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Healthcare Inspection

Community Nursing Home Program Patient Safety Concerns VA Northern California Health Care System Mather, California

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Executive Summary

At the request of Congressman John Garamendi, the VA Office of Inspector General conducted a healthcare inspection to assess the merit of allegations made by a complainant about patient safety concerns in the Community Nursing Home (CNH) Program at the VA Northern California Health Care System (facility), Mather, CA. Specifically, the complainant alleged that:

- One patient was "held against his will" and experienced a delay in receiving hearing aids.
- One patient was given opioids (narcotics) against his wishes and was denied physical therapy.
- Facility CNH Program (program) staff failed to report a concern of financial elder abuse to the California Adult Protective Services.
- Non-VA Care Coordination (NVCC) consults and authorizations and facility consults were delayed.
- Program staff did not comply with Veterans Health Administration requirements for follow-up visits.

We substantiated the allegation that Patient A was admitted to a locked CNH Alzheimer care center and verbalized to the complainant that he was being "held against his will." However, the patient's placement in a locked CNH was appropriate because his facility psychiatrist deemed the patient lacked decision-making capacity regarding his living situation and had demonstrated an inability to safely live independently in the community. We also substantiated a delay in receiving hearing aids with mitigating circumstances.

We did not substantiate the allegations that Patient B was given opioid medications against his wishes and that he was denied physical therapy. However, we identified a delay in obtaining prosthetic care and confusion about the provision of his mental health care. We concluded that communication and collaboration between facility staff needed improvement.

We did not substantiate the allegation that an alleged financial abuse involving Patient C was not reported to Adult Protective Services. The abuse was reported to Adult Protective Services; however, the facility social worker did not report it within 2 days and did not document the report in the patient's electronic health record, as required by facility policy.

We substantiated the allegation of treatment authorization delays for NVCC services. For the NVCC consults that we reviewed, the approval was timely; however, on average, NVCC staff took an additional 24 days before faxing the authorization approval to the CNH primarily due to staffing shortages and the inefficient manual process of transmitting authorizations. We determined that program staff needed to monitor the NVCC process and that NVCC staff needed to timely fax authorizations to the CNH.

We did not substantiate the allegation of delays for facility consult services. Although facility staff did not consistently take action on submitted consults within the required 7-day timeframe, CNH patients generally received the requested services within 30 days.

We substantiated the allegation that program staff did not consistently comply with the requirement that a registered nurse or social worker visit patients in CNH facilities either monthly or quarterly. We determined that regular monthly visits would have provided program staff opportunities to identify and resolve CNH patient-specific issues.

We recommended that the Facility Director ensure:

- Program staff coordinate mental health appointments, including verifying the necessity, between facility providers and assigned CNH physicians prior to scheduling.

- Clinical staff report suspected elder abuse within the required timeframe and document the reporting in the patient's electronic health record.

- Non-VA Care Coordination staff timely deliver authorizations for consulted services to contracted CNH staff and that facility scheduling staff recognize when patients reside in a community nursing home and coordinate appointments with program or contracted community nursing home staff to ensure timely response to consults.

- Program registered nurses and social workers consistently conduct monthly or quarterly follow-up visits and ensure timely resolution of patient care needs identified in these visits.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our findings and recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 15–18 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

At the request of Congressman John Garamendi, the VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations made by a complainant of patient safety concerns in the Community Nursing Home Program at the VA Northern California Health Care System (facility), Mather, CA.

Background

The facility is a 186-bed (66 hospital and 120 community living center) secondary care facility that provides health care services in medicine, surgery, mental health (MH), and extended care. It consists of a medical center in Mather, CA; a rehabilitation and extended care (community living center) facility in Martinez, CA; and outpatient clinics in Chico, Fairfield, Martinez, McClellan, Mare Island, Oakland, Redding, Yreka, and Yuba City, CA. The facility is part of Veterans Integrated Service Network (VISN) 21.

VA provides nursing home care to veterans through three national programs—VA owned and operated community living centers, State Veterans Homes owned and operated by the states, and contracted public or private community nursing homes (CNHs).[1]

VA CNH Program Overview. The purpose of the VA CNH Program is to meet the needs of patients who require nursing home care in their own community close to their families. Patients requiring nursing home care are assessed by a facility physician and, if eligible, are placed in a CNH.[2] Prior to placement, an individualized plan must be developed outlining the follow-up visits needed from facility staff, as well as identifying the patient's unique needs and the services to be provided.

Veterans Health Administration (VHA) policy[3] requires that a CNH Program (program) registered nurse (RN) or social worker (SW) from the contracting VA facility[4] conduct follow-up visits on all patients residing in a CNH at least every 30 days except when specific criteria applies such as patients placed for more than 1 year and in stable condition (long-term placements) or those who are in CNHs that are geographically located more than 50 miles from the facility. For the long-term placed patients and those in distant CNHs, program RNs and SWs are required to arrange monthly reviews of the patients' conditions by telephone, fax, or other forms of communication with CNH staff, patients, and/or patients' families. Program RNs and SWs alternate visits unless otherwise indicated by the patient's visit plan. During the visits, program staff evaluate

[1] http://www.va.gov/GERIATRICS/Guide/LongTermCare/Nursing_Home_and_Residential_Services.asp. Accessed September 30, 2015.
[2] VANCHCS Policy Statement 122-1, *Community Care Programs*, February 7, 2014
[3] VHA Handbook 1143.2, *VHA Community Nursing Home Procedures*, June 4, 2004. This Handbook was scheduled for re-certification on or before the last working day of January 2009 but has not yet been re-certified.
[4] For this report, we use the term program RN, program SW or program staff to designate staff who work for the VA and oversee/monitor the care of eligible veteran patients living in contracted CNHs. We use the term facility staff to designate other VA employees. We use the term CNH staff to designate staff who work for the CNH (not VA) and provide care to the veteran patients in the CNH.

the clinical needs and services provided to the patient, make observations, and gain impressions about the overall quality of care in the CNH. Concerns are to be immediately discussed with appropriate managers and clinicians and reported to the Program Review Team.[5]

Patients residing in a CNH at VA expense receive a full range of care that includes a bed, meals, nursing care, routine CNH medical provider visits, medications, minimal laboratory and radiology services, and other specialty services and supplies normally provided for CNH residents within the per diem (by the day) allowance in the contract. The provision of this comprehensive care is intended to minimize the need for patients to travel to other locations for routine care.[6]

CNH patients may need access to outpatient services, supplies, and equipment when the care is not a duplication of services provided by the CNH. When a CNH patient requires specialty services, program staff assess the patient's unique needs to determine the most suitable location for provision of this care. If the VA facility provides the specialized service, appointments are scheduled with VA physicians "subsequent to coordination with the assigned community physician who is legally responsible for the patient's medical care." Any treatment or medication changes must "…involve close collaboration with an agreement by the community physician."[7] When VA care is impractical, non-VA care can be authorized by the facility.[8]

Adult Protective Services. VHA requires VA facilities to follow relevant state statutes for the identification, evaluation, treatment, referral, and mandated reporting of possible victims of neglect and/or abuse of elders.[9] Facility policy requires health care providers to report any known or suspected elder abuse, including financial, by telephone "immediately or as soon as practicably possible, and by written report" within 2 working days to Adult Protective Services (APS). Following the report, the provider is to document that a report was made in a progress note in the patient's electronic health record (EHR).[10]

Non-VA Care. Formerly known as Fee Basis, non-VA care coordination (NVCC) is medical care provided to eligible patients when VA facilities and services are not reasonably available. The facility may authorize NVCC if the CNH patient meets eligibility requirements. CNH administrators contact program staff and request the specified care. Program staff (typically SWs) place an NVCC consult that is reviewed for appropriateness by a designated clinical leader (usually a facility physician) who approves the consult as warranted. Once approved, NVCC staff confirm

[5] VHA Handbook 1143.2, *VHA Community Nursing Home Procedures*, June 4, 2004.
[6] Ibid.
[7] VANCHCS Policy Statement 122-1, *Community Care Programs,* February 7, 2014.
[8] VHA Handbook 1143.2.
[9] VHA Directive 2012-022, *Reporting Cases of Abuse and Neglect,* September 4, 2012. This Directive expired March 31, 2015, and has not yet been updated.
[10] VANCHCS Policy Statement 122-03, *Mandatory Reporting of Suspected Abuse or Neglect of Elders, Dependent Adults, and Children*, May 20, 2011.

administrative eligibility, generate an "authorization" for NVCC, and fax the authorization to the CNH for completion of the consult and/or evaluation.

Facility CNH Program. From October 1, 2013 through December 31, 2014, the facility reported placing 230 patients in 42 CNHs. Program staffing consisted of 5.8 full-time equivalent (FTE) staff and an intermittent (part-time) RN. The workload was divided among a 1.0 FTE administrative support staff and three patient care teams:

- Sacramento (Team A) – SW (1.0 FTE) and RN (0.4 FTE)
- Chico-Redding (Team B) – SW (1.0 FTE) and RN (0.4 FTE)
- East Bay (Team C) – SW (1.0 FTE) and RN (1.0 FTE)

In January 2015, both the administrative support and the intermittent RN positions were vacant.

Allegations. On October 23, 2014, Congressman John Garamendi requested that we review allegations of patient safety concerns in the facility's CNH Program. The complainant provided us with the names of CNH patients who allegedly experienced patient-specific safety issues, delayed consults, or incomplete follow-up visits. Specifically, the complainant alleged that:

- One patient was "held against his will" and experienced a delay in receiving hearing aids (Patient A).
- One patient was given opioids (narcotics) against his wishes and was denied physical therapy (Patient B).
- Program staff failed to report a concern of financial elder abuse to the California APS (Patient C).
- NVCC consults and authorizations and facility consults were delayed.
- Program staff did not comply with VHA requirements for the frequency of follow-up visits.

Scope and Methodology

We conducted our review from January 2015 through May 2016. We requested and received updated information related to Patient A in November 2016. Prior to our January 27–29, 2015 site visit, we interviewed the complainant and an individual with information relevant to the allegations.

We interviewed facility program managers, SW coordinators, a program RN, quality management staff, the patient advocate, the patient safety manager, and the physician responsible for approving NVCC-related treatment or services. We visited one CNH and interviewed the administrator.

We reviewed VHA and facility policies, program data and meeting minutes, patient advocate reports, and other pertinent documents.

Our review included the patients identified by the complainant. To address timeliness of consults, we reviewed the VA EHRs of randomly selected CNH patients. We identified 200 clinical consults that were requested for 104 CNH unique patients during the period October 1, 2013–December 31, 2014. Of the 200 clinical consults, we randomly selected and reviewed 69 (26 NVCC and 43 facility) clinical consults of 21 CNH patients.

To determine if program staff (RN and SW) provided required oversight, we reviewed the VA EHRs of 167 patients who stayed for more than 30 days in CNHs from October 1, 2013, through December 31, 2014, to assess whether required monthly or quarterly visits had been completed.

Two policies cited in this report were expired or beyond the recertification date:

1. VHA Handbook 1143.2, *VHA Community Nursing Home Procedures*, June 4, 2004 (recertification due day January 31, 2009).

2. VHA Directive 2012-022, *Reporting Cases of Abuse and Neglect*, September 4, 2012 (expired March 31, 2015).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[11] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[12] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[13]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

[11] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[12] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[13] Ibid.

Inspection Results

Issue 1: Patient-Specific Concerns

Patient A

In 2015 Patient A was in his late 70s with a history of hearing loss, dementia, and chronic neurological and mental health disorders. Following his involvement in a motor vehicle accident in 2013, he was hospitalized at a non-VA hospital. The patient was discharged from the hospital and voluntarily admitted to a locked CNH Alzheimer care center a few weeks after the motor vehicle accident for rehabilitative therapies and long term care.

Placement and Conservatorship

We substantiated that Patient A was admitted to a locked CNH Alzheimer care center and the patient told the complainant that he was being held against his will. However, the patient's facility psychiatrist had deemed the patient lacked decision-making capacity regarding his living situation and was unable to live independently as evidenced by his "poor and dangerous decision-making ability." We did not identify information in the EHR that would lead us to disagree with the determination by the facility psychiatrist.

After the 2013 accident, a non-VA community hospital staff member contacted program SW staff regarding the patient's hospitalization and upcoming discharge needs to include physical, occupational, and recreational therapy, as well as long term placement. The program SW verified the patient's eligibility, obtained VA authorization for placement, and notified the hospital staff that the patient was approved for CNH placement. The non-VA hospital facilitated the transfer to the CNH Alzheimer care center.

A few weeks after admission to the care center, CNH staff[14] notified the program SW that the patient had attempted to elope by climbing a 10-foot fence. The CNH staff requested authorization for a 1:1 sitter (a dedicated staff assigned to constantly observe the patient). The program SW noted that the patient was unable to make his own decisions. Since the patient's family members declined to be his surrogate decision-makers, the program SW scheduled a facility MH appointment to evaluate his decision-making capacity. The patient was seen by a facility psychiatrist who noted that the patient was focused on going home but that the patient was unable to live independently in the community as evidenced by his poor decision-making. The psychiatrist determined that the patient lacked the capacity to make decisions about his placement options and recommended that a surrogate decision-maker or conservator

[14]For this report, we use the term CNH staff to designate staff who worked for the CNH (not VA) and provided care to the veteran patients in the CNH.

be found (in California, conservatorship is recommended when an adult cannot care for himself or manage his finances). [15]

Approximately one month later, a CNH Interdisciplinary Team (IDT) was formed to be the temporary decision-maker for the patient, with the patient's involvement to the extent possible. The team became the responsible party until a conservator could be appointed.

About the same time that the IDT was appointed the patient's decision-maker, the program RN noted that the patient was becoming adjusted to living at the CNH but that he expressed concerns about being held against his will every day. For the next 4-6 weeks, program SW and RN notes documented phone calls with CNH staff regarding the patient's refusal of medications leading to a seizure, incidents of verbal and physical aggression, and efforts made to obtain a conservator.

Throughout 2014 and 2015, documentation from the facility psychiatrist, program RN, and program SW noted the patient's persistent requests to go home, increasing frustration, attempts to elope, verbal and physical aggression, and refusal to take medications, resulting in the continued need for a 1:1 sitter. In 2015, the program SW noted that the patient had begun to write letters to individuals, whom he perceived to be in positions of power, to inform them that he was being held against his will. The program SW consulted with VA General Counsel who recommended that the patient be re-evaluated for decision-making capacity.

A few months later, a facility psychiatrist completed an updated evaluation of the patient's capacity to make decisions. The evaluation concluded that while the patient did not have the capacity to make decisions, he would benefit from a less restrictive setting to improve his quality of life. The psychiatrist recommended program staff and CNH providers meet to discuss whether a conservator could be appointed and a less restrictive environment identified. A program SW documented that the lack of an identified responsible party, such as a conservator, limited the patient's placement options. Therefore, the patient could not be transferred to a less restrictive environment.

The program staff and CNH staff made multiple attempts to obtain conservatorship[16] after the patient's admission in 2013. This included seeking conservatorship in two different counties. The patient lived in a county (county 1) CNH. Application for conservatorship from county 1 was submitted but declined because the patient owned property in a second county (county 2). Application for conservatorship from county 2 was submitted and declined because he was residing in a CNH in county 1.

[15] According to California Courts, conservatorship is defined as a court case where a judge appoints a responsible person or organization (called the "conservator") to care for another adult (called the "conservatee") who cannot care for himself or herself or manage his or her own finances. http://www.courts.ca.gov/selfhelp-conservatorship.htm. Accessed 4/28/2016.
[16] Ibid.

The program SW reapplied for conservatorship from county 2 in late 2015. The facility SW noted that county 2 denied the second conservatorship application and that an application was re-submitted to county 1 (where the CNH was located) on the same day. Approximately 5 months later, facility staff notified the OIG review team that a public guardian's office representative from county 1 had met with the patient and was processing a petition for conservatorship. A court date to appoint a conservator was set. The program RN follow-up visit note stated the patient was appointed a conservator.

We determined that facility staff did not aggressively pursue conservatorship for this patient; however, as of mid-late 2016, the issue of conservatorship was resolved. Therefore, we did not make a recommendation.

Medical Decision-Making

In the absence of family (or responsible party), the CNH IDT became the responsible party to determine how to best care for the patient. The IDT involved the patient to the extent that he was able to participate, such as to discuss the importance of taking his medication; however, the patient would at times refuse to take his medications.

Hearing Aids

We substantiated a delay in receiving hearing aids with mitigating circumstances.

The facility audiologist evaluated the patient for hearing difficulties in 2014 and recommended a cochlear implant due to his severe hearing impairment, but the patient preferred to try hearing aids instead of undergoing surgery. The audiologist noted that it was uncertain if the hearing aids would help because the patient needed a cochlear implant. Program and facility staff made several attempts to evaluate the patient, including hearing aid fittings.

Multiple appointments to evaluate the patient were made but were canceled either by the clinic or the patient because of transportation and/or behavioral issues. As of early 2015, neither the program nor the CNH staff had developed an alternate plan of care for his hearing aids. On a follow-up inquiry by OIG later in 2015, the CNH physician stated that the patient did not need hearing aids because CNH staff have been using a written communication board to communicate his needs. Per our review of the patient's record in 2016, effective and ongoing communication was occurring between patient and staff through the use of a white board. Because the facility, in collaboration with the CNH, had initiated and implemented an action plan, we made no recommendations.

Patient B

In 2015, Patient B was in his mid-60s with a history of multiple medical and mental health conditions, including stroke, chronic kidney disease, stroke-related hand contractures, and bilateral below-knee amputations. He was admitted to a CNH in 2005.

Opioid Medication

We did not substantiate that Patient B was given opioid medications against his wishes.

In 2012, a program RN note documented that the patient had been complaining of right hand and shoulder pain. The following RN visit, the program RN note stated that providers at the CNH had prescribed an opioid medication at a specific dose and time interval as needed for chronic pain. We did not find orders in the patient's EHR for opioids other than one that was ordered "as needed". During 2 subsequent visits in 2012, the program RN requested the CNH provider evaluate the patient for a non-opioid topical pain medication. The CNH provider ordered the topical pain medication. Given the patient's poor kidney function, this pain medication regimen, rather than non-steroidal anti-inflammatory medications, was appropriate for the clinical situation. The patient did not complain to the program RN that opioid medications were being administered against his wishes but, rather, that his pain regimen was not working. During a program RN visit, the patient willingly accepted an opioid medication for shoulder pain. In early 2016, the patient was taking non-opioid pain medications for occasional pain with good results.

Physical Therapy

We did not substantiate that Patient B was denied physical therapy.

We did not find documented evidence that either the patient or his providers requested physical therapy at the facility. In 2014, the program RN requested CNH staff obtain an NVCC shoulder x-ray for the patient and told the patient that if a problem was identified, he/she would ask his facility provider to refer him to a facility specialist. The results of an NVCC shoulder x-ray were not documented in the patient's EHR. In early 2015, the patient saw his facility primary care provider, who ordered a shoulder x-ray[17] and a transcutaneous electrical nerve stimulator unit.[18] The provider thought the patient was a poor rehabilitation candidate since his pain was caused by hand contractures, a chronic sequela of his stroke. According to the patient's facility provider, physical therapy would probably not be beneficial for long-standing nerve problems. At a subsequent 2015 visit, a program RN documented that the transcutaneous electrical nerve stimulator unit greatly reduced the patient's shoulder pain.

We determined that program staff did not ensure timely evaluation and treatment of the patient's shoulder pain.

Other Patient B Concerns

Delay in Prosthetic Adjustments. We found a 12-month delay (from initial documentation of the need) in obtaining necessary adjustments to the patient's

[17] The right shoulder x-ray showed no acute fractures or dislocation.
[18] A transcutaneous electrical nerve stimulator unit sends pulses across the skin surface and nerve endings to help with nerve related pains.

prostheses. The patient had bilateral below-knee amputations and required prostheses (artificial legs*).* In 2014, a facility provider evaluated the patient for prosthetic adjustments and instructed the patient to return as needed. Over the next 4 months, three program RN notes mentioned the patient had lost weight, and the prostheses no longer fit. The program RN asked if the contract prosthetist could go to the CNH to make adjustments. We did not find evidence in the EHR that program staff pursued timely resolution of the prosthetic adjustments. In early 2015, the program RN noted the patient's prostheses were still loose.

In a follow-up inquiry in 2015, we found the patient was fitted with new prostheses. A facility staff member stated a prosthetics request had been faxed to the contract provider in 2014 but was not completed. The facility staff did not know that the contractor had not fulfilled the requested evaluation until the program RN placed a new consult in 2015. Facility staff acknowledged a delay occurred, that a prosthetic consult was not resubmitted once the contract prosthetist failed to fulfill the initial August request. Approximately 4 months after the program RN submitted the new consult, the patient received new prostheses for both legs. A week later, the facility physical medicine and rehabilitation physician evaluated the patient and determined that they were fitting well. During a subsequent visit, the patient told the program RN that the new prostheses fit well and were comfortable.

We determined that program staff did not ensure timely evaluation and treatment of the patient's prosthetic needs because of inadequate consult management follow-up during monthly visits.

MH Care. We found a lack of communication and collaboration by the program staff (SW and RN) with the facility psychiatrist and the CNH providers concerning the provision of MH care. Program staff scheduled multiple appointments without communicating the necessity for the visits.

Facility policy requires VA physicians to see patients by scheduled appointment "subsequent to coordination with the assigned community (CNH) physician who is legally responsible for the patient's medical care." Treatment and medication changes must involve close collaboration with an agreement by the CNH physician.[19]

The program SW and RN staff scheduled multiple facility MH appointments from 2010 through 2015 without documenting a discussion of the appropriateness or purpose of these appointments with the facility psychiatrist or CNH physician. The program SW and RN continued to schedule MH appointments despite the facility psychiatrist's documentation at each visit that the patient was under the care of the CNH physician who was managing his medications, that neither he nor the patient knew why the appointments were scheduled, and that the patient should not return unless discharged from the CNH. This lack of communication and collaboration continued over the course of 6 years resulting in confusion and an ineffective use of resources.

[19] VANCHCS Policy Statement 122-1, *Community Care Programs,* February 7, 2014.

Since our inquiry, facility staff reported implementing a process to alert the psychiatrist of the patient's impending visits and requested the CNH to send a note with the patient stating the reason for the MH visits to improve communication. Although the facility implemented a process to improve communication with the facility psychiatrist and the CNH facility, we determined that the problems occurred because the SW and RN program staff independently scheduled VA appointments without documented evidence of agreement with the assigned community physician as required by facility policy. Furthermore, SW and RN program staff did not communicate and coordinate scheduled appointments with facility or CNH staff.

We determined that program staff did not consistently coordinate or verify the necessity of MH appointments with facility providers and assigned CNH physicians prior to scheduling the appointments.

Issue 2: Reporting to Adult Protective Services

Patient C

We did not substantiate that a Patient Aligned Care Team (PACT) SW failed to report the alleged financial abuse of Patient C to APS. We found that the PACT SW reported the potential abuse; however, the reporting was not timely.

Patient C was in his early 80s with a history of dementia and multiple medical conditions. He had used the VA for social work services only. In 2014, a PACT SW met with the patient's wife, who also had a hearing impairment and a mild cognitive disorder. A friend accompanied the wife. They complained that the patient's son and his spouse had been cashing the patient's checks. The PACT SW informed the patient's wife and her friend that they should file a report with APS. The PACT SW did not document that a report was made to APS.

Facility policy[20] requires written reports be sent to APS within 2 working days and that staff document the reporting in the patient's EHR. A program manager told us that the PACT SW contacted APS, but did not know when the contact was made as the PACT SW had not documented contacting APS in the EHR. We confirmed that the PACT SW faxed a report to APS 10 days after the meeting with the patient's wife. In a follow-up inquiry by OIG, the PACT SW confirmed that a contact was made but did not clarify why it took 10 days to report the alleged financial abuse.

[20] VA Northern California Health Care System Policy Statement 122-03, *Mandatory Reporting of Suspected Abuse or Neglect of Elders, Dependent Adults, and Children*, May 20, 2011.

Issue 3: Timeliness of NVCC Treatment Authorizations and Facility Consults

NVCC Authorizations/Consults

We substantiated the allegation of treatment authorization delays for NVCC services. However, consults were generally completed within 30 days.

Of the 66 NVCC consults requested for patients placed in CNHs from October 1, 2013 through December 31, 2014, we reviewed 39 percent (26/66). The facility physician reviewer approved requested consults within 7 days on average. However, it took an additional 24 days on average before NVCC staff faxed the authorization to the CNH. This authorization ensures payment and allows CNH staff to schedule or render required service. Table 1 describes the average wait time for approval and authorization of NVCC consults. We noted that for 13 consults, program staff had to remind NVCC personnel to fax the authorization to the CNH.

Table 1: Reviewed NVCC Consults (October 1, 2013 through December 31, 2014)

Timeliness	Average Days	Range in Days
Time from consult request to approval	7	0–44
Time from consult approval to faxing authorizations to CNH	24	0–166

Source: OIG analysis of facility CNH patient data October 2013 through December 2014.

During interviews, program staff acknowledged that the manual process of faxing NVCC authorizations to the CNH had been inefficient. The facility administrative staff member responsible for coordinating NVCC requests left the facility in September 2014, and the position remained vacant at the time of our site visit. Although program SW coordinators generally followed up on pending requests from CNH administrators regarding the status of the authorization, a CNH administrator told us that it usually took several inquiries before receiving an authorization. Program staff told the review team that the loss of the administrative staff resulted in untimely review of consults.

Facility Consults

We did not substantiate the allegation of delays for facility consult services for CNH patients. Patients were generally seen within 30 days. However, we identified that facility staff did not timely respond to consultation requests. Facility staff took an average of 11 days to respond, schedule the appointment, or change the consult status. VHA requires facilities to establish procedures to track and process clinical consultation requests that are without action within 7 days of the request.[21] Of the 134 facility consults requested for veteran patients living in CNHs from October 1, 2013 through

[21] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive was in effect during the time period discussed in this report but has been rescinded and replaced with VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016, amended September 2016. The 2016 Directive has the same or similar language regarding consults that are without action within 7 days of the request.

December 31, 2014, we reviewed 32 percent (43/134). Table 2 below describes the average wait time for facility consults.

Table 2: Reviewed Facility Consults October 1, 2013, through December 31, 2014

Timeliness	Average Days	Range in Days
Time from consult request to action taken or scheduling (43 consults)	11	0–67
Time from scheduling to completion (37 consults)[22]	20	0–126
Time from consult request to consult completion (37 consults)	29	0–127

Source: OIG analysis of facility CNH patient data October 2013 through December 2014.

We observed that a contributing factor to the delay in responding to facility consults was that facility scheduling staff attempted to contact the patient by mail or phone before making the appointment without recognizing the patient was in a CNH. Program RN or SW staff occasionally had to intervene and clarify with the scheduling staff that the patient was in a CNH and to coordinate the scheduling of the appointment with the CNH staff. We determined that the facility needs to develop a mechanism for facility scheduling staff to recognize when patients reside in a CNH and to coordinate appointments with program or CNH staff to ensure timely response to consults.

Issue 4: Follow-Up Visits by Program RNs and SWs

We substantiated the allegation that the program RNs and SWs did not consistently conduct monthly or quarterly visits as required.

VHA policy[23] requires program RNs or SWs to conduct follow-up visits at least every 30 days except when specific criteria apply, such as patients placed in CNHs for more than 1 year and in stable condition (long-term placements) or those that are in CNHs which are geographically located more than 50 miles from the facility. For the long-term placed patients and those in distant CNHs, program RNs and SWs are required to arrange for monthly review of the patient's condition by telephone, fax, or other forms of communication with CNH staff, the patient, and/or the patient's family. Program RNs and SWs are to alternate quarterly visits unless otherwise indicated by the patient's visit plan.

We reviewed the EHRs of 167 patients placed in CNHs for more than 30 days who required follow-up visits, during October 1, 2013 through December 31, 2014, including the patients identified in the complainant's letter. We found that program RN visits were generally more consistent throughout all three teams (Chico-Redding, East Bay, and Sacramento), and that the East Bay Team C (RN and SW) had better compliance with

[22] Of the 43 reviewed consults, 6 consults were discontinued or canceled by staff for 3 reasons: patient did not respond to the scheduling letter, patient did not show for the scheduled appointment, or the consult was no longer needed.
[23] VHA Handbook 1143.2, *VHA Community Nursing Home Procedures*, June 4, 2004.

the follow-up visits. Of these, 146 patients required follow-up visits at least every 30 days (monthly), and 21 required quarterly visits. Program RNs/SWs completed 82 percent (1034/1254) of the monthly visits and 76 percent (79/104) of the quarterly follow-up visits. Table 3 below describes follow-up visits from October 1, 2013, through December 31, 2014.

Table 3: Program RN and SW CNH Visits October 1, 2013 Through December 31, 2014

Follow-up	Monthly (146 Patients)	Quarterly (21 Patients)
Required visits	1,254	104
Completed visits	1,034 (82 percent)	79 (76 percent)

Source: OIG analysis of facility CNH patient data October 2013 through December 2014.

We determined that program RNs and SWs did not consistently conduct monthly or quarterly visits as required and that regular visits would have provided staff opportunities to identify and resolve CNH patient-specific issues such as the delay in the shoulder x-ray and prosthetics adjustments for patient B. We did not identify any patient from our review that had an extensive time period (6 months or longer) without follow-up visits from program RNs or SWs.

Conclusions

We substantiated that Patient A was admitted to a locked CNH Alzheimer Care Center and the patient told the complainant that he was being held against his will. However, the patient's initial placement in a locked facility was appropriate as a facility psychiatrist indicated the patient was unable to live independently and determined the patient lacked the capacity to make decisions about his placement. Because family members declined responsibility for this patient, the CNH Interdisciplinary Team served as the temporary surrogate decision-maker. Efforts by program and CNH staff to obtain a conservator were hindered by the patient living and owning a home in different counties. County 1 did not approve the conservatorship application, schedule a court hearing, and appoint a conservator until 2016, over 3 years from the start of the application process. We also substantiated a delay in receiving hearing aids for this patient with mitigating circumstances. A review of the patient's record in 2016 indicated effective and ongoing communication between patient and staff through the use of a white board.

We did not substantiate that Patient B was given opioid medications against his desires or that he was denied physical therapy. However, we identified a delay in obtaining an evaluation and treatment for shoulder pain and prosthesis care. We also identified a lack of coordination and communication concerning the provision of his MH care.

We did not substantiate that an alleged financial abuse involving Patient C was not reported to APS. However, we found that the PACT SW failed to report suspected financial abuse to APS within the timeframe required by facility policy, and did not document the reporting in the patient's EHR.

We substantiated the allegation of treatment authorization delays for NVCC services. The approval of NVCC services was timely; however, on average, for the NVCC consults that we reviewed, NVCC staff took an additional 24 days before faxing the authorization approval to the CNH. We determined that program staff needed to monitor the NVCC process and that NVCC staff needed to timely fax authorizations to the CNH once the request has been approved.

We did not substantiate the allegation of delays for facility consult services. Patients generally received a requested service within 30 days. However, we found that facility staff did not respond to consultation requests within 7 days as required by VHA.

We substantiated that program RNs and SWs did not consistently conduct monthly or quarterly visits as required. We determined that regular visits would have provided staff opportunities to identify and resolve CNH patient-specific issues.

Recommendations

1. We recommended that the Facility Director ensure that program staff coordinate mental health appointments, including verifying the necessity, between facility providers and assigned community nursing home physicians prior to scheduling.

2. We recommended that the Facility Director ensure clinical staff report suspected elder abuse within the required timeframe and document the reporting in the patient's electronic health record.

3. We recommended that the Facility Director ensure Non-VA Care Coordination staff timely deliver authorizations for consulted services to contracted community nursing home staff and that facility scheduling staff recognize when patients reside in a community nursing home and coordinate appointments with program or contracted community nursing home staff to ensure timely response to consults.

4. We recommended that the Facility Director require program registered nurses and social workers consistently conduct monthly or quarterly follow-up visits and ensure timely resolution of patient care needs identified in these visits.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 3, 2017

From: Director, Sierra Nevada Network (10N21)

Subj: Healthcare Inspection—Community Nursing Home Program Patient Safety Concerns, VA Northern California Health Care System, Mather, California

To: Director, Los Angeles Office of Healthcare Inspections (54LA)
Director, Management Review Service (VHA10E1D MRS OIG Hotlines)
Tonia Bock (Tonia.Bock@va.gov); Brandon Fureigh (Brandon.Fureigh@va.gov)

1. VA Northern California HCS has completed their review of your draft report and has developed their action plan to address the findings, which is attached.

Sheila M. Cullen
Attached

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 24, 2017

From: Director, VA Northern California Health Care System (612/00)

Subj: Healthcare Inspection—Community Nursing Home Program Patient Safety Concerns, VA Northern California Health Care System, Mather, California

To: Director, Sierra Nevada Network (10N21)

1. I wish to extend my thanks to the Office of Inspector General (OIG) for conducting a professional review of the organization. The Recommendations contained in the Community Nursing Home Program Patient Safety Concerns report have been reviewed. Attached are the facility responses addressing each Recommendation.

(original signed by:)

Kathryn Bucher, DNP, RN for

David Stockwell, MHA
Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that the program staff coordinates mental health appointments, including verifying the necessity, between facility providers and assigned community nursing home physicians prior to scheduling.

Concur
Target date for completion: June 2017

Facility response: The increase of Community Nursing Home (CNH) Program staffing since 2015 has improved the coordination of mental health appointments between the facility providers and CNH physicians prior to scheduling.

The Table below shows the increase in Registered Nurse (RN) and Nurse Practitioner (NP) staffing since 2015.

Team	2015 Nurse Staffing	2017 Nurse Staffing
Sacramento	RN (0.4 FTE)	RN (1.5 FTE) & NP (0.3 FTE)
North State (Chico/Redding)	RN (0.4 FTE)	RN (0.5 FTE) & NP (0.3)

The Chief, Social Work & Chaplain Service will monitor CNH mental health appointments to ensure that patient-specific concerns related to mental health appointments are addressed in a timely manner and appointments occur as needed. Results will be reported quarterly to the Community Nursing Home (CNH) Oversight Committee. Target 90%.

Recommendation 2. We recommended that the Facility Director ensure clinical staff report suspected elder abuse within the required timeframe and document the reporting in the patient's electronic health record.

Concur
Target date for completion: March 2017

Facility response: The Chief, Social Work & Chaplain Service confirmed that 100% of staff has received training on Elder Abuse according to PS122-3, Mandatory Reporting of Suspected Abuse or Neglect of Elders, Dependent Adults and Children. Chief, Social Work & Chaplain Service monitored the compliance of the timely reporting of Elder Abuse within two (2) working days and the compliance with ensuring documentation in the Computerized Patient Record System (CPRS). To date, VANCHCS has achieved 100% compliance. Target 90%.

Elder Abuse Audits	October 2016	November 2016	December 2016
Elder Abuse Reported within two (2) working days	No applicable patients	No applicable patients	2/2=100%
Elder Abuse Documented in CPRS	No applicable patients	No applicable patients	2/2=100%

Recommendation 3. We recommended that the Facility Director ensure Non-VA Care Coordination staff timely deliver authorizations for consulted services to contracted community nursing home staff and that facility scheduling staff recognize when patients reside in a community nursing home and coordinate appointments with program or contracted community nursing home staff to ensure timely response to consults.

Concur
Target date for completion: June 2017

Facility response: The facility has substantially increased the staffing in the Non-VA Care Coordination (NVCC) program to improve the timely delivery of authorizations for consulted services to contract CNH staff.

Chief, Social Work & Chaplain Service will ensure that timeliness of consults will be monitored for action within seven (7) days and the provision of the contracted service within thirty (30) days. This monitor will be reported quarterly to the CNH Oversight Committee. Target 90%.

Recommendation 4. We recommended that the Facility Director require facility program registered nurses and social workers consistently conduct monthly or quarterly follow-up visits and ensure timely resolution of patient care needs identified in these visits.

Concur
Target date for completion: June 2017

Facility response: Chief, Social Work & Chaplain Service will monitor to ensure that monthly or quarterly follow-up CNH visits are conducted in a timely manner to resolve patient care needs that were identified during the visits. This monitor will be reported quarterly to the CNH Oversight Committee. Target 90%.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix D

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