, and November 29 through December 2, 2021.

The OIG reviewed Veterans Health Administration (VHA) directives and handbooks, facility policies, and standard operating procedures (SOPs). The OIG also reviewed CLC nurse staffing assignments, CLC resident census and acuity, and nursing staff personnel documents, as well as the facility's quality reviews, Factfinding Memorandum, and Corrective Action Plan. The OIG reviewed the resident's death certificate and emergency medical service (EMS) notes from the evening of the resident's death.

⁴ Facility SOP 00-10B-118-07, Charge Nurse Responsibility, May 2016. A charge nurse is a registered nurse assigned to coordinate patient care and communications on a patient care unit throughout a shift. The charge nurse addresses staffing and patient transfers into and out of the unit, and reports any out of the ordinary problems to the nurse manager.

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.

Resident Case Summary

The resident, who was in their sixties with a history of [morbid obesity](#) and [hypertension](#), was diagnosed with severe [obstructive sleep apnea](#) and severe [obesity hypoventilation syndrome](#) in 2006 and was issued a [positive airway pressure device](#) for treatment of these conditions.⁵ In early 2021, the resident was admitted from home to a non-VA hospital with shortness of breath and diagnosed with presumptive [congestive heart failure](#). The resident requested to be transferred to the facility. Two days later, the resident was admitted through the facility's Emergency Department and treated for [hypoxemic hypercapnic respiratory failure](#). A sleep medicine consultant noted the resident had not been using the positive airway pressure machine because it was broken. The sleep medicine consultant recommended treatment of obstructive sleep apnea, obesity hypoventilation syndrome, and hypoxemic hypercapnic respiratory failure with a positive airway pressure device known as AVAPS continuously "until acute respiratory failure resolves" and to then transition to only nightly use of the machine. The sleep medicine consultant also recommended that the resident's family bring in the resident's home AVAPS machine for repair, "otherwise [the resident] will need a new [machine] on discharge."

Three days after admission to the facility, the resident was diagnosed with a [saddle pulmonary embolus](#) and a right sided kidney stone. An ultrasound showed [deep vein thrombosis](#) in the left leg. Anticoagulation was initiated and the resident underwent a successful bilateral pulmonary

⁵ The OIG uses the singular form of they (their) in this instance for privacy purposes.

artery [thrombectomy](#) followed by placement of an infusion catheter in the right main pulmonary artery for [catheter directed thrombolysis](#) of remaining blood clots. Once thrombolysis was completed, [subcutaneous enoxaparin](#) was initiated and an anticoagulation pharmacist was consulted for appropriate dosing given the resident's obesity.

During the resident's facility inpatient admission, the resident had intermittent shooting pain in the abdomen and leg. The medical team assessed that this pain was likely due to the deep vein thrombosis and less likely due to the kidney stone and continued with a plan for pain medication as needed. A [urology](#) consultant assessed that the kidney stone was not causing significant obstruction of the urinary tract and recommended outpatient follow-up.

Thirteen days after admission to the facility, the resident was discharged from the inpatient ward and admitted to the CLC for rehabilitation. Nursing notes on the day of CLC admission indicated the resident was using supplemental oxygen and was "bedbound and dependent" on nursing "for all ADLs [[activities of daily living](#)] and mobility." A CLC nurse practitioner documented that the resident was a [full code](#) and had capacity to make medical decisions.

The CLC nurse practitioner documented requesting that staff contact the resident's spouse about the AVAPS "to avoid delay in care" and entered an order to "please make sure the Veteran has [the resident's] AVAP[S] machine from the hospital via sleep medicine or if the [spouse] can bring in [the resident's] home machine." Two days after admission to the CLC, the CLC nurse practitioner ordered a sleep consult stating the resident "will need a new BIPAP/VPAP [*sic*] [bilevel positive airway pressure]/[average volume-assured pressure support machine]...machine as the one [the resident] brought to the CLC is broken."

The next morning at 7:26 a.m., a CLC registered nurse documented that the resident's respirations were unlabored and that the resident did not have chest pain or shortness of breath. The resident had eaten most of breakfast. The resident was administered the oral pain medications [oxycodone](#) 5 mg at 6:43 a.m. and 12:56 p.m. and [acetaminophen](#) 650 mg at 9:39 a.m., 12:55 p.m., and 5:31 p.m. [Capsaicin](#) and [lidocaine](#) were also administered topically for pain of the lower extremities.

At 3:45 p.m., the day charge nurse documented that the resident was nauseous and had experienced pain in the right side of the abdomen rated at a level of 9 out of 10 since that morning, and that nothing made the pain better.⁶ The day charge nurse placed a call to the on-call provider at 3:30 p.m.

The on-call provider documented speaking with the day charge nurse by phone at 3:54 p.m. The on-call provider documented that the day charge nurse reported the resident had experienced right upper quadrant abdominal pain rated 9 out of 10 since that morning, that the resident was

⁶ Pain intensity is assessed on a 0 to 10 point scale, with 0 indicating the absence of pain and 10 representing the most severe pain.

nauseous and not eating, and that the resident wanted to go to the Emergency Department. The on-call provider documented a recommendation to send the resident to the Emergency Department, and documented that the day charge nurse stated the recommendation would be passed on to the nurse who was covering charge nurse duties until the arrival of the evening charge nurse.

The evening charge nurse documented checking on the resident at 4:10 p.m.; the resident reported pain had improved from 9 out of 10 to 6 out of 10. The evening charge nurse informed the resident that the on-call provider had given an order to send the resident to the Emergency Department for evaluation “if [the resident’s] pain get worst [sic].” The evening charge nurse documented that the resident understood and would let the nurse know if pain was not controlled. The evening charge nurse entered an addendum at 8:11 p.m. that the resident had stated at 4:15 p.m. not wanting to go to the hospital.

The evening charge nurse documented that at 6:48 p.m., a licensed vocational nurse called because the resident was unresponsive. The evening charge nurse “rushed to the room” and noted the resident was [cyanotic](#) with heavy breathing. The evening charge nurse documented that 911 was called at 6:50 p.m. CLC staff continued to care for the resident until emergency medical services (EMS) personnel arrived at 7:03 p.m. and assumed care of the resident.

When EMS arrived, the resident was unconscious and unresponsive. The resident experienced cardiac arrest shortly thereafter. EMS administered [cardiopulmonary resuscitation](#) for 24 minutes, but resuscitation efforts were not successful. The resident’s death was pronounced at 7:37 p.m. The evening charge nurse documented informing the on-call provider of the resident’s death at 7:50 p.m. The resident’s death certificate listed respiratory arrest as the immediate cause of death.

Inspection Results

1. Delayed and Incomplete Assessment and Failure to Properly Document

The OIG found that the day charge nurse’s assessment was delayed and incomplete, and that the day charge nurse failed to properly document the resident’s reassessments, treatments, and interventions. However, the OIG did not substantiate that any other individual nursing staff member involved with the resident’s care failed to assess the resident who was complaining of pain and to properly document the resident’s assessments, reassessments, treatments, and interventions.

The day charge nurse told the OIG that a licensed vocational nurse had reported the resident’s complaint of abdominal pain to the day charge nurse around 2:15 p.m. on the afternoon of the resident’s death. The day charge nurse then went to check on the resident, but found the resident

asleep. The day charge nurse told the OIG that after going to lunch, checked on the resident at 3:00 p.m., and at that time the resident reported increased pain. At 3:49 p.m., the day charge nurse signed an EHR note that documented the resident's pain as 9 out of 10 and having called the on-call provider at 3:30 p.m. to make the on-call provider aware of the resident's pain level, and was waiting for a response.

Facility policy requires nursing staff to promptly assess patients for pain when indicated.⁷ The pain assessments use a zero to 10-point scale and must evaluate intensity, location, and effects of the pain on quality of life. If a resident reports increased pain, facility policy requires a comprehensive, detailed assessment that includes a focused physical examination evaluating the intensity, location, and effect of the pain. Facility policy also provides that nursing staff are to assess and reassess residents with new or ongoing pain at a "suitable interval following any pain intervention."⁸ These assessments, along with any treatments or interventions, must be documented in a resident's plan of care whenever there is a significant change.⁹

Based on a lack of documentation and the account provided by the day charge nurse, the OIG determined the day charge nurse likely failed to promptly assess and reassess the resident, who was complaining of pain. In an interview with the OIG, the day charge nurse's account of the day indicated that 45 minutes passed between learning of the resident's pain and when the resident was assessed. However, the timing of the events described by the day charge nurse were not documented in the EHR and therefore could not be confirmed by the OIG. The OIG determined that the assessment done by the day charge nurse was more likely than not incomplete because the EHR lacked documentation of a focused physical exam.

The OIG would have expected to see documentation that included the following

- the licensed vocational nurse's report informing the day charge nurse of the resident's pain,
- the day charge nurse's physical examination after assessing the resident's upper right quadrant pain, and
- interventions to relieve the resident's pain.

The OIG also found that on the day of the resident's death, the day charge nurse copied and pasted a note verbatim from two days preceding the resident's death. According to VHA policy, if VHA staff copy and paste information previously recorded in a progress note, the author is responsible for verifying that the content of the copied information is accurate. VHA expects

⁷ Facility Policy 00-11-24, Pain Management, May 2019.

⁸ Facility Policy 00-11-24.

⁹ Facility Policy 00-10B-118-04, *Documentation of Nursing Care: Assessment, Reassessment, Plan of Care, Transfer, and Discharge*, September 2016.

documentation to be “accurate, relevant, timely and complete.”¹⁰ Based on review of the EHR, the OIG determined that the note was not accurate as it was copied and not modified to communicate the resident’s current health status, lacked updated assessments and reassessments of pain on the day of the resident’s death, and the information in the body of the note did not reflect the correct date.

The day charge nurse’s failure to promptly assess and reassess the resident, document the resident’s pain assessments, and complete a focused physical exam, as well as the use of outdated copied and pasted information, may have hindered the understanding of the nature and duration of the resident’s pain throughout the day of death by other CLC nursing staff involved in the resident’s care and the on-call provider.

2. Failure to Follow and Document a Provider’s Telephone Order

The OIG substantiated that nursing staff failed to document and carry out a telephone order to transfer the resident to the Emergency Department. The OIG found that the resident had a medical emergency in the CLC and died approximately three hours after a transfer order to the Emergency Department was given and not followed. However, the OIG was unable to determine if transferring the resident to the Emergency Department would have prevented the resident’s death.

Through a review of records and an interview with the on-call provider, the OIG found that, at or around 3:54 p.m. on the day of the resident’s death, the on-call provider returned the day charge nurse’s call and gave a telephone order to send the resident to the Emergency Department for evaluation. The day charge nurse told the OIG that the on-call provider’s order to transfer the resident to the Emergency Department was conveyed to the covering charge nurse. The covering charge nurse informed the OIG that the [hand-off](#) received from the day charge nurse was to send the resident to the Emergency Department “if pain gets worse.” A few minutes after receiving the hand-off from the day charge nurse, the covering charge nurse relayed this information to the evening charge nurse.

According to documentation in the EHR, the evening charge nurse assessed the resident’s pain within 10 minutes of receiving the hand-off from the covering charge nurse. The evening charge nurse told the resident that the on-call provider had given an order to send the resident to the Emergency Department if the pain got worse. The evening charge nurse documented that the resident demonstrated understanding of the order, said the pain had improved, and told the evening charge nurse if the pain wasn’t controlled the resident would let the evening nurse know. There was documentation in the EHR that the resident “indicated that [the resident] doesn’t want

¹⁰ VHA Handbook 1907.01, Health Information Management and Health Records, March 19, 2015.

to go to the hospital” but there was no documentation in the EHR of nursing staff informing the on-call provider that the resident had declined transfer to the Emergency Department.

The resident became unresponsive approximately three hours after the on-call provider gave the telephone order to transfer the resident to the Emergency Department. Seventeen minutes after becoming unresponsive, the resident experienced cardiac arrest and died.

The OIG found the day charge nurse received the on-call provider’s telephone order specifying that the resident was to go to the Emergency Department, not that the resident was to go to the Emergency Department only if the pain worsened. However, the day charge nurse failed to document the order in the resident’s EHR and initiate the resident’s transfer to the Emergency Department. Facility policies state telephone orders from providers may be accepted by nursing staff when direct entry of a medical order into the EHR is impossible due to the urgent nature of the order and when it is in the best interest of resident care.¹¹ Facility policy specifies that nursing staff receiving telephone orders are to immediately write down the order, read the order back to the prescriber, document the read back of the order, enter the order into the resident’s EHR, and then sign the order.¹² The on-call provider told the OIG that when telephone orders are given to nursing staff, the expectation is that the nurse will document the order in the EHR and ensure the order is carried out. Through interviews with CLC staff, the OIG learned that CLC nursing staff did not regularly document telephone orders into the EHR. The OIG determined that nursing leaders failed to ensure that nursing staff were aware of, and following, the policy for telephone orders. Through interviews and a review of documents, the OIG learned that, since the resident’s death, CLC leaders have provided training along with additional monitoring to ensure nursing staff follow the facility’s telephone orders policy.

According to facility policy, departing charge nurses are responsible for initiating and completing hand-off communication reports to arriving charge nurses.¹³ Hand-off communication reports allow nursing staff to ask and answer questions about a resident’s care needs with the goal of safety and efficiency. Hand-offs can be a vulnerable time as care is transitioned from one nursing team to the next.¹⁴ Through interviews with the involved charge nurses, the OIG found the day charge nurse left at the end of the shift, but before the evening charge nurse had arrived. As such, the day charge nurse handed off the resident’s care to a covering charge nurse who then gave a hand-off to the evening charge nurse.

¹¹ Facility Policy 10B-118-46, *Read Back Process Utilized for Verbal or Telephone Orders and Critical Test Results*, March 2016. Facility Policy, *Bylaws and Rules of the Medical Staff*, February 21, 2020.

¹² Facility Policy 10B-118-46.

¹³ Facility Policy 00-10B-118-07. Facility Policy, *CLC Charge Nurse Handbook*, 2019.

¹⁴ Mary Ann Friesen, Susan V. White, Jacqueline F. Byers, “Handoffs: Implications for Nurses,” in *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, editor RG Hughes, Rockville: Agency for Healthcare Research and Quality, 2008), 2-285 to 2-286.

The OIG was unable to determine if transferring the resident to the Emergency Department would have prevented the resident's death. However, due to the day charge nurse's failure to document and carry out the telephone order, the resident did not receive care in the Emergency Department, a setting better equipped to manage the decline in condition and subsequent medical emergency. Further, the OIG concluded that back-to-back hand-offs increased the potential for error as key elements of the resident's care were communicated between three nurses within less than 10-minutes.

3. Failure to Conduct a Comprehensive Review

The OIG determined that following the resident's death, the facility failed to conduct a comprehensive review of the events leading up to and contributing to the resident's death. Rather, the OIG found that the facility conducted an administrative factfinding over the course of six and a half months.

Lack of Quality Assurance Reviews

Adverse events include negative occurrences directly associated with care or services provided within the jurisdiction of a VHA facility. Adverse events may occur from acts of omission.¹⁵ Depending on the circumstances, the unexpected death of a CLC resident may be considered an adverse event and therefore warrant a [quality assurance review](#). Quality assurance reviews are done "in the interest of improving the quality of care" provided.

VHA's patient safety program consists of a three-step approach to learn about and "effectively mitigate system vulnerabilities that can lead to patient harm." The steps include "understanding the health care continuum as a system, and exploring system vulnerabilities that can result in patient harm," "reporting of adverse events and close calls," and "emphasizing prevention rather than punishment as the preferred method to mitigate system vulnerabilities and reduce adverse events."¹⁶

Reporting adverse events within VHA has "provided valuable opportunities to evaluate the identified root causes and contributing factors, as well [*sic*] associated actions and outcome measures to mitigate future events from reoccurring within that facility."¹⁷ Adverse events may be submitted by VHA staff using a [Joint Patient Safety Report](#) (JPSR), which allows the communication of safety concerns and events. Once submitted, the event is reviewed by the patient safety manager and given a score that reflects the probability of the event occurring again at the facility and severity of the event. Events scored at a level three trigger a [root cause analysis](#) (RCA).

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

¹⁶ VHA Handbook 1050.01.

¹⁷ VHA Handbook 1050.01.

[Peer reviews](#) are also available as a mechanism to evaluate the care provided to a resident.¹⁸ JPSRs, RCAs, and peer reviews all allow for review of events and are intended to promote a “culture of safety” that encourages a non-punitive environment to address concerns related to the systems of care as well as improve patient outcomes.¹⁹ Quality assurance reviews offer structured processes with prescribed time frames and reporting expectations designed to review system issues within the healthcare setting. The failure to utilize quality assurance reviews can make it more challenging to identify quality of care and other patient safety concerns, to implement early interventions, to identify practices in need of improvement, and to potentially prevent future adverse patient events.

Joint Patient Safety Report

VHA requires staff report adverse events to patient safety managers.²⁰ Staff may report an adverse event using the JPSR system. There are no required time frames for submitting an event; however, the earlier it is done, the more likely that facts surrounding the event will be accurately recalled by those involved.

The Chief Nurse of Geriatrics and Extended Care (Chief Nurse) told the OIG about considering the lack of an appropriate and updated assessment of the resident’s pain, the lack of a documented transfer order, and an inadequate verbal hand-off to be close calls.²¹ The Chief Nurse reported the issues with the resident’s care were discussed on the Monday following the event during a nursing morning call attended by nursing leaders, nurse managers, nursing off-tour supervisors, and Quality Management staff. The Chief Nurse told the OIG that JPSRs are often discussed on this call by attendees from Quality Management, so the Chief Nurse assumed the group was discussing a JPSR. The Chief Nurse only later realized that a JPSR had not been entered. The Chief Nurse told the OIG about not consulting with Quality Management regarding what actions to take after the resident’s death and the Chief Nurse believed Quality Management staff were addressing the issue through the JPSR system. In an interview with the Chief Nurse, the OIG was told that the circumstances leading up to the resident’s death were considered to be close calls, and the death was described as unexpected. Therefore, the event should have been entered into the JPSR system by the Chief Nurse or any other CLC staff member with knowledge of the event. Failure to do so resulted in a missed opportunity to initiate formal engagement with Quality Management staff and the structured patient safety process for reviewing and scoring the event.

¹⁸ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

¹⁹ VHA Handbook 1050.01.

²⁰ VHA Handbook 1050.01.

²¹ The Chief Nurse of Geriatrics and Extended Care has supervisory responsibility for the CLC.

Root Cause Analyses

Root cause analyses are completed to improve performance and identify system and process issues for mitigation to prevent reoccurrences from causing harm to patients. Root cause analyses are expected to be timely, include an interdisciplinary team and organizational leaders, and focus on systems and processes rather than individuals. Once the need for an RCA is identified, the process must be chartered and completed within 45 calendar days. The OIG determined that the lack of a JPSR entry and the failure to engage Quality Management staff in the review of this case resulted in a missed opportunity to consider completion of an RCA. As such, the care leading up to the death of the resident was not reviewed for system issues by an interdisciplinary team.

Peer Reviews

Peer review is a confidential process used to review the clinical care provided by healthcare professionals. The review is intended to be non-punitive and can lead to short and long-term improvements to patient care “by revealing areas for improvement in the provision of health care of one or multiple clinicians.”²² Peer reviews can allow for the identification of staff who may need additional training or oversight, thereby improving quality of care.

One way that episodes of care requiring peer review are identified is through an occurrence screening process where Quality Management staff review selected patient cases based on a list of criteria that includes the death of a resident during an inpatient hospitalization.²³ Based on the criteria in an occurrence screen, the death of the resident met the criteria for peer review.

The OIG was told that a Risk Manager, who is no longer at the facility, assigned a registered nurse who was temporarily assigned to Quality Management to conduct an occurrence screening review. The OIG evaluated the occurrence screen review completed by the registered nurse and found it to be incomplete.²⁴

VHA policy identifies serious clinical events that require peer review.²⁵ Included on the list of events requiring review are “death that was preceded by a change in the patient’s condition when there are questions regarding response to, management of, and/or communication related to the referenced change” and when there is a “cardiac or pulmonary arrest that may have been

²² VHA Directive 1190.

²³ VHA Directive 1190. VHA Directive 1320, *Quality Management and Patient Safety Activities that can Generate Confidential Records and Documents*, July 10, 2020.

²⁴ VHA Directive 1320. Occurrence screen reviews are protected under 38 USC 5705 per VHA directive; therefore, this report will not include substantive findings relating to the occurrence screen.

²⁵ VHA Directive 1190.

preventable.” The Facility Director is responsible for ensuring peer reviews are done for clinical events warranting one.²⁶

On September 20, 2021, the OIG requested that, by October 1, 2021, the facility provide the OIG with evidence of any peer reviews that were performed related to the death of the resident. The OIG did not receive any peer reviews in response to this request.

The OIG determined that the resident’s death was unexpected and the events that preceded it met criteria for peer review. The OIG found that the lack of a thorough and complete occurrence screen review, as well as the failure to identify the death of the resident as an event requiring peer review, resulted in a missed opportunity to conduct peer reviews of relevant clinical staff who provided care to the resident.

Administrative Reviews

Administrative investigation boards (AIB) and factfindings are two types of reviews done within VA when an administrative investigation is needed.²⁷ Of the two, AIBs are more formal reviews that are typically conducted under oath by an AIB Board following specific procedural requirements and documentation. “A Factfinding has fewer procedural requirements than an AIB, is generally conducted more quickly, and results in a less thorough investigative report and review.” Factfindings are generally conducted by one person. Both investigation types can be used when investigating potential disciplinary actions.

Factfinding

In an interview with the OIG, the Chief Nurse explained that after the resident’s death, a CLC Nurse Manager was asked to conduct a factfinding to review the death of the resident. Five days after the resident’s death, the CLC Nurse Manager submitted the completed factfinding report to the Chief Nurse. The Chief Nurse told the OIG that the submitted report was completed quickly and “...the way the report was written...it was pretty much shallow and incomplete. I am not here to discredit [the CLC Nurse Manager’s] work, but it didn’t rise to where I needed [it] to have, given the magnitude of the incident.”

Twenty-five days after receiving the first factfinding report, the Chief Nurse chartered a second factfinding and assigned an off-tour supervisor to conduct it. The off-tour supervisor submitted the second factfinding report 17 days after the investigation was chartered. Twenty days after receiving the second report, the Chief Nurse asked the off-tour supervisor to provide clarification. The Chief Nurse told the OIG that the off-tour supervisor was asked to answer the additional questions to better understand the events.

²⁶ VHA Directive 1190.

²⁷ VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

- What were the sequence of events?
- What were nurses' thought processes from the time the resident reported pain to when the hand-off occurred?
- How did the resident present when the day charge nurse made the decision to call the on-call provider about transferring the resident to the ED?

The second factfinding report, updated with responses to the questions and eight conclusions, was resubmitted to the Chief Nurse 42 days after being chartered.

The Chief Nurse told the OIG about conducting a third review because of wanting “to know personally by interviewing the folks officially in the record to understand the issues one more time.” This review was done six and a half months after the resident’s death and included interviews with the original witnesses to the events as well as with a new interviewee, a nursing assistant who reported witnessing the hand-off between the day charge nurse and the covering charge nurse. The OIG determined that this review identified a finding, not included in the prior factfindings, that the day charge nurse failed to document the patient’s condition as well as the content of the hand-off provided to the covering charge nurse.

When asked by the OIG if conducting three factfindings were the most appropriate method to review the resident’s care, the Chief Nurse acknowledged that in hindsight, they were not and stated that an RCA would have been a more appropriate method to study the system issues and ensure they were addressed.²⁸

The OIG found that significant time was spent conducting three separate factfindings with the same staff over an extended period of time that resulted in the gathering of facts specific to a single day with the focus of potential administrative or disciplinary action and that the more formal AIB process was not completed. In addition, facility staff failed to conduct an RCA in order to provide an analysis or understanding of system issues reflected in the resident’s course of care.

Corrective Action Plan

A corrective action plan “responds to an identified risk or to organizational compliance failures.”²⁹ Corrective action plans outline the “specific steps the organization will take to minimize the likelihood of a risk being realized” and “implement prevention mechanisms to ensure the [compliance] failure does not resurface.” The OIG learned that the Chief Nurse developed and implemented a Corrective Action Plan four days after receiving the first factfinding report. The Corrective Action Plan was created to address deficiencies identified

²⁸ When responding to this inquiry, the Chief Nurse noted that AIBs are not initiated at the level of a Chief Nurse. Therefore, consideration was not given to conducting one.

²⁹ VHA Directive 1030(1), VHA Integrity and Compliance Program, December 29, 2020, amended January 7, 2021.

during the first factfinding and through brainstorming sessions with nursing leaders. The areas identified included

- failure to follow telephone orders policy and document a provider’s telephone order,
- failure to document a comprehensive pain assessment,
- failure to communicate hand-off reports of pain,
- gaps in nurse to provider communication,
- adherence to CLC admission criteria,
- notification of off-tour supervisor when emergent situations occur,
- staff training,
- patient transfer processes,
- charge nurse responsibilities,
- after hour and weekend provider coverage,
- use of telephone orders in the CLC, and
- response by providers to pages.

When questioned by the OIG, the Chief Nurse said the Corrective Action Plan was a “single action plan that has been evolving.” At the time of the OIG’s virtual site visit, more than seven months after the Corrective Action Plan was created, several items were still listed as “ongoing” or “pending” action and some action items had no target dates for completion.

The OIG found the unresolved action items and inattention to the Corrective Action Plan reflected an overall lack of urgency and oversight. The OIG determined that due to the multiple patient safety risks identified by the facility, the corrective actions identified in the plan should have been completed by the time of, or prior to, the OIG’s inspection.

4. Related Concern: Institutional Disclosure

The OIG found that over the course of 10 months, facility Quality Management and medical staff leaders considered the need for disclosure, eventually determining that an institutional disclosure of the failure to follow a provider’s order to transfer the resident to the Emergency Department was indicated.

VHA policy requires disclosure of harm related to an adverse event to patients, or their personal representatives.³⁰ VHA defines institutional disclosure as a formal process in which facility

³⁰ VHA Directive 1050.01.

leaders and respective clinicians inform the patient or representative about the adverse event.³¹ The intent of institutional disclosure is to fully inform patients and their families about all clinically significant facts related to the harm caused by VA medical care and options to pursue potential compensation.³² When institutional disclosures are not completed when required, patients and families may inadvertently be denied their rights.

The Chief of Quality Management told the OIG that an institutional disclosure was not considered at the time of the occurrence screen in June because “there was [*sic*] no red flags for an institutional disclosure.” On September 28, 2021, more than six months after the resident’s death, the facility’s Risk Manager emailed the Chief of Staff and Deputy Chief of Staff to request input on the resident’s case. The Risk Manager noted that the factfinding did not find that the day charge nurse had caused the resident’s death and that the death certificate listed the primary cause of death as respiratory arrest. As such, the Risk Manager opined that there was not enough information to disclose to the family that actions by facility staff caused the resident’s death.

The Risk Manager told the OIG about requesting on October 7, 2021, almost three and a half months after Quality Management staff completed the occurrence screen, that a staff provider conduct a clinical EHR case review of the resident’s care received at the facility and at an outside hospital. The Risk Manager stated the review was not “a mandate” but warranted “from a risk management perspective.” On October 12, 2021, after receiving the clinical EHR case review from the staff provider, the Risk Manager forwarded the review to the Chief of Staff’s office in correspondence with a subject of “Institutional Disclosure.” Between October 12, and December 15, 2021, the Risk Manager and Deputy Chief of Staff reviewed records and considered the need for an institutional disclosure.

On December 21, 2021, the OIG submitted a written request to the facility asking if a determination regarding the need for an institutional disclosure had been made and if so, what decision was made, by whom, and what the rationale was for the decision. The facility Chief of Staff’s January 5, 2022, response to the OIG request stated that upon review, an institutional disclosure was warranted as “an opportunity for intervention (transfer to the Emergency Department) existed and was considered but not acted on, prior to the terminal event.”

The decision to complete an institutional disclosure is in alignment with the “VA core values of integrity, commitment, advocacy, respect, and excellence.” The OIG is concerned that it took 10 months, and repeated reviews, to determine that an institutional disclosure was appropriate. Failure to conduct institutional disclosures in this situation has the potential to erode the trust that

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

³² VHA Directive 1004.08.

veterans and their families have in their healthcare team and may inadvertently deny them of their right to be fully informed regarding their care.

5. Related Finding: Inadequate Care Coordination at Discharge

During the inspection, the OIG identified an additional concern related to care coordination at the time of inpatient discharge from the acute facility and admission to the CLC. The OIG determined that the facility inpatient discharging team did not ensure the resident had a functioning AVAPS machine at the time of discharge despite recommendations from the sleep consultant that the resident use one. Further, the OIG found that the resident did not have access to a functioning AVAPS machine during the CLC stay.

VHA defines care coordination as “a system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services.”³³ Facility bylaws and rules of the medical staff require the discharging multidisciplinary treatment team initiate discharge planning and document those plans in the EHR to ensure “continuity of care to meet identified needs.”³⁴

The resident had a history of obesity hypoventilation syndrome and obstructive sleep apnea. The primary admission diagnosis was “hypoxemic/hypercapnic respiratory failure, in the setting of not using AVAPS as [the machine] was broken.” According to the EHR, the sleep clinic was consulted on day two of the hospitalization and the sleep consultant recommended the resident continuously use an AVAPS machine while acutely ill and then transition to night use only. The sleep consultant also recommended that the resident’s home machine be brought in by the resident’s family and repaired, “otherwise [the resident] will need a new [machine] on discharge.” During the inpatient stay, the resident used an AVAPS machine loaned by the respiratory therapy department. The OIG found evidence in the EHR that the family said they would bring the resident’s machine to the facility but did not find evidence that the facility followed up with family to ensure the machine was brought in prior to the resident’s discharge.

Thirteen days after admission, the resident was discharged to the CLC, and the loaner AVAPS machine was returned to the respiratory therapy department. The sleep consultant would have expected staff ensure the resident had a working AVAPS machine at the time of discharge from the inpatient ward.

On the day of the resident’s admission to the CLC, the CLC nurse practitioner placed an order for staff to ensure the resident had an AVAPS machine “from the hospital via sleep medicine or if the [spouse] can bring in [the resident’s] home machine.” The OIG learned that the respiratory therapy department does not loan AVAPS machines to CLC residents. The Acting Director of

³³ VHA Directive 1110.04(1), *Integrated Case Management Standards of Practice*, September 6, 2019.

³⁴ Facility Policy, *Bylaws and Rules of the Medical Staff*, February 21, 2020.

Respiratory Care explained that inpatients are provided loaner machines “because we don’t know how they clean or disinfect their machine at home so we don’t allow them to use their machine from home [while an inpatient].” The CLC nurse practitioner shared that inpatients in need of a new machine can be provided one upon discharge from the inpatient setting. In the CLC, however, residents who have machines are expected to bring the machines that are used at home to the CLC and residents with broken machines are asked to bring them to the facility for repair or replacement. The CLC Medical Director had not been aware of this practice and told the OIG that inpatients with loaner machines, like the AVAPS machine, “always came over [to the CLC] with them, but apparently that is not the case.” The OIG found that, more than six months after the resident’s death, the CLC Medical Director told the CLC Admission Nurse “For veterans who are on CPAP/BiPAP [continuous positive airway pressure/bilevel positive airway pressure]...if they are using a machine from the medical center...we should not accept the veteran for admissions [*sic*] unless they come with a lender.” While the Chief Nurse also told the OIG that the CLC would no longer accept residents without positive airway pressure devices when clinically-indicated, the OIG did not find evidence of a formalized change to policy or procedure that reflected this new admission practice.

The OIG was told that, upon admission to the CLC, the resident’s family was again asked to bring the AVAPS machine from home. Two days later, the family brought the resident’s AVAPS machine to the CLC. Later that day, the CLC nurse practitioner placed a sleep medicine consult for a new AVAPS machine as the resident’s machine was broken; however, sleep medicine staff did not complete the routine consult before the resident’s death the following day.

The OIG determined that due to a lack of coordination of care at the time of discharge from the inpatient unit, the resident did not have the recommended AVAPS machine upon admission to the CLC. The OIG found that the discharging team had time to ensure the resident’s machine was brought from home and repaired, or to issue a new machine, prior to discharge. However, due to the complexity of the resident’s medical condition, the OIG cannot determine if the lack of an AVAPS machine contributed to the resident’s death.

Conclusion

A review of the resident’s care found that on the day of the resident’s death, the day charge nurse’s assessment of the resident was delayed and more than likely incomplete, and the day charge nurse failed to properly document the resident’s reassessments, treatments, and interventions. The OIG would have expected to see documentation that included the licensed vocational nurse’s report informing the day charge nurse of the resident’s pain, the day charge nurse’s physical examination after assessing the resident’s pain, and interventions to relieve the resident’s pain. In addition, on the day of the resident’s death, the day charge nurse copied and pasted a note verbatim from two days preceding the resident’s death without modifying it to communicate the resident’s current health status. These documentation failures may have

hindered the understanding by other CLC nursing staff, and the on-call provider, of the nature and duration of the resident's pain throughout the day of death.

The day charge nurse failed to document and carry out a telephone order to transfer the resident to the Emergency Department. The OIG was unable to determine if following the provider's order to transfer the resident to the Emergency Department would have prevented the resident's death. However, due to the day charge nurse's failure to document and carry out the telephone order followed by back-to-back hand-offs miscommunicated between three nurses during a less than 10-minute period, the resident did not receive care in the Emergency Department, a setting better equipped to manage the decline in condition and subsequent medical emergency.

Following the resident's death, the facility failed to conduct a comprehensive review of the events leading up to and contributing to the death. Rather, the facility conducted a factfinding over the course of six and a half months. Failure to enter the unexpected death into the JPSR system resulted in a missed opportunity to initiate formal engagement with Quality Management staff and the structured patient safety process for reviewing and scoring the event including the consideration of an RCA and peer review. Significant time was spent conducting three separate factfindings with the same staff over an extended period that resulted in the gathering of facts specific to a single day. The failure to conduct quality assurance reviews resulted in the lack of analysis or understanding of system issues reflected in the resident's course of care.

More than seven months after the Chief Nurse created the Corrective Action Plan, several items were still listed as "ongoing" or "pending" action and some action items had no target dates for completion, which reflected an overall lack of urgency and oversight. The OIG determined that due to the multiple patient safety risks identified by facility staff, the corrective actions identified in the plan should have been completed by the time of, or prior to, the OIG's inspection.

Over the course of 10 months, the facility's Quality Management and medical staff leaders considered and reconsidered the need for disclosure. In January 2022, the facility's Chief of Staff recognized that an institutional disclosure was warranted. However, the OIG is concerned that it took 10 months, and repeated reviews, to determine that an institutional disclosure should have been conducted.

Recommendations 1–10

1. The VA Greater Los Angeles Health Care System Director confirms that a process is in place to ensure community living center staff have knowledge of policies pertaining to nursing practice and documentation in the community living center.
2. The VA Greater Los Angeles Health Care System Director ensures all nursing staff assigned to the community living center have received training on the completion and documentation of all required elements for pain assessments.
3. The VA Greater Los Angeles Health Care System Director verifies that community living center nursing staff demonstrate knowledge of the procedure for managing verbal and telephone orders and monitors compliance.
4. The VA Greater Los Angeles Health Care System Director reviews the Greater Los Angeles Healthcare System hand-off communication policy to determine if changes are warranted to address the procedure for managing hand-offs, ensures understanding of policy by staff, and monitors compliance.
5. The VA Greater Los Angeles Health Care System Director verifies that community living center staff are aware of events warranting submission of a Joint Patient Safety Report and how to submit one.
6. The VA Greater Los Angeles Health Care System Director evaluates the circumstances surrounding the death of the resident and determines if peer reviews of relevant clinical staff are warranted.
7. The VA Greater Los Angeles Health Care System Director ensures that community living center managers receive training on the types of reviews, including quality assurance and administrative investigations and when each is appropriate for use, and documents attendance.
8. The VA Greater Los Angeles Health Care System Director ensures that actions identified in the Corrective Action Plan are tracked to completion.
9. The VA Greater Los Angeles Health Care System Director confirms that an institutional disclosure is completed and documented to share that an “opportunity for intervention (transfer to the Emergency Department) existed and was considered but not acted on, prior to the terminal event.”
10. The VA Greater Los Angeles Health Care System Director directs community living center leaders to review policy and admission processes to ensure respiratory therapy equipment needed in the care of a resident is in place at the time of admission.

Appendix A: Detailed Resident Case Summary

The resident who was in their sixties had a history of morbid obesity and hypertension and in 2006 was diagnosed with severe obstructive sleep apnea and severe obesity hypoventilation syndrome. Between 2006 and 2019, the facility issued the resident four different positive airway pressure machines to treat obstructive sleep apnea and obesity hypoventilation syndrome when the resident reported the machines lost or broken. Each time a positive airway pressure machine was issued, the facility respiratory therapist documented educating the resident on proper use.

In 2020, the resident complained that the positive airway pressure machine was not working, and a facility respiratory therapist attempted to resolve the issue by phone rather than in person due to the [COVID-19](#) pandemic. When those efforts were not successful, the resident's primary care provider at the facility encouraged the resident to bring the machine to the sleep clinic. The OIG did not find documentation in the EHR of the resident bringing the machine to the sleep clinic.

In early 2021, during a telephone conversation with the primary care provider, the resident reported an inability to walk due to the resident's leg giving out. The primary care provider noted the resident sounded short of breath and advised the resident to seek urgent or emergent care. That day, the resident was admitted to a non-VA hospital with symptoms of shortness of breath and diagnosed and treated for presumptive congestive heart failure. Later that day, in a second telephone conversation with the primary care provider, the resident requested to be transferred to the facility. The primary care provider alerted the facility transfer coordinator of the request and advised the resident that arranging transfer may take time.

During the resident's stay at the non-VA hospital, a [computed tomography scan](#) (CT scan) of the chest was negative for [pulmonary embolus](#), although the images were limited, and an [echocardiogram](#), whose images were also limited, showed normal [left ventricular function](#). Tests for COVID-19 and [influenza](#) were negative.

The resident was admitted through the facility's Emergency Department two days later and treated for hypoxemic hypercapnic respiratory failure. The resident was a full code; the surrogate decision maker was the resident's spouse. Tests for COVID-19 and influenza were negative. A sleep medicine specialist consultant noted the resident had not been using the positive airway pressure machine because it was broken. The sleep medicine specialist consultant recommended treatment of obstructive sleep apnea, obesity hypoventilation syndrome, and hypoxemic hypercapnic respiratory failure with a positive airway pressure machine setting known as AVAPS around the clock "until acute respiratory failure resolves" and to then transition to only nightly use of AVAPS.

Three days after admission to the facility, CT scans of the chest and abdomen were ordered to evaluate the resident's continued [hypoxia](#) and complaints of abdominal pain. The CT scan of the chest diagnosed a saddle pulmonary embolus with evidence of [right heart strain](#). [Intravenous heparin](#) was initiated, and [interventional radiology](#) was consulted to consider local [thrombolytic](#)

[therapy](#) or thrombectomy. The CT scan of the abdomen showed a right sided kidney stone measuring 1.8 cm in diameter. Urology was consulted to evaluate the kidney stone and assessed that this is “not [a] significantly obstructing stone” and recommended outpatient follow-up.

The next day, the resident underwent successful bilateral pulmonary artery thrombectomy followed by placement of an infusion catheter in the right main pulmonary artery for catheter directed thrombolysis of remaining blood clots. Another test for COVID-19 was negative at that time. An echocardiogram demonstrated resolution of right heart strain. An ultrasound of the lower extremity veins showed deep vein thrombosis in the left leg.

Once the 24-hour infusion of [tissue plasminogen activator](#) was completed, intravenous heparin was discontinued and subcutaneous enoxaparin was initiated. An anticoagulation pharmacist was consulted for appropriate dosing of enoxaparin given the resident’s obesity.

During the resident’s facility inpatient admission, the resident had intermittent shooting pain in the abdomen and leg. The medical team assessed this pain was likely due to the deep vein thrombosis and less likely due to kidney stones and continued with a plan for pain medication as needed.

Eight days after admission, the medical intensive care unit provider assessed that the resident no longer required intensive care unit care since the condition had shown steady improvement. That day, the resident was transferred to the general medicine [telemetry](#) floor where the accepting inpatient attending provider noted that physical therapy and occupational therapy would evaluate the resident to identify the level of care needed upon discharge.

A physical therapist evaluated the resident the following day. The physical therapist assessed that the resident’s functional abilities were limited by muscle weakness and the resident required total assistance with all activities, and recommended physical therapy at a community nursing home or short-stay rehabilitation center at discharge. During the admission, an occupational therapist who evaluated the resident also recommended physical rehabilitation placement.

The resident declined transfer to a non-VA community nursing home. Two days after the physical therapist’s assessment, a CLC consult was entered requesting short-stay skilled rehabilitation and indicated nursing needs of “CPAP/BiPAP.”

A CLC screening assessment note, completed by a CLC nurse and acknowledged by the inpatient attending provider, stated that prior to transfer to the CLC, the resident would need to be off of a telemetry monitor for 24 hours and would need to have adequate pain control on an oral pain regimen. Prior to CLC admission, the CLC team ordered a [bariatric](#) mattress and bed to accommodate the resident. Two days later, the CLC nurse documented that the resident’s pain was well-controlled on oral medication and entered a note accepting the resident for admission to the CLC.

During the resident’s inpatient admission, a sleep medicine consultant had recommended that the resident’s family either bring in the resident’s home AVAPS machine so it could be repaired or

replaced on discharge. A discharge summary signed by the inpatient attending provider on the day of discharge, provided the recommended settings for the AVAPS machine and stated that the resident had a working AVAPS machine at home. EHR documentation did not show that the resident's family brought in the home AVAPS machine for repair prior to discharge, or that the facility provided the resident a new AVAPS machine at the time of the resident's discharge.

Thirteen days after inpatient admission, the resident was discharged from the inpatient ward and admitted to the CLC. A test for COVID-19 was negative on the day of transfer to the CLC and an influenza vaccine was administered. A nursing note at the time of CLC admission indicated the resident was using 3 liters of oxygen by nasal canula and the resident was "bedbound and dependent" on nursing "for all ADLs [activities of daily living] and mobility."

A CLC nurse practitioner entered a note on the day of CLC admission documenting that the reason for the resident's admission to CLC was for rehabilitation with a plan to discharge the resident home after "completion of therapy." The CLC nurse practitioner also documented requesting that staff contact the resident's spouse about the AVAPS "to avoid delay in care" and entered an order to "please make sure the [resident] has [the] AVAP[S] machine from the hospital via sleep medicine or if the [spouse] can bring in [the resident's] home machine." The loaner AVAPS machine used by the resident during the inpatient admission had been returned to the respiratory department when the resident was discharged and transferred to the CLC.

A nurse case manager noted that the resident's spouse was aware of transfer to the CLC, that the resident's spouse did not speak English, and that the spouse preferred that the facility communicate with the family through the resident's granddaughter. The CLC nurse practitioner assessed that the resident had capacity to make personal medical decisions. The resident was a full code.

Two days after admission to the CLC, the CLC nurse practitioner documented the resident's pain and noted that the resident stated the current treatment plan was providing acceptable relief of pain. The note also acknowledged the resident had stabbing right upper quadrant pain and a right kidney stone and documented a plan to continue to monitor these conditions. That day the CLC nurse practitioner ordered a sleep consult stating the resident "will need a new BIPAP/VPAP [*sic*] machine as the one [the resident] brought to the CLC is broken."

The next morning at 7:26 a.m., a CLC registered nurse documented that the resident's respirations were unlabored and the resident did not have chest pain or shortness of breath. The resident had eaten most of breakfast. The resident was administered the oral pain medications oxycodone 5 mg at 6:43 a.m. and 12:56 p.m. and acetaminophen 650 mg at 9:39 a.m., 12:55 p.m., and 5:31 p.m. Capsaicin and lidocaine were also administered topically for pain of the lower extremities.

At 1:28 p.m. the day charge nurse entered a CLC registered nurse note that the resident was using 2 liters of oxygen, did not have shortness of breath, and breathing was not labored.³⁵ The day charge nurse entered a second CLC registered nurse note at 3:45 p.m., signed at 3:49 p.m., documenting that the resident was nauseous and had experienced pain in the right side of the abdomen rated at a level 9 out of 10 since that morning, and that nothing made the pain better. The day charge nurse placed a call to the on-call provider at 3:30 p.m.

The on-call provider documented speaking with the day charge nurse by phone at 3:54 p.m. The on-call provider documented that the day charge nurse reported the resident had experienced right upper quadrant abdominal pain rated 9 out of 10 since that morning, that the resident was nauseous and not eating, and that the resident wanted to go to the Emergency Department. The on-call provider documented a recommendation to send the resident to the Emergency Department, and documented that the day charge nurse stated the recommendation would be passed on to the covering charge nurse who would pass this on to the evening charge nurse because the nurses were changing shifts.

The evening charge nurse documented checking on the resident at 4:10 p.m.; the resident reported pain had improved from 9 out of 10 to 6 out of 10. The evening charge nurse informed the resident that the on-call provider had given an order to send the resident to the Emergency Department for evaluation “if [the resident’s] pain get worst [*sic*].” The evening charge nurse documented that the resident understood and would let the nurse know if pain was not controlled.” The evening charge nurse entered an addendum at 8:11 p.m. that the resident had stated at 4:15 p.m. not wanting to go to the hospital.

The evening charge nurse documented that at 6:48 p.m. a licensed vocational nurse called because the resident was unresponsive. The evening charge nurse “rushed to the room” and noted the resident was cyanotic with heavy breathing. A [nonrebreather mask](#) was placed to deliver oxygen. The evening charge nurse documented that 911 was called at 6:50 p.m.; at that time, a [carotid](#) pulse was present, and an attempt to place an intravenous line was unsuccessful. At 7:03 p.m., EMS personnel arrived and assumed care of the resident.

When EMS arrived, the resident was unconscious and unresponsive. The resident experienced cardiac arrest shortly after EMS arrived. EMS administered cardiopulmonary resuscitation for 24 minutes, but resuscitation efforts were not successful. EMS pronounced the resident’s death at 7:37 p.m. The evening charge nurse documented informing the on-call provider of the resident’s death at 7:50 p.m. The resident’s death certificate listed respiratory arrest as the immediate cause of death.

³⁵ This CLC registered nurse note was signed at 3:53 p.m. The EHR shows the time that a progress note is entered or initiated and the time that the note is signed. Notes may be entered or initiated at one time and signed by the author at a later time. EHR entries are not visible to others until the author signs the note.

The on-call provider documented not having received any communication about the resident between 3:54 p.m. and 7:45 p.m., at which time the on-call provider was informed that the resident had died.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 1, 2022

From: Network Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California.
2. I have reviewed and concur with the findings, recommendations and submitted action plans of the VA Greater Los Angeles Health Care System.
3. If you have any additional questions or need further information, please contact the VISN 22 Quality Management Director.

(Original signed by:)

Michael Fisher
VISN 22 Network Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 1, 2022

From: Director, Greater Los Angeles Healthcare System (691/00)

Subj: Healthcare Inspection—Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. I have reviewed and concur with the OIG's report, Healthcare Inspection-Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care.
2. I would like to thank the Office of Inspector General for their thorough review of this case and recommendations on process improvements. VA Greater Los Angeles Health Care System appreciates the opportunity to partner with the OIG on our high reliability journey. We remain steadfast in our commitment to zero harm.
3. If you have additional questions or need further information, please contact the Chief, Quality Management.

(Original signed by:)

Steven E. Braverman, M.D.
Medical Center Director

Facility Director Response

Recommendation 1

The VA Greater Los Angeles Health Care System Director confirms that a process is in place to ensure community living center staff have knowledge of policies pertaining to nursing practice and documentation in the community living center.

Concur.

Target date for completion: December 30, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director confirms that there is a process in place to ensure Community Living Center (CLC) staff have knowledge of policies pertaining to nursing practice and documentation. The VA GLA Healthcare System Geriatrics and Extended Care (GEC) Chief Nurse ensures the conduct of training sessions for all Registered Nurses (RNs) including documentation requirements for weekly, monthly and focused assessments in change of conditions events; including timely submission of resident safety events and elevating resident care conditions and/or safety concerns to appropriate staff. Formal ongoing training occurred between February and March, 2022. Phase two training of all CLC Licensed Vocational Nurses (LVNs) will incorporate similar training on nursing policies, processes and documentation relative to their scope of practice.

Documentation reflecting a change in condition with associated communication to providers and/or supervisors for intervention will be monitored a minimum of three consecutive months with a 90% or greater compliance sustained. Data will be reported monthly to the Quality Executive Council (QEC).

Recommendation 2

The VA Greater Los Angeles Health Care System Director ensures all nursing staff assigned to the community living center have received training on the completion and documentation of all required elements for pain assessments.

Concur.

Target date for completion: September 30, 2021

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director confirms Nursing Education provided training to all Community Living Center (CLC) licensed staff pertaining to required elements of a comprehensive pain assessment. Between August and September 2021, the VA

GLA Healthcare System Chief Nurse of GEC, in collaboration with subject matter experts, amended the CLC Pain Assessment Note to ensure that all important components of the comprehensive pain assessments were captured for improved documentation in the resident's electronic medical record (EMR).

Repeat training August through October 2021 included the requirement to notify CLC medical providers if the Veteran's acceptable pain goal(s) were not met despite administration of the initial, recommended pain intervention(s) both pharmaceutical and nonpharmaceutical. Sixty-three (63) out of seventy-two (72) licensed staff were able to return demonstration and verbalize understanding in the areas of comprehensive pain assessment for both episodic and weekly pain assessment to include as needed (PRN) effectiveness, as well as ensure reporting of pain greater than the acceptable level to the CLC medical provider.

In addition, CLC leadership added the comprehensive pain assessment and required documentation to reinforcement training at the upcoming 2022 CLC Annual Skills Fair in December 2022. As of October, 2021, 63 out of 72 of West Los Angeles CLC licensed staff completed training with return demonstration.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

The VA Greater Los Angeles Health Care System Director verifies that community living center nursing staff demonstrate knowledge of the procedure for managing verbal and telephone orders and monitors compliance.

Concur.

Target date for completion: April 29, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director confirms that Community Living Center (CLC) nursing staff demonstrate knowledge of the procedure for managing verbal and telephone orders and monitors compliance. The VA GLA Healthcare System Chief Nurse of GEC and nurse educators in the CLC trained GLA CLC RNs in the management and execution of telephone orders in March 2021 and repeated the training between September and October 2021. The training included a) the read back requirement to ensure order accuracy and safe residents care delivery, b) timely (less than 30 minutes for emergent orders, one (1)hour for all others) transcription of the order(s) into the electronic record with inclusion of the provider's co-signature and 3) emphasis on timely execution of the order(s) and notification to the ordering

physician if the order was not carried out in accordance with GLA Policy Read Back Process Utilized for Verbal or Telephone Orders and Critical Test Results # 10B-118-46.

CLC leadership conducted a random chart audit of telephone orders and closely monitored results until 90% or greater compliance was reached for a minimum of three (3) consecutive months. As of December 2021, 97% (28/29) of WLA CLC licensed staff completed training with return demonstration regarding telephone orders. From February 2022 through April 2022, electronic records of CLC residents were audited for telephone order documentation with a 94% cumulative compliance.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 4

The VA Greater Los Angeles Health Care System Director reviews the VA Greater Los Angeles Health Care System hand-off communication policy to determine if changes are warranted to address the procedure for managing hand-offs, ensures understanding of policy by staff, and monitors compliance.

Concur.

Target date for completion: July 30, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director confirms that a review of the hand-off communication policy was conducted to determine if changes were warranted to address the procedure for managing hand-offs, ensuring understanding of policy by staff, and monitoring compliance. Based on the review, changes were required to the hand-off process to improve management of communication. The VA GLA Healthcare System Chief Nurse of GEC and his team trained GLA CLC RNs on the hand-off communication process in accordance with GLA CLC Hand Off Communication and Change of Shift Report Standard Operating Procedures (SOP) #10H3-2021-04, in March 2022. The training included the timeliness of the hand-off reporting at the end of the shift, when Veterans are transferred out of the CLC neighborhoods, or for any outpatient procedure/appointments using the SBAR (Situation, Background, Assessment, Recommendations) format. The CLC also developed an End of Shift Report Tool to ensure consistency in practice and standardize hand-offs throughout the CLC neighborhoods.

In March 2022, 92% (22/24) of GLA CLC licensed staff (RNs) were trained in the hand-off communication process. This process is included as part of the CLC employee competency training during orientation.

To ensure effectiveness of the hand-off training process, the VA GLA Healthcare System Chief Nurse of GEC will ensure that the CLC neighborhood Nurse Managers review all end of shift hand-off communication and monitor monthly compliance until 90% or greater success is reached for a minimum of three (3) consecutive months. Monitoring data will be reported monthly to the Quality Executive Council (QEC). From April 2022 through June 2022, electronic records of CLC residents were audited for documentation of hand-offs with a 100% cumulative compliance.

OIG Comments

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

Recommendation 5

The VA Greater Los Angeles Health Care System Director verifies that community living center staff are aware of events warranting submission of a Joint Patient Safety Report and how to enter one.

Concur.

Target date for completion: March 30, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director confirms that Community Living Center (CLC) staff are aware of events warranting submission of a Joint Patient Safety Report (JPSR) and how to enter a Joint Patient Safety Report. The VA GLA Healthcare System Chief Nurse of GEC has involved the frontline staff during daily CLC neighborhood huddles to promote a focus on a culture of safety and continuous process improvement. The VA GLA Healthcare System Chief Nurse of GEC and the CLC Nurse leadership team provided re-education to the CLC's licensed nurses regarding patient safety events and the timely process for submission of a Joint Patient Safety Report in February and March 2022.

To ensure ongoing compliance, similar training will be provided to all future CLC employees as part of their CLC orientation competencies. This training will also be included at the upcoming CLC Annual Skills Fair in December 2022. As of June 22, 2022, 92% (22/24) of WLA CLC licensed staff have received training pertaining to submission of a Joint Patient Safety Report (JPSR).

OIG Comments

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

Recommendation 6

The VA Greater Los Angeles Health Care System Director evaluates the circumstances surrounding the death of the resident and determines if peer reviews of relevant clinical staff are warranted.

Concur.

Target date for completion: July 30, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director evaluates the circumstances surrounding the death of the resident and determines if peer reviews of relevant clinical staff are warranted. The VA GLA Healthcare System completed the death review of the resident on June 21, 2021. VA GLA Healthcare System has conducted extensive review of the case:

1. Independent comprehensive physician medical review; including coordination of care with the outside hospital prior to admission to VA GLA Healthcare System. This included a review of the inpatient care, CLC care and circumstances surrounding the death. This provider reviewed the pharmacy records, coagulation process and policy, laboratory, radiographic images and all the notes.
2. In December 2021 through March 2022 a high-risk rapid process improvement multidisciplinary work group was initiated by the VA GLA Healthcare System Risk Manager to address respiratory therapy equipment needs for new CLC residents.
3. Several system opportunities were identified: including incongruencies in respiratory therapy inpatient vs outpatient processes; gaps existed in relationship due to case management duties with CPAP versus respiratory therapy; communication and education gaps resource allocation opportunities; need for a policy; and national supply chain issues of CPAP equipment, including national recalls. As a result, several actions were implemented to mitigate the gaps.
4. Action items that were determined from the rapid process improvement work group were as follows: Digital communication tool was created in EMR between respiratory therapy and CLC; created a process map on how to obtain manage high risk resident in the CLC, education was provided on the new process, draft SOP/Guidelines were created, rounding on high risk CLC residents were established along with a potential audiovisual rounding with pulmonary providers; established a admission criteria for CLC regarding high risk pulmonary residents; established high risk monitoring by nursing staff for high risk pulmonary residents.
5. A management review of the nursing care was performed by the GEC service.
6. VA GLA Healthcare System has determined based on the above reviews no further quality peer review is required.

The VA GLA Healthcare System Chief of Quality Management will monitor completion of all VA GLA Healthcare System occurrence screens (109), and if indicated, ensure all VA GLA Healthcare System occurrence screens (109) that meet peer review criteria, receive a peer review. Monitoring will be ongoing until 90% or greater compliance is sustained for a minimum of three consecutive months. Data will be reported monthly to the Quality Executive Council (QEC). From January 2022 through March 2022, 50 death reviews of VA GLA Healthcare System residents/patients were audited with 100% cumulative compliance, and death reviews requiring peer review with 100% cumulative compliance.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 7

The VA Greater Los Angeles Health Care System Director ensures that community living center managers receive training on the types of reviews, including quality assurance and administrative investigations and when each is appropriate for use and documents attendance.

Concur.

Target date for completion: July 30, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director ensures that CLC managers receive training on the types of reviews, including quality assurance and administrative investigations, when each is appropriate for use, and document participant attendance. The VA GLA Healthcare System Risk Manager re-educated the CLC nursing staff managers on types of reviews, including quality assurance and administrative investigations, and events which trigger the appropriate use. WLA CLC nurse managers will receive training by July 15, 2022.

The VA GLA Healthcare System Chief of Quality Management will report training data monthly to the Quality Executive Council (QEC) to achieve 90% or greater compliance.

OIG Comments

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

Recommendation 8

The VA Greater Los Angeles Health Care System Director ensures that actions identified in the Corrective Action Plan are tracked to completion.

Concur.

Target date for completion: September 30, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director ensures that actions identified in the Corrective Action Plan (CAP) are tracked to completion. The VA GLA Healthcare System Chief of Quality Management reports ongoing CAPs at the Quality Executive Council (QEC).

The VA GLA Healthcare System Chief of Quality Management will report the status of the actions identified in the CLC CAP to the QEC until compliance is achieved.

Recommendation 9

The VA Greater Los Angeles Health Care System Director confirms that an institutional disclosure is completed and documented to share that an “opportunity for intervention (transfer to the Emergency Department) existed and was considered but not acted on, prior to the terminal event.”

Concur.

Target date for completion: October 15, 2022

Director Comments

The VA Greater Los Angeles Healthcare System Director ensures the completion and documentation of the institutional disclosure to include “opportunity for intervention (transfer to the Emergency Department) existed and was considered but not acted on, prior to the terminal event.” An institutional disclosure was indicated for the failure to timely document a provider’s order and communicate the order in a hand-off for the transfer of the resident to the Emergency Department. The institutional disclosure was completed and documented in EMR on June 30, 2022. The VA GLA Health Care System Risk Manager will monitor other opportunities for institutional disclosure.

The Chief of Quality Management will report monitoring to the Quality Executive Council (QEC) monthly until compliance is achieved.

Recommendation 10

The VA Greater Los Angeles Health Care System Director directs community living center leaders to review policy and admission processes to ensure respiratory therapy equipment needed in the care of a resident is in place at the time of admission.

Concur.

Target date for completion: September 30, 2022

Director Comments

The VA Greater Los Angeles (GLA) Healthcare System Director directs Community Living Center (CLC) leaders to review policy and admission processes to ensure respiratory therapy equipment needed in the care of a resident is in place at the time of admission. In December 2021 through March 2022 a high-risk rapid process improvement multidisciplinary work group was initiated by the VA GLA Healthcare System Risk Manager to address respiratory therapy equipment needs for new CLC residents.

1. Several system opportunities were identified: including incongruencies in respiratory therapy inpatient vs outpatient processes; gap existed in relationship due to case management duties with CPAP versus respiratory therapy; communication and education gaps resource allocation opportunities; need for a policy; and national supply chain issues of CPAP equipment, including national recalls. As a result, several actions were implemented to mitigate the gaps.
2. Action items that were determined from the rapid process improvement work group were as follows: Digital communication tool was created in EMR between respiratory therapy and CLC; created a process map on how to obtain manage high risk resident in the CLC, education was provided on the new process, draft SOP/Guidelines were created, rounding on high risk CLC residents were established along with a potential audiovisual rounding with pulmonary providers; established a admission criteria for CLC regarding high risk pulmonary residents; established high risk monitoring by nursing staff for high risk pulmonary residents.

The VA GLA Healthcare System Chief of Quality Management will report to Quality Executive Council (QEC) monthly until the SOP is approved and education of the SOP is completed.

Glossary

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

acetaminophen. A medication that is used to treat pain and fever.¹

activities of daily living. Daily personal tasks that are performed to care for one’s self such as bathing, toileting, and eating.²

average volume-assured pressure support. A method “of noninvasive ventilation that provides a targeted tidal volume by automatically adjusting the inspiratory pressure support within a set range.”³

bariatric. Having to do with the treatment of obesity.⁴

capsaicin. A colorless substance found in hot peppers that is used in topical creams for its pain-relieving properties.⁵

cardiopulmonary resuscitation. “An organized sequential response to cardiac arrest including recognition of absent breathing and circulation, basic life support with chest compressions and rescue breathing, advanced cardiac life support with definitive airway and rhythm control using defibrillation and medications, and post-resuscitative care.”⁶

carotid. “Belonging to or situated near a carotid artery.” There are two carotid arteries in the neck that supply blood to the head.⁷

¹ Merriam-Webster.com Dictionary, “acetaminophen,” accessed January 3, 2022, <https://www.merriam-webster.com/dictionary/acetaminophen>.

² The Centers for Medicare and Medicaid Services, “activities of daily living,” accessed January 31, 2022, https://www.cms.gov/research-statistics-data-and-systems/research/mcbs/downloads/2008_appendix_b.pdf.

³ Vishal Saddi et al., “Average volume-assured pressure support vs conventional bilevel pressure support in pediatric nocturnal hypoventilation: a case series.” *Journal of Clinical Sleep Medicine*, vol 17, No. 5 (2021):S925-930.

⁴ Merriam-Webster.com Dictionary, “bariatric,” accessed December 20, 2021, <https://www.merriam-webster.com/dictionary/bariatric>.

⁵ Merriam-Webster.com Dictionary, “capsaicin,” accessed January 3, 2022, <https://www.merriam-webster.com/dictionary/capsaicin>.

⁶ Merck Manual, “Cardiopulmonary Resuscitation (CPR) in Adults,” accessed May 3, 2022, <https://www.merckmanuals.com/en-pr/professional/critical-care-medicine/cardiac-arrest-and-cpr/cardiopulmonary-resuscitation-cpr-in-adults>.

⁷ Merriam-Webster.com Dictionary, “carotid,” accessed January 3, 2022, <https://www.merriam-webster.com/dictionary/carotid>.

catheter directed thrombolysis. A procedure where a catheter is advanced through a blood vessel to the site of a blood clot followed by the slow infusion of a medication through the catheter to dissolve the blood clot.⁸

computed tomography scan. “a cross-sectional, three-dimensional image of an internal body part.”⁹

congestive heart failure. Occurs when the heart muscle does not pump effectively, blood backs up and fluid may build up in the lungs, creating shortness of breath.¹⁰

COVID-19. A virus that causes a severe acute respiratory syndrome called coronavirus disease 2019.¹¹

cyanotic. Bluish or purplish discoloration of the skin and mucous membranes due to low oxygen level in the blood.¹²

deep vein thrombosis. A blood clot in one or more of the deep veins in the body, such as in the legs.”¹³

echocardiogram. A procedure that uses sound waves to produce images of the heart and can be used to diagnose heart disease.¹⁴

enoxaparin. A low molecular weight heparin which is administered by injection and is used to prevent or treat blood clots.¹⁵

⁸ Drew Fleck, et. al., “Catheter-directed thrombolysis of deep vein thrombosis: literature review and practice considerations,” *Cardiovascular Diagnosis and Therapy*, vol. 7, Suppl 3 (2017):S228-S237.

⁹ *Merriam-Webster.com Dictionary*, “CT Scan,” accessed October 4, 2021, <https://www.merriam-webster.com/dictionary/CT%20scan>.

¹⁰ Mayo Clinic, “heart failure,” accessed December 10, 2021, <https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142>.

¹¹ Mayo Clinic, “COVID-19,” accessed December 20, 2021, <https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963>.

¹² *Merriam-Webster.com Dictionary*, “cyanotic,” accessed December 20, 2021, <https://www.merriam-webster.com/dictionary/cyanotic>.

¹³ Mayo Clinic, “deep vein thrombosis,” accessed September 27, 2021, <https://www.mayoclinic.org/diseases-conditions/deep-vein-thrombosis/symptoms-causes/syc-20352557>.

¹⁴ Mayo Clinic, “echocardiogram,” accessed December 20, 2021, <https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856>.

¹⁵ Physician Desk Reference, “enoxaparin,” accessed September 29, 2021, <https://pdr.net/drug-summary/Lovenox-enoxaparin-sodium-521.2354>.

full code. If a patient does not have a do not resuscitate order, the patient is considered a full code, and should be provided with emergency medical interventions such as cardiopulmonary resuscitation in the event of a cardiac arrest.¹⁶

hand-off. Communication when patient care responsibility is transferred from nurse to nurse with the goal of safety and efficiency.¹⁷

heparin. A medication that is administered by injection and is used to prevent or treat blood clots.¹⁸

hypercapnic respiratory failure. A rise in carbon dioxide in the blood resulting from conditions that impair the lungs' ability to exchange gas. Symptoms include shortness of breath and confusion. Treatment requires the use of a ventilator.¹⁹

hypertension. "High blood pressure is a common condition in which the long-term force of the blood against your artery walls is high enough that it may eventually cause health problems, such as heart disease."²⁰

hypoxemic. The condition of having low levels of oxygen in the blood.²¹

hypoxia. "a deficiency of oxygen reaching the tissues of the body."²²

influenza. a viral infection that affects the respiratory system.²³

interventional radiology. A "medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases."²⁴

¹⁶ VHA Handbook 1004.03 (2), *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017, amended May 20, 2021.

¹⁷ Facility Policy 00-10B-118-49, *Hand-Off Communication*, May 2016.

¹⁸ National Cancer Institute, "heparin," accessed October 5, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/heparin>.

¹⁹ Merck Manual, "Ventilatory Failure," accessed May 3, 2022, <https://www.merckmanuals.com/professional/critical-care-medicine/respiratory-failure-and-mechanical-ventilation/ventilatory-failure?query=hypercapnia>.

²⁰ Mayo Clinic, "hypertension," accessed December 20, 2021, <https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410>.

²¹ *Merriam-Webster.com Dictionary*, "hypoxemia," accessed September 27, 2021, <https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930?p=1>.

²² *Merriam-Webster.com Dictionary*, "hypoxia," accessed May 3, 2022, <https://www.merriam-webster.com/dictionary/hypoxia>.

²³ Mayo Clinic, "influenza," accessed December 27, 2021, <https://www.mayoclinic.org/diseases-conditions/flu/symptoms-causes/syc-20351719>.

²⁴ Johns Hopkins, "interventional radiology," accessed on October 6, 2021, https://www.hopkinsmedicine.org/interventional-radiology/what_is_IR.html.

intravenous. “Occurring within or entering by way of a vein.”²⁵

Joint Patient Safety Report. A joint patient safety reporting system utilized by the Department of Defense and VA to report and document patient safety events.²⁶

left ventricular function. An assessment of the ability of the left side of the heart to pump blood to the body, which is often evaluated using an echocardiogram and a measurement of the ejection fraction, or percentage of blood leaving the heart with each heartbeat.²⁷

lidocaine. A drug that is used as a local anesthetic agent and as a treatment for certain cardiac arrhythmias.²⁸

morbid obesity. A serious health condition that results from a body mass index of 40 or greater.²⁹

nonbreather mask. Oxygen mask that delivers a high amount of oxygen.³⁰

obesity hypoventilation syndrome. “A breathing disorder seen in some people who are obese that leads to low oxygen levels and too much carbon dioxide in your blood.”³¹

obstructive sleep apnea. A sleep-related breathing disorder in which the soft tissues of the airway block normal breathing, causing a person to intermittently stop breathing during sleep.³²

²⁵ Merriam-Webster.com Dictionary, “intravenous,” accessed December 27, 2021, <https://www.merriam-webster.com/dictionary/intravenous>.

²⁶ Defense Health Agency, “Joint Patient Safety Reporting,” accessed on January 3, 2022, <https://health.mil/Reference-Center/Fact-Sheets/2021/10/13/JPSR-Fact-Sheet>.

²⁷ Mayo Clinic, “ejection fraction,” accessed January 3, 2022, <https://www.mayoclinic.org/tests-procedures/ekg/expert-answers/ejection-fraction/faq-20058286#:~:text=The%20left%20ventricle%20is%20the%20heart%27s%20main%20pumping,to%2075%25%2C%20according%20to%20the%20American%20Heart%20Association.>

²⁸ Merriam-Webster.com Dictionary, “lidocaine,” accessed January 3, 2022, <https://www.merriam-webster.com/dictionary/lidocaine>.

²⁹ Cleveland Clinic, “morbid obesity,” accessed December 30, 2021, <https://my.clevelandclinic.org/health/treatments/17285-obesity-surgery#:~:text=A%20morbidly%20obese%20person%20has%20a%20BMI%20of,Advertising%20on%20our%20site%20helps%20support%20our%20mission.>

³⁰ Merck Manual, “nonbreather mask,” accessed February 24, 2022, <https://www.merckmanuals.com/professional/critical-care-medicine/approach-to-the-critically-ill-patient/oxygen-desaturation>.

³¹ American Thoracic Society, “obesity hypoventilation syndrome,” accessed October 6, 2021, <https://www.thoracic.org/patients/patient-resources/resources/obesity-hypoventilation-syndrome.pdf>.

³² Mayo Clinic, “obstructive sleep apnea,” accessed September 27, 2021, <https://www.mayoclinic.org/diseases-conditions/obstructive-sleep-apnea/symptoms-causes/syc-20352090>.

oxycodone. A drug that is classified as a narcotic pain reliever.³³

peer review. “a critical review of care performed by a peer.”³⁴

positive airway pressure device. Machines or devices that deliver pressured air through a tight fitting mask to treat conditions such as sleep apnea.³⁵

pulmonary embolus. “Obstruction of a pulmonary artery or one of its branches that is usually produced by a blood clot.”³⁶

quality assurance review. A healthcare review activity that is conducted in an effort to improve the quality of care provided.³⁷

right heart strain. Dysfunction of the right side of the heart, which may be caused by pulmonary embolism. It is also known as right ventricular strain and can be assessed by an echocardiogram or CT scan.³⁸

root cause analysis. “a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls.”³⁹

saddle pulmonary embolus. A type of blood clot located at the bifurcation of the main pulmonary artery which can cause sudden hemodynamic collapse and death.⁴⁰

subcutaneous. “Under the skin.”⁴¹

telemetry. The process of monitoring a patient’s vital signs, such as pulse and respiratory rate, using radio frequency communication.⁴²

³³ Merriam-Webster.com Dictionary, “oxycodone,” accessed January 3, 2022, <https://www.merriam-webster.com/dictionary/oxycodone>.

³⁴ VHA Handbook 1190, *Peer Review for Quality Management*, November 21, 2018.

³⁵ Mayo Clinic, “positive airway pressure devices,” accessed December 20, 2021, <https://www.mayoclinic.org/diseases-conditions/central-sleep-apnea/multimedia/img-20209540>.

³⁶ Merriam-Webster.com Dictionary, “pulmonary embolism,” accessed October 6, 2021, <https://www.merriam-webster.com/medical/pulmonary%20embolism>.

³⁷ VHA Handbook 1190, *Peer Review for Quality Management*, November 21, 2018.

³⁸ David M. Dudzinski, et al., “Assessment of Right Ventricular Strain by Computed Tomography Versus Echocardiography in Acute Pulmonary Embolism,” *Academic Emergency Medicine* 3, (March 2017): 337-343.

³⁹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

⁴⁰ Kevin J. Wong, et al., “Saddle Pulmonary Embolism: Demographics, Clinical Presentation, and Outcomes,” *Critical Care Explorations* 6, (June 2021): 1-7.

⁴¹ Merriam-Webster.com Dictionary, “subcutaneous,” accessed January 3, 2022, <https://www.merriam-webster.com/dictionary/subcutaneous>.

⁴² Food and Drug Administration, “wireless medical telemetry systems,” accessed December 28, 2021, <https://www.fda.gov/medical-devices/wireless-medical-devices/wireless-medical-telemetry-systems>.

thrombectomy. A procedure to remove a blood clot from the inside of an artery or vein.⁴³

thrombolytic therapy. The administration of medications (called thrombolytic medications) that dissolve blood clots.⁴⁴

tissue plasminogen activator. A medication that dissolves blood clots and is administered by injection.⁴⁵

urology. The branch of medicine specializing in the diagnosis and treatment of issues “involving the male and female urinary tract and the male reproductive organs.”⁴⁶

⁴³ Johns Hopkins, “surgical thrombectomy,” accessed December 28, 2021, <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/surgical-thrombectomy>.

⁴⁴ Society for Vascular Surgery, “thrombolytic therapy,” accessed October 7, 2021, <https://vascular.org/patients/vascular-treatments/thrombolytic-therapy>.

⁴⁵ Merriam-Webster.com Dictionary, “tissue plasminogen activator,” accessed February 24, 2022, <https://www.merriam-webster.com/dictionary/tissue%20plasminogen%20activator>.

⁴⁶ Mayo Clinic, “urology,” accessed February 15, 2022, <https://www.mayoclinic.org/departments-centers/urology/sections/tests-procedures/orc-20336022>.

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