DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California

HEALTHCARE INSPECTION | REPORT #20-00005-271 | SEPTEMBER 29, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection at the Community Living Center (CLC) within the San Francisco VA Health Care System (facility) in California in response to allegations regarding facility leaders' failure to adequately address known nurse staffing shortages that may have led to adverse events, environment of care concerns, and infection control related issues.[1] Specifically, it was alleged that (1) facility leaders failed to adequately address known CLC nurse staffing shortages, yet continued to accept resident admissions; (2) insufficient nurse staffing at the CLC led to adverse events, including wandering and missing residents, and inability to manage residents admitted with disruptive behaviors; (3) the CLC did not have 24-hour housekeeping aides available; (4) the CLC was dirty and infested with fruit flies (flying insects); (5) CLC staff did not wash their hands; and (6) the CLC was quarantined more than two times during the 12-month period of October 1, 2018, through September 30, 2019.

During the inspection, the OIG received and reviewed additional allegations that inadequate staffing led to resident falls, and the sole contracted staffing company (registry agency) used to provide temporary nursing assistants (registry staff) was not able to meet the requested number of staff, per the terms of the contract. Facility staff reported that registry staff did not have VA-issued personal identity verification (PIV) cards and were unable to access the electronic health records (EHRs) of CLC residents at the facility.

The OIG substantiated that facility leaders failed to adequately address known CLC nurse staffing shortages yet continued to accept resident admissions.

The Veterans Health Administration (VHA) requires use of a standardized staffing methodology to determine inpatient nursing personnel requirements to support safe and effective patient care based on a calculation of the number of nursing hours per patient day needed to provide safe care. A dedicated staffing methodology coordinator must be appointed and remain current with nurse staffing methodology processes, tools, and resources, and train facility stakeholders.

The facility's Staffing Methodology Coordinator (Coordinator) had insufficient knowledge of VHA nurse staffing methodology. The Coordinator used unapproved nursing hours per patient day targets that were lower than the targets supported by the approved staffing methodology.

[1] VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017. Nurse staffing refers to registered nurse, licensed practical nurse, and nursing assistants on a unit. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Adverse events are "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers,* August 13, 2008. For this report, the term resident refers to a veteran living in the CLC.

This resulted in an underestimation of the severity of the staffing deficit. The OIG determined that the Coordinator needed additional training.

Due to significant nursing assistant vacancies, CLC managers were unable to meet the nursing hours per patient day target, a calculation used to determine staffing levels, and increasingly relied on registry staff to supplement nursing assistants. Multiple factors contributed to high vacancy rates and difficulty hiring nursing assistants including a high cost of living, low pay, and administrative process barriers.

The CLC contracted with a registry agency to hire registry nursing assistants to meet staffing targets. The registry agency did not consistently supply the requested number of nursing assistants, per the registry contract.[2] The Coordinator notified the registry agency and facility contract staff of the staffing deficiencies beginning in January 2019, but did not track the number of requested and supplied registry staff until June 2019, and the tracking was inconsistent. The Veterans Integrated Service Network received notice of the deficiencies in staffing supplied by the registry agency in July 2019.

The lack of adequate and consistent staffing for the VA position that would have monitored the implementation of the contract hindered communication regarding adequate staffing by the registry agency. The registry agency did not meet facility staffing requests per the contract, and a comprehensive review of the registry agency contract is warranted to determine whether the agreement is sufficient to meet the staffing needs of the CLC.

The CLC maintained a high resident census while CLC leaders struggled to meet the staffing targets. More than 10 years ago, facility leaders internally and without VHA authorization reduced the number of operating beds from 120 to 104 due to insufficient nurse staffing. Based on 104 operating beds, the CLC occupancy rate was generally above 90 percent.[3] With insufficient staffing, a reduction in the number of operating beds may be a short-term solution while leaders address the nurse staffing challenges.

The CLC had experienced high turnover or vacancy in CLC Chief and CLC nurse manager positions since October 1, 2017. The CLC Chief position has turned over at least five times since October 2017. The Associate Chief of Staff for Geriatrics, Palliative and Extended Care opined that the enormous responsibilities required for the CLC Chief position was the reason for the turnover.[4]

The Nurse Executive provided inadequate oversight and intervention while the CLC struggled with inconsistent leadership and endured progressive staffing challenges. The Nurse Executive

[2] On May 21, 2018, VHA awarded the registry agency a contract to provide nursing staff "as needed 24 hours a day, 7 days per week, 365 days per year."

[3] Occupancy rate is the percentage of beds occupied by residents.

[4] In February 2020, to relieve the CLC Chief of some of the responsibilities, facility executive leadership approved two new CLC leadership positions.

told the OIG about being aware of these challenges but attributed the lack of oversight to CLC management turnover and competing priorities related to facility staffing and issues external to the CLC.

The OIG was unable to determine if insufficient staffing levels at the CLC led to adverse events or the inability to manage residents with disruptive behaviors due to a variety of contributory factors that can affect resident outcomes and quality of care.[5] Staff responded appropriately and documented required assessments and mitigating measures. Quality management processes were in place to track and analyze events.

The OIG identified one wandering and missing resident event that had a higher potential for an adverse clinical outcome.[6] A Patient Safety Manager reportedly would have evaluated the event as a higher risk "due to [the resident's] inability to judge risk or make appropriate decisions due to cognitive impairment." The facility may have missed an opportunity to initiate a root cause analysis to further understand all potential elements contributing to the wandering and missing resident event.

CLC registry staff did not have VA-issued PIV cards required to access EHRs, which may have affected the provision of care.[7] The OIG reviewed the terms of the contract for registry staff and found conflicting requirements related to the issuance of PIV cards. Without EHR access, registry staff were unable to review resident care information or document care provided such as vital signs and completion of activities of daily living. EHR documentation is an important communication tool to promote continuity of care, and to support the metrics to develop CLC targets.[8]

While the CLC did not have a dedicated 24-hour Environmental Management Service (EMS) staff member assigned consistently, EMS services were available as needed. However, CLC nursing staff were unclear how to contact EMS during off-tour hours. The OIG noted varying EMS contact information with a lack of information specific to shift coverage, making it difficult to determine the correct point of contact.

[5] Contributory factors to adverse events include poor clinical assessment, poor documentation, inadequate communication, equipment, and gaps in continuity of care. Andersson A. et al., "Factors contributing to serious adverse events in nursing homes," *Journal of Clinical Nursing* (January 2018):27(1-2):354-362. https://www.ncbi.nlm.nih.gov/pubmed/28618102. (The website was accessed on February 29, 2020.)

[6] An adverse event may result in an adverse clinical outcome. Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

[7] VA Directive 0735, *Homeland Security Presidential Directive 12 (HSPD-12) Program*, October 26, 2015.

[8] VHA Directive 1907.01, *Health Information Management and Health Records*, March 19, 2015. VHA Handbook 1142.02. VHA Directive 1351. VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

At the time of the OIG site visits, the CLC was not dirty; however, the OIG substantiated the presence of flying insects. Facility leaders acknowledged flying insects were an ongoing problem and attributed this to residents having food in their rooms, and open doors and windows.

In August 2019, facility and CLC leaders developed an action plan that included the installation of bug lights and walking rounds inspections to assess the presence of flying insects. However, the action plan was only partially implemented because facility leaders had not determined which service line would be responsible for maintaining the lights and there was confusion related to rounding frequency. A CLC leader informed the OIG that nurse managers had not conducted rounding three times per month as outlined in the action plan.[9]

The OIG substantiated that CLC staff were not consistently meeting the facility hand-hygiene compliance goal. Oversight staff did not consistently monitor CLC staff for compliance due to staff turnover. Facility staff identified a contributing factor was low CLC staffing levels, so staff were too busy to wash their hands. Proper hand hygiene and measuring adherence to hand hygiene reduces healthcare-associated infection rates.

The OIG substantiated that one or both CLC floors closed to admissions and visitors on six different occasions between January 3, 2018, and September 3, 2019, due to infectious disease.[10] During the outbreaks, staff followed facility infection control processes, such as surveilling for new cases and closing the units to admissions and visitors to contain and minimize exposures.

The OIG made ten recommendations to the Facility Director related to staffing methodology, approved CLC operating beds, nursing assistant staff retention and recruitment, response to an adverse event, CLC registry nursing assistant staff access to the EHR, pest control in the CLC, hand hygiene, and the registry agency agreement and performance.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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[9] The CLC Manager reported that as of March 2020, weekly rounding was occurring using a streamlined audit tool that includes observations for flying insects.

[10] None of the outbreaks mentioned in this report were related to COVID-19. This inspection reviewed events and infection control policy in effect through February 2020 and did not review COVID-19-related policies.

Contents

Abbreviations

CLC	Community Living Center
EHR	electronic health record
EMS	Environmental Management Service
NHPPD	nursing hours per patient day
OIG	Office of Inspector General
PIV	personal identity verification
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection at the Community Living Center (CLC) within the San Francisco VA Health Care System (facility) in California in response to allegations regarding facility leaders' failure to adequately address known nurse staffing shortages that may have led to adverse events, environment of care concerns, and infection control related issues.[11]

Background

The facility, part of Veteran Integrated Service Network (VISN) 21, comprises the San Francisco VA Medical Center and six community outpatient clinics located in Santa Rosa, Eureka, Ukiah, Clearlake, San Bruno, and downtown San Francisco, California. The Veterans Health Administration (VHA) classifies the facility as a Level 1a–highest complexity facility.[12] From October 1, 2017, to September 30, 2018, the facility served 68,784 patients and had a total of 255 hospital operating beds, including 112 inpatient beds, 120 CLC authorized beds, and 11 compensated work therapy/transitional residents beds. The facility has an affiliation with the University of California, San Francisco School of Medicine.

Community Living Center

VHA CLCs, formerly referred to as nursing home care units, provide short- and long-term care to residents with a variety of medical conditions.[13] Residents can receive assistance with their activities of daily living (such as bathing or dressing), skilled nursing services (including wound care or medication administration), hospice and palliative care, rehabilitation, and medical care.[14] Some CLCs have separate memory care units that focus on the care of residents with dementia. These units have secured perimeters to allow maximum independence for residents at risk for

[11] VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017. Nurse staffing refers to the skill mix of patient care provided by the different skill and educational levels (registered nurse, licensed practical nurse, and nursing assistant) of nurses on a unit. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Adverse events are "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility." Some examples of common adverse events include patient falls and missing patient events. VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers,* August 13, 2008.

[12] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing.

[13] For this report, the term resident refers to a veteran living in the CLC for either short- or long-stay services.

[14] VHA Handbook 1142.01.

wandering. CLCs are meant to restore residents to their highest level of well-being, prevent a decline in health, and provide comfort at the end of life.[15] CLCs are intended to have a home-like environment.

Prior OIG Reports

In a December 20, 2018, report *Comprehensive Healthcare Inspection of the San Francisco VA Health Care System, California,* the OIG noted findings in five of the eight areas of clinical operations reviewed and issued 12 recommendations that were attributable to the Director, Chief of Staff, and Associate Director for Patient Care Services (Nurse Executive). The OIG noted opportunities for improvement for the Associate Director based on low employee satisfaction surveys. Identified areas included nursing salary disparities, inadequate communication, staffing shortages, and turnover. All 12 recommendations have been closed.[16]

Allegations and Related Concerns

On September 17, 2019, the OIG Hotline division received a complaint alleging multiple deficiencies at the facility's CLC. The OIG further reviewed the following allegations:

1. Facility leaders failed to adequately address known CLC nurse staffing shortages and continued to accept resident admissions.
2. Insufficient nurse staffing at the CLC led to adverse events, specifically, wandering and missing residents, and inability to manage residents admitted with disruptive behaviors.[17]
3. The CLC does not have 24-hour housekeeping aides available.[18]

[15] VHA Handbook 1142.02, *Admission Criteria Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Center*, September 2, 2012.

[16] VA Office of Inspector General, *Comprehensive Healthcare Inspection of the San Francisco VA Health Care System, California*, Report No.18-01153-43, December 20, 2018. These reviews are part of the OIG's overall efforts to ensure that our nation's veterans receive high-quality VA healthcare services. The reviews focus on key clinical and administrative processes and are performed approximately every three years for each facility. https://www.va.gov/oig/publications/default.asp. (The website was accessed on February 20, 2020.)

[17] VHA Handbook 1142.01. VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010. VHA policy considers a patient to be at risk if there is the potential "for harm to themselves or others if not returned to a safe environment." An at-risk wandering patient is one who "strays beyond the view or control" of staff, and an at-risk missing patient is one "who disappears from patient care areas (on VA property)." VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration Facilities*, September 27, 2012. VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, VA employees, or individuals at the facility."

[18] For the purposes of this report, housekeeping aides will be referred to as environmental management services (EMS) staff.

4. The CLC is dirty and infested with fruit flies (flying insects).[19]
5. The CLC staff do not wash their hands.
6. The CLC was quarantined more than two times during the 12-month period of October 1, 2018, through September 30, 2019.

During the inspection, the OIG received and reviewed additional allegations that inadequate staffing led to resident falls, and that the sole contract registry agency used to provide registry staff was not able to meet the requested number of staff.[20] Facility staff reported that registry staff did not have VA-issued personal identity verification (PIV) cards and were unable to access the electronic health records (EHRs) of CLC residents at the facility.

Scope and Methodology

The OIG initiated the inspection on October 1, 2019, and conducted a site visit at the facility from December 9 through 12, 2019. An additional unannounced site visit occurred from February 2 through 6, 2020. The second site visit focused on environment of care, specifically cleanliness, and interviewing additional leaders and frontline staff.

The OIG team interviewed the VHA Chief Nursing Officer; VISN quality management staff; VISN and facility contract staff; facility leaders; service level managers; safety chiefs; the Staffing Methodology Coordinator (Coordinator); and facility staff from quality management, the CLC, engineering, environmental management services (EMS), biomedical, and information technology, and residents' family members.[21]

The OIG reviewed VHA directives and handbooks; facility policies; CLC staffing methodology; meeting minutes of the CLC Clinical Operations, Resident Council, Cognitive Ability Life and Meaning, and Geriatric, Palliative and Extended Care committees; meeting minutes of the facility's Environment of Care, Infection Control, and Disruptive Behavior committees and falls workgroup; facility Human Resources and personnel documents; internal and external quality reviews; facility action plans; medical literature; and a staffing contract. The OIG reviewed the electronic health records (EHRs) of seven residents who were identified as having an adverse event. The names of the seven residents were provided by the complainants, a family member, or

[19] As the species of insect observed at the CLC could not be identified, the OIG uses the term flying insects in this report rather than fruit flies.

[20] VA National Center for Patient Safety, *Implementation Guide Fall Injury Reduction*, revised February 2015. "VHA defines a fall as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions." The facility uses registry staff, temporary nursing assistants in the CLC from a contracted staffing company (registry agency).

[21] The Coordinator also served as the Nurse Resource Manager. "Environmental Management Service is responsible at the facility for ensuring a state of physical and biological cleanliness." VHA Directive 1850, *Environmental Programs Service*, March 31, 2017.

facility staff during interviews. The OIG reviewed facility data related to CLC nurse staffing, quality improvement, hand hygiene, and Strategic Analytics for Improvement and Learning metrics, and other relevant documents. The OIG did not assess the accuracy of the facility data but reviewed processes for data collection and actions taken in response to data indicators and results. The OIG conducted multiple inspections of both floors of the CLC during the site visits.

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, § 7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

1. Facility Leaders' Response to Insufficient CLC Nurse Staffing

The OIG substantiated that facility leaders failed to adequately address known CLC nurse staffing shortages and continued to accept resident admissions. The OIG found that CLC managers were unable to meet nursing hours per patient day (NHPPD).[22] The OIG learned that CLC managers struggled with the significant number of nursing assistant vacancies and

[22] NHPPD refers to the number of nursing care hours needed to manage the patient workload and mix of nursing staff, including nursing assistants. NHPPD is calculated using "the total number of nursing hours of care available divided by the number of patients in a 24-hour period." VHA Directive 1351.

increasingly relied on registry staff to supplement staffing while maintaining a high resident census in the CLC.[23]

During the inspection, the OIG identified that the Coordinator had insufficient knowledge of VHA nurse staffing methodology. The OIG determined that due to competing priorities, facility leaders did not provide the CLC with the attention necessary to address the staffing shortages.

VHA Nurse Staffing Methodology

A 2010 VHA policy required the use of a standardized staffing methodology to determine inpatient nursing personnel requirements based on an analysis of multiple variables, including resident needs, organizational supports, and professional judgment.[24] These variables are used to recommend staffing levels that are intended to support safe and effective patient care. A unit-based expert panel generates and recommends a staffing plan and proposes the NHPPD target (target) for each nursing unit, based on clinical judgment, knowledge of the nursing unit, and relevant comparison data. The proposed staffing plan is reviewed by a facility-based expert panel and the nurse executive, and is approved by the facility director. VHA requires that the staffing plan is reviewed annually, and the staffing methodology is completed biennially or more frequently, if needed.[25] Coordinators are responsible for reporting facility staffing methodology to the VHA Office of Nursing Services through the VISN. VHA requires facility nurse leaders to review staffing levels daily.[26]

Altering the target has a direct effect on the number of staff needed to manage the patient workload. For example, lowering the target may require fewer staff to reach that target.[27] The NHPPD gap (gap) is the difference between the target and the actual NHPPD.[28] The VHA Office of Nursing Services does not mandate the gap limit but allows facilities to determine their own

[23] McGraw-Hill Concise Dictionary of Modern Medicine. "census." https://medical-dictionary.thefreedictionary.com/census. (The website was accessed on May 6, 2020.) Census is the number of beds occupied by patients in a service, unit, ward, or health care facility.

[24] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This directive was in effect before the events discussed in this report and is used for background information only; it was rescinded and replaced by VHA Directive 1351.

[25] VHA Directive 1351.

[26] VHA Directive 1351.

[27] VHA Office of Nursing Services, *Staffing Methodology Conference, July 2019, Step by Step Process*.

[28] For example, a floor with 20 residents has four nursing personnel (nurses and nursing assistants) on duty for each eight-hour shift during a 24-hour period. The number of nursing hours during each eight-hour period is 32. There are three, eight-hour shifts, so the total number of nursing hours is 96. The total number of nursing hours (96) divided by the number of residents (20) equals the NHPPD (4.8 nursing hours per resident). Increasing or decreasing staffing or resident census will alter the NHPPD. This is only an example of NHPPD calculations and does not reflect actual staffing at the CLC.

limit. Typically, the gap limit is 5–10 percent of the target. However, the "ultimate goal" of VHA's staffing methodology is to achieve the target consistently.[29]

Facility Nurse Staffing Methodology

The Facility Director and the Nurse Executive retroactively approved a staffing methodology in November 2018 that covered the period of October 1, 2017, through September 30, 2019. The Facility Director reported that the staffing methodology was not timely signed because "nobody knew how to do it." The Nurse Executive, who was assigned to the position in October 2017, stated that the prior Staffing Methodology Coordinator left, and no one knew how to do staffing methodology. A new team, including the Coordinator, was formed and learned staffing methodology together.

CLC Nurse Staffing Methodology

The approved staffing methodology reflected a target of 6.0 for the CLC ground floor and 6.5 for the CLC first floor. Despite the approved targets, the OIG found that the Coordinator had adopted unapproved targets of 5.7 for CLC ground floor and 5.9 for CLC first floor. According to the Coordinator, a CLC nurse manager suggested lowering the targets. The Coordinator cited not communicating the change to the Nurse Executive and believed the lower targets had been approved. The Coordinator provided reports to the Executive Leadership Team, such as the daily calculated gap, based on the unapproved targets.

The OIG reviewed the Coordinator's annual report covering staffing methodology data from October 1, 2018, through September 30, 2019. On February 4, 2020, the Coordinator stated the report was "still under review and not quite finalized." The OIG found that the Coordinator used unapproved targets in the calculation of the actual NHPPD and used the approved targets when calculating the gap limits, thus, underestimating the severity of the staffing deficit. The Coordinator reportedly calculated the gap limits using 20 percent as the maximum gap, well above the typical 5–10 percent.[30]

The annual report did not reflect the severity of the staffing deficits, and showed that the CLC did not exceed the gap limit in any of the months for either floor. When the OIG recalculated the gap based on the approved targets, the CLC ground floor exceeded the facility's gap limit for three of the nine months, and CLC first floor exceeded the gap limit for all nine months (see table 1).

[29] VHA Office of Nursing Services. *NHPPD Monitoring*, July 2019.

[30] For example, a 20 percent gap for the CLC ground floor is calculated as follows: 6.0 target x 20 percent = 1.2 NHPPD, thus, the acceptable range is from 4.8 to 7.2 NHPPD (6.0 target - 1.2 hours and 6.0 target + 1.2 hours).

Table 1. VA OIG's Recalculation of CLC Gaps by Floor Using Approved Targets (January through September 2019)

CLC Unit	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
CLC Ground Floor (*Gap limit: -1.2*)	-0.78	-0.58	**-1.27**	-1.15	-0.74	-1.14	-1.2	**-1.3**	**-1.21**
CLC First Floor (*Gap limit: -1.3*)	**-1.31**	**-1.56**	**-1.62**	**-1.45**	**-1.68**	**-1.46**	**-1.61**	**-1.64**	**-1.58**

Source: VA OIG analysis of facility Staffing Methodology Report for October 1, 2018, through September 30, 2019 data.
Note: The OIG bolded the deficits that exceeded the gap limit.

The Coordinator stated agreeing "inadvertently" to using the unapproved targets based on the belief that the Nurse Executive had approved the change. The Nurse Executive told the OIG about being unaware that the Coordinator was using the unapproved targets until December 2019.

The OIG found that the Coordinator lacked understanding of basic staffing methodology. According to VHA policy, the facility staffing methodology coordinator is responsible for "remaining current with nurse staffing methodology processes, tools, and resources, and training facility stakeholders."[31]

The Coordinator, who received staffing methodology training in April 2018, identified herself as a "novice." The Nurse Executive reported confidence in the Coordinator but expressed displeasure after learning of the NHPPD reporting errors.

Nursing Assistant Vacancies

The OIG found that the dwindling number of CLC nursing assistants contributed to the challenge of meeting the target. According to the Chief Nurse of Geriatrics and Palliative and Extended Care (CLC Chief) who oversaw the CLC and other facility programs, the nursing assistant vacancy rate increased from approximately 45.0 percent in March 2019 to 47.5 percent in October 2019. The CLC Chief reported that some nursing assistants transferred to non-CLC positions in the facility.

According to the CLC Chief, San Francisco is "very expensive" and the nursing assistant position is "low-paying" making the vacancies the "most difficult to fill." The CLC Chief, who took over recruiting in Spring 2019, cited challenges with Human Resources that affected hiring efforts, such as a new Human Resources Chief acclimating to the position. The CLC Chief

[31] VHA Directive 1351.

reported being stopped from working with the facility nurse recruiter (who is the CLC Chief's spouse), which "hobbled" progress for approximately six months.

From Spring 2019 through early December 2019, the CLC Chief reportedly selected 17 applicants from 30 interviews, and from that process, one nursing assistant was hired. According to a Human Resources specialist, barriers to hiring included not having proper applicant documentation, and competing Human Resources assignments. The OIG learned during the eight weeks between site visits, three nursing assistants started or were scheduled to begin work at the CLC.

Facility Sole Contract with Registry Agency

When developing the staffing schedule, CLC nurse managers first scheduled CLC nursing assistant staff then utilized other in-house options, such as overtime and float staff from other areas of the facility, as available.[32] When in-house options were exhausted, the Coordinator contacted the registry agency to request the number of needed nursing assistants.

On May 21, 2018, VHA awarded a sole indefinite delivery, indefinite quantity contract (contract) to a registry agency with an aggregate ceiling of $50 million.[33] The contract was established for performance from July 1, 2018, through June 30, 2023. VHA paid the registry agency for staff who "may be assigned to work anywhere within Nursing Service of the San Francisco VAMC [facility], as determined by competency, the Staffing Office, or by request from the nurse managers."[34] The contract requires the registry agency to furnish these services "as needed 24 hours per day, 7 days per week, 365 days per year including local, State, and Federal holidays." Within the facility, the nursing service line is the point of contact for registry staff. The VA contracting officer and VA contracting officer's representative are responsible for managing the contract. The contracting officer's representative is responsible for ensuring

[32] Christine Kane-Urrabazo. "Said Another Way Our Obligation to Float," *Nursing Forum* 41, no. 2, (April 2006): 95-101. https://onlinelibrary.wiley.com/doi/10.1111/j.1744-6198.2006.00043.x#.XtFA1B_P_WQ.email. (The website was accessed on May 29, 2020.) Float staff are nursing staff that are pulled from one unit in the facility to cover a shift staffing shortage on another unit.

[33] Indefinite delivery, indefinite quantity contracts are used for services when a facility cannot determine the exact amount of services above a specified minimum they may need over a specified contract period. In this case, the facility was not able to estimate with certainty the number of hours of temporary nursing services required. U.S. General Service Administration, *Indefinite Delivery, Indefinite Quantity Contracts.* https://www.gsa.gov/buying-selling/new-to-gsa-acquisitions/how-to-sell-to-the-government/indefinite-delivery-indefinite-quantity-contracts. (The website was accessed on April 6, 2020.)

[34] This contract was established to provide temporary nursing staff including registered nurses, licensed practical nurses, and nursing assistants. However, the facility only requested nursing assistants.

performance and serves as the point of contact between the vendor, contracting officer, and the program office staff. [35]

The OIG found that the CLC's use of registry staff quadrupled from September 1, 2018, through December 31, 2019 (see figure 1). Studies indicate that long-term use of registry staff may jeopardize resident safety, which will be discussed in section 2 of this report.

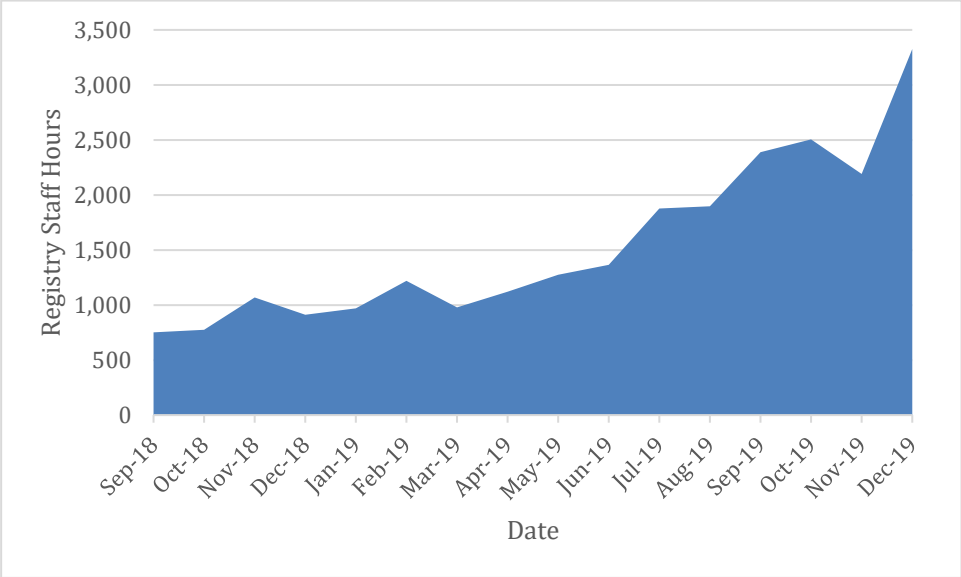

Figure 1. Utilization of Registry Staff Hours by the CLC by Month, September 1, 2018, through December 31, 2019
Source: OIG analysis of facility registry data

CLC Census

The OIG found that the CLC continued to accept admissions as evidenced by maintaining a high resident census while CLC leaders struggled to meet the targets. The OIG learned that the CLC has 120 authorized beds. However, prior to 2010, leaders internally and without VHA authorization reduced the number of operating beds to 104 due to insufficient nurse staffing. The OIG determined that, based on 104 operating beds, the CLC averaged a daily occupancy rate of 94 percent from April through September 2019. The CLC occupancy rate was generally above 90 percent (see figure 2).[36] Although nurse staffing has been insufficient, leaders have not reduced the number of beds since 2010. The OIG recognizes that reducing the number of

[35] Federal Acquisition Institute, *Contracting Officer's Representative (FAC-COR).* https://www.fai.gov/certification/fac-cor. (The website was accessed on April 6, 2020.)

[36] Occupancy rate is the percentage of beds occupied by residents within a defined time period.

operating beds may be a short-term solution while leaders focus on addressing the nurse staffing challenges.

Figure 2. CLC Daily Occupancy Rate from April 1 through September 2019
Source: OIG analysis of facility's CLC daily census data

Facility and CLC Leaders' Lack of Consistent Oversight of the CLC

The OIG found that the CLC had experienced high turnover or vacancy in the CLC Chief and CLC nurse manager positions since October 1, 2017. The CLC Chief position oversees other facility programs in addition to the CLC, and this position has turned over at least five times since October 2017. (Details of facility and leader changes are provided in appendix A.) The OIG learned that the CLC Chief, who was in place since March 2019, retired at the end of March 2020. The Associate Chief of Staff for Geriatrics, Palliative and Extended Care opined that the enormous responsibilities required for the CLC Chief position is the reason for the turnover. In February 2020, to relieve the CLC Chief of some of the responsibilities, facility executive leadership approved two new CLC leadership positions.

The OIG determined that the Nurse Executive provided inadequate oversight and intervention while the CLC struggled with inconsistent leadership and endured progressive staffing challenges. The Nurse Executive told the OIG about being aware of these challenges but attributed the lack of oversight to CLC management turnover and the Nurse Executive's competing priorities related to facility staffing and issues external to the CLC.

CLC managers struggled with significant nursing assistant vacancies, inaccurate staffing methodology, and increasing reliance on registry staff to supplement staffing while maintaining a high resident census in the CLC.

2. Alleged Adverse Events Related to Nurse Staffing Shortages

The OIG was unable to determine if insufficient staffing levels at the CLC led to adverse events or the inability to manage residents with disruptive behaviors. A variety of contributory factors

can affect resident outcomes and quality of care making it difficult to conclusively attribute the events to nurse staffing shortages.[37] Thus, the OIG reviewed facility staff's response to adverse events and disruptive behavior. Additionally, the OIG learned that CLC registry staff did not have VA-issued personal identity verification (PIV) cards and were unable to access the EHRs of CLC residents at the facility, which could affect the provision of care.[38]

The OIG reviewed the EHRs of the seven residents alleged to have had adverse events or disruptive behavior or both, and that occurred from October 1, 2017, through December 31, 2019. Of the seven residents, the OIG found adverse events involving two residents who wandered or were missing, five residents who fell, and three with documented disruptive behavior.[39] One of the falls resulted in an adverse clinical outcome.[40] The OIG also reviewed the facility's processes for tracking and analyzing wandering and missing residents, falls, and disruptive behavior in the CLC to determine whether required processes were in place.

VHA and Facility CLC Policies

According to VHA policy, CLC staff are required to provide care in the safest manner that also promotes resident independence, is person-centered, and ensures quality of life and improved clinical outcomes. To achieve these outcomes, the care spectrum must include safe facility design, appropriate assessments, and planning for activities of daily living in consideration of the resident's physical and cognitive abilities, including the ability to safely move about.[41] VHA requires that care in the CLC be integrated with mental health services, including for those veterans who require dementia care, and those with behavioral symptoms such as anxiety, depression, aggression, and wandering.[42] VHA also requires that facility staff perform quality improvement activities such as clinical tracking.[43]

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[37] Contributory factors to adverse events include poor clinical assessment, poor documentation, inadequate communication, and gaps in continuity of care. Asa Andersson. et al., "Factors contributing to serious adverse events in nursing homes," *Journal of Clinical Nursing* 27, no. 1-2, (January 2018): 354-62. https://www.ncbi.nlm.nih.gov/pubmed/28618102. (The website was accessed on February 29, 2020.)

[38] VA Directive 0735. A VA-issued Personal Identity Verification Card is a sole identity issued card provided to VA employees, contractors, and affiliates who require "access to VA facilities, services, and/or information systems on a recurring basis."

[39] The number does not sum as a resident may have had one or more events.

[40] An adverse event may result in an adverse clinical outcome. Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

[41] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016; VHA Handbook 1142.01.

[42] VHA Directive 1140.11.

[43] VHA Directive 1140.11.

VHA's patient safety program focuses on preventing adverse events to residents and building a culture of safety. The program requires the review of adverse events to identify underlying causes and implementation of changes needed to reduce the likelihood of recurrence.[44]

Facility and CLC policies related to resident wandering, falls, and disruptive behavior include similar requirements. The policies outline specific steps including the assessment of residents at the time of admission and during continued care in the CLC to identify and minimize safety risks, protocols to activate when an event occurs, as well as the reporting and analysis of events to identify areas for improvement.[45]

Wandering and Missing Residents

The OIG reviewed the EHRs of the two residents identified as wandering or reported missing from the CLC. In addition, the OIG reviewed reported CLC wandering and missing resident data from October 1, 2017, through September 30, 2019, to determine whether facility staff tracked and analyzed these events. Review of the data revealed no additional events for this period.

VHA acknowledges that facility staff are responsible for all residents receiving care and notes that residents with physical, mental, or cognitive impairments may require additional monitoring and protection. As per VHA policy, facility staff are required to know the whereabouts of residents and determine their potential risk to wander or become missing.[46]

Resident A

The resident had lived in the CLC since 2007 and was familiar with the facility. Initially, the resident had limited cognitive deficits and was not at risk to wander. The resident used a manual wheelchair and could self-propel. Over time, the resident's dementia progressed, and CLC staff identified the resident as having an increased risk to wander. One morning in summer 2019, nursing staff noticed the resident was no longer on the unit, (having last been seen 30 minutes prior) and initiated a search of the CLC and adjacent building. Staff discovered the resident at a

[44] VHA Handbook 1050.01.

[45] Facility CLC Policy 42, *Management of Wandering Behavior and Prevention of Elopement*, March 10, 2015. The 2015 CLC policy was replaced by Facility CLC Policy 42, *Management of Wandering Behavior and Prevention of Elopement*, March 10, 2019. The two policies contain the same or similar language related to assessing and managing CLC residents with wandering behavior or attempt elopement. Facility Memorandum 11.57 *Wandering and Missing Patient Policy*, March 28, 2014. Facility Memorandum 11-100, *Falls and Falls with Injury Prevention*, May 25, 2016. The 2016 memorandum was replaced by Facility Memorandum 11-100, *Falls Prevention and Management*, October 15, 2018. The two policies contain the same or similar language related to preventing and managing resident's falls. Facility Memorandum 05-33, *Violence and Threatening Behavior in the Workplace*, February 18, 2016.

[46] VHA Directive 2010-052.

facility cafeteria, in a building connected to the CLC. The OIG determined the resident had no adverse clinical outcome.

Resident B

The resident was diagnosed with dementia and was admitted from a facility acute care unit to the CLC in summer 2019 while awaiting transfer to another nursing facility with a memory care and dementia unit.[47] The resident had a documented history of wandering in acute care and had been placed on electronic monitoring that alerted staff when the resident was near an exit. The CLC did not have an electronic monitoring system. As such, prior to admission, CLC staff requested that the electronic monitoring be removed for a few days to assess wandering risk and appropriateness of admission. During that period, the resident had no episodes of wandering or eloping, and the CLC accepted the resident. The resident eloped several hours after admission to the CLC. A CLC staff member notified VA police and the resident's family. The resident's family found the resident several miles from the facility and returned the resident to the CLC approximately five and a half hours after eloping. The OIG determined the resident had no adverse clinical outcome.

CLC Staff Response to Wandering and Missing Events

The OIG found that facility staff documented the required initial and ongoing wandering risk assessments of Residents A and B.[48] Upon discovering the residents were gone from the CLC, staff followed the facility's wandering and missing resident protocol, including notifying family and the VA police when indicated. Following the elopements, CLC staff recognized that both residents would benefit from admission to a secured CLC; however, the facility was unable to locate a facility with a secured unit for transfer.[49] CLC staff relocated the residents to a CLC floor with limited egress and implemented continuous monitoring for Resident B. As of April 1, 2020, neither resident had additional elopements from the facility.

VHA's National Center for Patient Safety requires a facility to complete a root cause analysis when a safety assessment score is 3; however, a facility is not prevented from conducting a root

[47] The CLC does not have a dedicated dementia unit.

[48] VHA Directive 2010-052.

[49] The CLC does not have a secured floor or an electronic monitoring system. The ground floor unit has multiple means of egress to the outside of the building.

cause analysis with a lower safety assessment score.[50] The OIG determined the potential severity of an adverse outcome for this event may have been scored higher. The facility may have missed an opportunity for improvement by not initiating a root cause analysis to further understand all potential elements contributing to Resident B's missing resident event, including the resident's cognitive impairments and the facility infrastructure.

Falls

One of VHA's patient safety goals is to promote mobility and enhance veterans' quality of life while reducing falls. To prevent falls, CLC staff should assess the milieu and implement interventions to ensure a safe environment. Interventions may include ensuring that assistive devices and call lights are within reach, reminding residents to call for assistance, and increasing the frequency of staff rounds.[51] VHA also requires patient safety managers to complete an annual falls Patient Safety Assessment Tool to help staff identify program strengths and weaknesses.[52]

Facility policy required nurses to complete a fall risk assessment upon admission and at various points throughout a resident's stay. The fall risk-assessment tool assigns a point value to determine the level of risk as low, moderate, or high. When nurses recognize a resident as a fall risk, nurses identify and implement interventions to reduce the risk of falls. In the event of a fall, an interdisciplinary team assesses for additional interventions that could be utilized to decrease the risk of a future fall. A fall workgroup is required to identify trends and implement recommendations to prevent falls. Quality Improvement staff are required to report the information to nursing leaders quarterly.[53]

The OIG reviewed entries from October 1, 2017, through December 31, 2019, in the seven residents' EHRs and found that five of the seven identified residents had fallen. At the time of

[50] VHA Handbook 1050.01. A root cause analysis is a type of focused review used for adverse events and close calls that require examination. A safety assessment score is a method used to evaluate the severity of the actual and potential adverse events that occur. 38 U.S.C. § 5705(a) (2016) provides in pertinent part, "records and documents created by the Department as part of a medical quality-assurance program…are confidential and privileged" The issues discussed in this report relate to procedures and processes and not the substance of the reviews. VHA Directive 2008-077, *Quality Management and Patient Safety Activities That Can Generate Confidential Documents*, November 7, 2008.

[51] VA National Center for Patient Safety, *Falls Prevention Tools for Veterans and Caregivers*, https://www.patientsafety.va.gov/veterans/falls.asp. (The website was accessed on March 22, 2020.) VA National Center for Patient Safety, *Guide for Fall Injury Reduction*, revised February 2015, https://www.patientsafety.va.gov/docs/fallstoolkit14/falls_implementation_%20guide%20_02_2015.pdf. (The website was accessed on March 23, 2020.)

[52] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum*, Continuation of Aggregate Review Process for High Frequency Patient Safety Events, April 3, 2019.* Deputy Under Secretary for Health for Operations and Management (DUSHOM) *Memorandum, Falls Aggregates Review Requirement*, June 6, 2017.

[53] Facility Memorandum 11-100, May 2016; Facility Memorandum 11-100, October 2018.

admission and throughout the residents' stay, nursing staff assessed the residents to determine fall risk levels and implemented interventions to decrease the risk of falls. After each fall, the interdisciplinary team completed fall-focus reviews to identify contributing factors and reassessed and adjusted interventions. The OIG found that facility staff did not document insufficient staffing as a contributing factor in any of the post-fall EHR documentation reviewed. The OIG was unable to directly attribute insufficient staffing as a cause of the fall events.

The OIG found the facility met the requirements related to fall prevention and management. The OIG reviewed the CLC fall data and determined that a quality improvement nurse tracked and analyzed fall events and reported quarterly findings to nursing leadership. In addition, the Patient Safety Manager completed the annual Patient Safety Assessment Tool evaluations.

Adverse Clinical Outcome

The OIG identified that of the five residents who fell, one resident's fall resulted in an adverse clinical outcome in spring 2019. Specifically, the resident fell from a wheelchair resulting in a fracture of their nasal septum.[54] CLC staff transferred the resident to the facility's Emergency Department for higher level of care than available at the CLC. The resident did not require surgery nor admission to an acute medical floor and returned to the CLC.

The OIG reviewed the EHR and determined that upon the resident's admission to the CLC in summer 2017, nursing staff assessed the resident's fall risk as moderate. Nursing staff noted several elements that could have increased the resident's risk for falls, including right-sided weakness, forgetting limitations, and dependence on staff for transfers.[55] Nursing staff reassessed the resident throughout their stay at the CLC. Since autumn 2017, nurses assessed their risk for falls as high. At the time of the fall with injury in May 2019, facility staff had fall precautions in place including keeping a call light within reach, keeping the environment clear of obstructions, and assisting with transfers. A physical therapist performed a post-fall assessment and documented that the resident's wheelchair had worn brakes that were replaced. The fall was reported to patient safety and evaluated in accordance with VHA guidance and did not meet the requirement for root cause analysis.[56]

The OIG determined the resident experienced an adverse clinical outcome, specifically, the need for a higher level of care (emergency department), as a result of an injury resulting from a fall that required treatment in the Emergency Department. CLC staff had assessed the resident prior to the event, and implemented measures to mitigate the fall risks associated with the resident's

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

[55] VA National Center for Patient Safety, *Implementation Guide fall Injury Reduction*, revised February 2015. Provides guidance to assess multi-focal elements such as gait, and neurological and cognitive function for impairments that increase the risk of falls.

[56] VHA Handbook 1050.01.

diagnosis while attempting to maximize the resident's independence. The interdisciplinary care plan team completed a fall-focus review of the incident and responded with additional interventions.[57]

Disruptive Behavior

VHA CLCs are designed to serve residents with stable chronic conditions, including dementia. Memory and judgment problems are issues common to residents with dementia, as well as aggression that may include physical or verbal behavior such as hitting, kicking, and yelling.[58] CLC populations also include residents with mental health disorders who may exhibit behaviors of aggression.[59] VHA staff are exposed to the risks associated with caring for violent residents. VHA managers and staff must balance the rights and healthcare needs of aggressive and disruptive residents with the health and safety of other residents, visitors, and staff.

Disruptive Behavior Prevention and Management

VHA and facility policies aim to reduce and prevent disruptive behavior to enhance the safety of residents and staff. [60] The facility's CLC policy requires an assessment for disruptive behavior at the time of admission and throughout each CLC stay. The assessment may determine that a behavioral care plan is required, and one should be developed that considers the resident's cognitive functioning, diagnosis, and adjustment issues.[61] Members of the Disruptive Behavior Committee determine the need for and activate a patient (resident) record flag in a resident's EHR to communicate to staff when a resident has exhibited disruptive or violent behavior.[62]

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[57] Facility Memorandum 11-100.

[58] Diane Dettmore, Ann Kolanowski, Malaz Boustani, "Aggression in Persons with Dementia: Use of Nursing theory to Guide Clinical Practice," *Geriatric Nursing* 30, no. 1, (January—February 2009)8-17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3365866/. (The website was accessed on March 16, 2020.)

[59] Mental health disorders prevalent in CLC residents include schizophrenia, bipolar disorder, and other psychotic disorders. Anjana Muralidharan et al., "Preparing Long-Term care Staff to Meet the Needs of Aging Persons with Serious Mental Illness," *Journal of American Medical Directors Association* 20, no. 6, (June 2019): 683-8. https://www.ncbi.nlm.nih.gov/pubmed/31056455. (The website was accessed on March 24, 2020.)

[60] VHA Directive 2012-026. VHA Directive 2010-053, *Patient Record Flags,* December 3, 2010. Facility Memorandum 05-33. Facility CLC Policy-34, *Management of Patients at High Risk for Violent, Abusive, Disruptive Behavior*, March 9, 2015.

[61] Facility CLC Policy-34.

[62] VHA Directive 2010-053. Facility Memorandum 11-07, *Identification and Warning about Veterans at High Risk for Violent, Abusive, Threatening or Disruptive Behavior and the Function of the Disruptive Behavior Committee (DBC)*, April 13, 2017. A "patient record flag was originally developed for the specific purpose of improving safety in providing health care to patients who are identified as posing an unusual risk for violence. The use of PRFs has expanded to address a limited number of additional safety vulnerabilities that present in the initial moments of a patient encounter."

Additionally, the Disruptive Behavior Committee is required to track and analyze reported incidents of disruptive behavior to identify trends and implement system improvement.[63]

The OIG reviewed the EHRs of the seven identified residents and found all included CLC staff assessments for risk of disruptive behavior at the time of admission and throughout the CLC stay, and care plans were reviewed and adjusted based on the resident's cognitive functioning, diagnosis, and adjustment issues according to facility policy. Three of the seven residents had documented events that warranted a disruptive behavior flag in their EHRs. Resident record flags included guidance to staff on ways to avoid disruptive behavior events. The reduction of events may increase staff availability to address other resident care needs. None of the EHR notes reviewed by the OIG cited staffing levels as a contributing factor to the events.

The OIG reviewed the VHA Disruptive Behavior Reporting System documents and confirmed that the Committee tracked and analyzed the events that occurred in the CLC from October 1, 2017, through September 30, 2019. The OIG found the facility met the requirements reviewed to assess, track, and reduce disruptive behavior. The OIG was not able to directly attribute staffing issues to disruptive behavior events.

Safety Concerns Related to the Use of Registry Staff

The OIG reviewed literature examining the relationship between nurse staffing and quality of care. Although a considerable number of studies focus on staffing numbers and care outcomes, other covariates were identified as impactful in determining quality of care including, consistent staff assignments, training and experience of staff, and resident-staff relationships.[64] Additionally, literature identified safety concerns with high use of registry staff such as interruption in continuity of care, and unfamiliarity with facility and floor policies.[65] VHA discourages the use of float staff and changing assignments frequently in the CLC.[66]

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[63] VHA Directive 2010-053. VHA Directive 2012-026.

[64] Karen Spilsbury et al., "The relationship between nurse staffing and quality of care in nursing homes: A systematic review," *International Journal of Nursing Studies* 48, no. 6, (June 2011): 732-50. https://www.ncbi.nlm.nih.gov/pubmed/21397229. (The website was accessed on March 26, 2020.) L. D. Kimmey, S. C. Streans, "Improving Nursing Home Resident Outcomes: Time to Focus on More than Staffing?" *The Journal of Nursing Home Research*, (January 2015): 89-95. https://www.researchgate.net/publication/308964980. (The website was accessed on March 26, 2020.)

[65] Dall'Ora C. "Temporary Staffing and Patient death in Acute Care Hospitals: A Retrospective Longitudinal Study," *Journal of Nursing Scholarship* 2, no. 52, (March 2020): 210-6. https://sigmapubs.onlinelibrary.wiley.com/doi/full/10.1111/jnu.12537. (The website was accessed on March 24, 2020.) Safety concerns were identified with all nursing staff levels including nursing assistants. Ann Page, "Temporary, Agency, and Other Contingent Workers," in *Patient Safety and Quality: An Evidence-Based Handbook for Nurse,* edited by R.G. Hughes, Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 27. https://www.ncbi.nlm.nih.gov/books/NBK2655/. (The website was accessed on March 26, 2020.)

[66] VHA Handbook 1142.01.

As discussed in section 1, the facility relied heavily on the use of registry staff to supplement staffing needs. Overreliance on registry staff can present challenges in providing Facility CLC residents with consistent care. The OIG identified two areas of concern including staff and assignment changes, and limited facility EHR access.

CLC residents with dementia and mental health diagnoses benefit from having the same staff provide care, building relationships with their caregivers and establishing routines. Consistent staff may become adept at recognizing residents' needs and avoiding behavioral triggers for agitation and disruptive behavior.[67] Frequently changing caregivers by using intermittent registry staff results in inconsistent staffing assignments that may then interfere with residents' routines, their development of relationships with caregivers, and may limit staff's ability to proactively identify behavioral triggers.

Lack of EHR Access for Registry Staff

During interviews, staff reported that registry staff did not have VA-issued PIV cards and were unable to access the EHRs of CLC residents at the facility. VA policy provides guidance that persons accessing VA facilities less than 180 aggregated days in a one-year period do not require PIV credentials.[68] A nurse leader stated that registry staff were not provided PIV access since they were not at the facility long-term. Therefore, registry staff could not review the behavioral flags, which provide information regarding a resident's triggers and offer strategies to reduce potential escalations.

The OIG reviewed the terms of the contract for registry staff and found conflicting requirements related to the provision of PIV cards to registry staff. VA may, but is not required to, provide access to the VHA EHR system to registry staff, subject to certain training requirements. However, the contract also states that VA may provide "computer access for performing services required by this contract," and that contracted staff "are responsible for completing all charting documentation while on duty." The Nurse Executive told the OIG that registry staff would receive PIV cards if registry staff were there for "an extended period of time." The Contracting Officer reported the Deputy Nurse Executive did not want registry staff to have PIV cards, but that as of February 5, 2020, 24 new registry staff employees were awaiting PIV clearance.

The OIG also learned that registry staff were unable to review resident care information due to the lack of EHR access and were unable to document the care provided (vital signs and

[67] Muralidharan, A. "Preparing Long-Term care Staff to Meet the Needs of Aging Persons with Serious Mental Illness," 684. https://www.ncbi.nlm.nih.gov/pubmed/31056455. (The website was accessed on March 23, 2020.) Tilly, J. "Dementia care Practice Recommendations for Assisted Living Residences and Nursing Homes—Phases 1 and 2," *Alzheimer's Association*, 2006. https://www.alz.org/media/documents/dementia-care-practice-recommend-assist-living-1-2-b.pdf . (The website was accessed on March 16, 2020.)

[68] VA Directive 0735.

completion of activities of daily living) to each resident. EHR documentation of patient care is an important communication tool to ensure care continuity.[69] Additionally, CLC performance metrics are dependent on EHR documentation. CLC managers and unit-based expert panels rely on these metrics when developing CLC targets.[70] To address this deficiency, nurse managers reported that CLC nursing assistants are paired with registry staff to care for residents. Also, registry staff complete a written account of the care provided to each resident and CLC staff enter this information into the EHR. The written account is later scanned into the record. The OIG determined that the practice limited the ability of registry staff to access information needed to perform their duties and was an inefficient use of CLC staff time, limiting the availability of CLC staff to provide care, and may have affected the accuracy of data used in developing CLC targets.

Use of registry staff is an alternative to staffing units when CLC staffing levels are below those needed to provide patient care and meet NHPPD. When making the decision to use registry staff, nurse managers must consider the consequences of having often changing, unfamiliar staff responsible for much or most of the care for residents. Nurse managers need to assess the effects of doing so and put processes in place to mitigate potential negative impact to residents.[71]

3. Availability of 24-Hour Environmental Management Service at the CLC

The OIG substantiated that 24-hour EMS support was not available at the CLC; however, the OIG found no VHA requirement for 24-hour coverage. Although EMS did not have a staff member consistently dedicated to the CLC during off tours, EMS services were available as needed.[72] The OIG found that CLC staff were unclear how to contact EMS during off-tour hours.

VHA policy designates responsibility to EMS for ensuring a state of physical and biological cleanliness at VA medical facilities; however, the policy is not prescriptive regarding how to accomplish this goal.[73] During OIG interviews, CLC staff provided varied answers regarding when EMS staff were available to the CLC and how to contact them when needed. Understanding ranged from not having 24-hour EMS support available to various methods regarding how to contact EMS. Additionally, CLC staff raised concerns that EMS staff did not answer calls.

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[69] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[70] VHA Handbook 1142.02. VHA Directive 1351. VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[71] Ann Page, "Temporary, Agency, and Other Contingent Workers."

[72] Off tours include the evening shift which occurs from 3:30 p.m. until midnight, and night shift, which occurs from midnight until 8:30 a.m.

[73] VHA Directive 1850.

The Chief of EMS told the OIG that due to EMS staffing shortages, the CLC did not have designated EMS staff assigned for off tours between February 2018 and September 2019. However, CLC staff were provided with the EMS shift supervisor contact information to access EMS 24 hours a day. Although OIG team members found EMS contact information posted on both floors when they toured the CLC, the multiple postings had different telephone numbers and a lack of information specific to shift coverage making it difficult to determine the correct point of contact. The OIG team was present when a CLC manager called one of the posted numbers during an off tour; an EMS staff member responded to the test call. The OIG determined that EMS support was available to CLC staff, but CLC nursing staff were unclear as to how to contact EMS during off-tour hours.

4. Unclean Conditions and Infestation of Insects in the CLC

The OIG did not substantiate that the CLC was dirty; however, the OIG substantiated the presence of flying insects in the CLC. Flying insects were noted in hallways, residents' rooms, and in a resident's shower.[74]

VHA policy requires facilities "provide a safe, clean, functional, and high-quality environment for veterans, their families, visitors, and employees."[75] Additionally, facilities are required to establish and maintain an Integrated Pest Management Operating Plan to "promote safe, efficient, and environmentally-preferred strategies, and [prevent or control] disease vectors and other pests."[76] The facility had a plan in place that required all pest sightings be documented and tracked on a Pest Sighting Log sheet.

During interviews, facility leaders discussed awareness of general cleanliness issues in the CLC and acknowledged a recent focus on addressing these concerns and improvement. Facility leaders implemented changes including dedicated CLC EMS supervisors, work leaders, and EMS staff, as well as a team-clean approach to improve cleanliness.[77] Additionally, the Chief of EMS stated as EMS increases staff, additional dedicated EMS staff would be assigned to the CLC.

A facility leader and several managers stated the presence of flying insects was an ongoing problem in the CLC. Managers attributed this problem to residents being allowed to have food in their rooms in order to create a home-like environment. A VISN audit report and facility

[74] The OIG team toured the CLC on December 12, 2019, February 2, 2020, and February 5, 2020.

[75] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

[76] VHA Directive 1850.02(1), *Pest Management Operation*s, April 6, 2017, amended October 30, 2018.

[77] The Chief of EMS explained that "team clean" consisted of 10 to 15 EMS staff from other areas coming to the CLC on weekdays for an hour to assist with washing walls, cleaning base boards, handrails, window seals, dining rooms, dividers in dining rooms, elevators, restrooms, and resident rooms.

managers identified open doors and windows as additional factors that may have contributed to the presence of flying insects.

The OIG reviewed the facility's Integrated Pest Management Operations Plan and found that the Chief of EMS kept an active Pest Sighting Log to track pest sightings and action items, and that an exterminator consistently evaluated the CLC.

In August 2019, facility and CLC leaders developed an action plan to address the ongoing presence of flying insects in the CLC. The plan included the installation of bug lights throughout the CLC and conducting walking rounds three times a month to assess the presence of flying insects. The OIG interviewed facility staff and reviewed documents and determined that bug lights had been purchased but not installed. The Associate Director attributed the installation delays to the CLC building's electrical system being unable to support the bug lights and made the decision to order battery operated lights. The battery-operated lights had been received and were ready for installation in CLC rooms. However, as of February 4, 2020, the battery-operated bug lights had not been installed because facility leaders had not determined which service line would be responsible for maintaining the lights.

The OIG determined that walking rounds were only occurring monthly. A CLC leader informed the OIG that nurse managers had not conducted rounding three times per month as outlined in the action plan due to confusion related to rounding frequency. The CLC manager reported as of March 2020, weekly rounding was occurring using a streamlined audit tool that included observations for flying insects. Selected staff completed the weekly audits. The completed audit tool was then submitted to a CLC quality improvement nurse who compiled the data and reported this information monthly to facility leaders.

5. CLC Staff Noncompliance with Hand-Hygiene Practices

The OIG substantiated that CLC staff were not consistently meeting the facility hand-hygiene compliance goal of 90 percent. The OIG found that although the facility monthly monitoring process was in place, CLC leaders and quality improvement staff did not consistently monitor CLC staff for compliance.

The Centers for Disease Control, VHA, and facility policy require that healthcare workers with direct patient contact use an alcohol-based hand rub or antimicrobial soap and water to decontaminate their hands before and after having contact with a resident. These products must be available at the point of resident care.[78] VHA policy requires each VA medical facility to

[78] VHA Directive 1131(2), *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 07, 2017. Center for Disease Control. Guideline for Hand Hygiene in Health Care Settings, https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm. (The website was accessed on February 11, 2020.) Facility Memorandum 111W-03, *Infection Control Required Hand Hygiene Practices*, August 16, 2017.

establish a hand-hygiene program to monitor and track compliance and provide feedback to staff.[79] Facility policy requires nurse managers and quality improvement staff monitor adherence to hand-hygiene practices, and as part of the infection control plan, compliance data are reported to the Infection Control Committee on a quarterly basis.[80]

The OIG reviewed the facility's Infection Control Program hand-hygiene data for each CLC floor for eight quarters from October 1, 2017, through September 30, 2019. CLC ground floor staff did not report data for four of the eight quarters; of the four quarters reported, two met the facility hand-hygiene compliance rate. CLC first floor staff reported data that met the facility hand-hygiene compliance rate in four of the eight quarters.[81] Data provided to the OIG demonstrated inconsistent hand-hygiene monitoring and tracking by the CLC ground floor. An infection control manager attributed the CLC's lack of tracking hand-hygiene compliance to staff turnover amongst CLC leaders and CLC floor hand-hygiene champions who monitored compliance.[82] The OIG found that infection control staff reported available CLC hand-hygiene data quarterly to the Infection Control Committee.

In August 2019, facility and CLC leaders developed an action plan to address hand-hygiene noncompliance that included reeducating staff on proper hand-hygiene practices and conducting unannounced weekly observation rounds. The OIG reviewed documentation that reported all CLC staff were reeducated about hand-hygiene practices in August 2019. However, monitoring audits from August 2019 indicated that staff hand-hygiene compliance remained below 90 percent. Proper hand hygiene and measuring adherence to hand hygiene reduces healthcare-associated infection rates.

During interviews, facility leaders acknowledged that CLC staff continued to be inconsistent with hand-hygiene compliance. Facility staff identified a contributing factor was low CLC staffing levels, so staff were too busy to wash their hands. Additionally, a facility manager and staff noted that alcohol-based hand rub dispensers were frequently empty or broken. The OIG confirmed this during environment of care CLC rounds in December 2019. EMS leaders informed the OIG that EMS staff check and fill dispensers during their daily rounds, and staff may call and notify EMS when dispensers need maintenance. EMS leaders could not provide reasons why the process was not working. The OIG conducted additional tours of the CLC during the February 2020 site visit and found that all tested dispensers were filled with gel and working properly.

[79] VHA Directive 1131(2).

[80] Facility Memorandum 111W-03.

[81] The OIG found CLC staff hand-hygiene compliance ranged from 63 percent to 100 percent.

[82] Hand-hygiene champions are staff within a service area designated to monitor hand-hygiene compliance through observation and report data to the infection control staff.

6. Infectious Disease Outbreaks Resulted in CLC Floor Closures

The OIG substantiated that one or both CLC floors closed to admissions and visitors on six different occasions between January 3, 2018, and September 3, 2019, due to infectious disease.[83] The OIG determined that staff followed facility infection control processes, such as surveilling for new cases and closing the units to admissions and visitors, to contain and minimize additional exposures during the outbreaks.

VHA policy states that during an outbreak or epidemic the chairperson of the Infection Prevention and Control Committee has the authority to "implement strategies for prevention and control of disease directed towards patients/residents, visitors, employees, and others." VHA policy allows facility leaders to implement outbreak control measures "if there is a suspicion or evidence of transmission of an epidemiologic significant pathogen or communicable disease."[84]

The OIG reviewed the infection control documents. During interviews, managers expressed concerns that noncompliance with hand hygiene and lack of adequate EMS staff and cleaning processes may have contributed to the number and length of outbreaks. The OIG did not find sufficient evidence to confirm or discount these reasons for the occurrences or length of outbreaks.

The CLC is an area with many visitors of all ages and demographics, and exposures are difficult to prevent. The OIG recognizes that closures are disruptive to residents and families; however, these steps may be necessary to limit potential exposure to others.

7. Other Finding: Contract Registry Agency Oversight

During the inspection, facility managers and staff raised concerns about having only one contracted registry agency. The OIG found that the registry agency was not consistently supplying the requested number of nursing assistants to the facility and that VISN and facility contract staff were aware of these deficiencies. The OIG also identified that the Nurse Resource Manager (Resource Manager), who also served as the Coordinator, did not consistently track the number of requested and supplied registry staff.

Facility managers reported that the registry agency did not supply the requested number of nursing assistants per shift. The CLC Chief reported that from March through May 2019, CLC nurse managers requested 10–12 registry staff each day but were sent five.

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[83] None of the outbreaks mentioned in this report were related to COVID-19. This inspection reviewed events and infection control policy in effect through February 2020, and did not review COVID-19-related policies.

[84] VHA Directive 1131(2). Epidemiology is the method used to find the causes of health outcomes and diseases in populations. Centers for Disease Control and Prevention, *Epidemiology*, https://www.cdc.gov/careerpaths/k12teacherroadmap/epidemiology.html. (The website was accessed on February 27, 2020.)

The OIG reviewed correspondence between the Resource Manager and the registry agency and found that the Resource Manager notified the registry agency regarding staffing deficiencies beginning in January 2019. The registry agency identified that the gaps occurred primarily on evening shifts and weekends; however, the Resource Manager reported gaps during all days and shifts.

The Resource Manager notified the VISN and facility contract staff of the staffing deficiencies. The Contracting Officer reported that the registry agency acknowledged difficulties in providing the requested number of registry staff on weekends and night shifts.

The OIG found that the lack of adequate and consistent staffing for the contracting officer representative position hindered communication regarding adequate staffing by the registry agency. According to the Contracting Officer, the contracting officer representative position experienced turnover and was staffed by individuals who were not skilled to manage the contract. Additionally, the Contracting Officer reported that while the registry agency was responsible for staffing gaps, nurse managers were not attending meetings to resolve issues with the registry agency.

The OIG identified that the Resource Manager did not adequately track the use of registry staff nor clearly identify staffing shortages consistently. The facility's Resource Manager reported tracking the number of requested and supplied registry staff. The OIG reviewed the Resource Manager's documentation and found that tracking did not begin until June 2019 and was sporadic. Between June 2019 and December 2019, the Resource Manager did not track the coverage gap for 22 days, frequently did not track all three shifts, and for those days that were partially tracked, did not consistently track the number of registry staff provided for each shift. The OIG concluded from the days that were tracked that on most days the registry agency failed to provide the requested number of registry staff per the contract.

Conclusion

Facility leaders failed to adequately address known CLC nurse staffing shortages and continued to accept admissions as evidenced by maintaining a high resident census. CLC managers were unable to meet the NHPPD target. CLC managers struggled with significant nursing assistant vacancies and increasingly relied on registry staff to supplement staffing while maintaining a high resident census in the CLC. During the inspection, the OIG identified concerns about the Coordinator's insufficient knowledge of staffing methodology. Facility leaders did not provide the CLC with the attention necessary to address the staffing shortages.

The OIG was unable to determine if insufficient staffing levels at the CLC led to adverse events or the inability to manage residents with disruptive behaviors. A variety of contributory factors can impact resident outcomes and quality of care making it difficult to conclusively attribute the events to staffing. The facility may have missed an opportunity for improvement by not initiating

a root cause analysis to further understand all potential elements contributing to a missing resident event. Registry staff did not have VA-issued PIV cards and were unable to access the EHRs of CLC residents at the facility, which limited their ability to document the provision of care.

Twenty-four-hour EMS dedicated support was not consistently available at the CLC; however, the OIG found no VHA requirement for 24-hour coverage. CLC staff were unclear how to contact EMS when they were needed, and dedicated EMS staff were not assigned to the CLC.

The OIG did not substantiate that the CLC was dirty; however, the OIG substantiated the presence of flying insects in the CLC. Flying insects were present in hallways, residents' rooms, and in a resident's shower.

CLC staff did not consistently meet the facility hand-hygiene compliance goal of 90 percent. Although a facility monthly monitoring process was in place, CLC staff were not consistently monitored for compliance.

One or both CLC floors were closed to admissions and visitors on six different occasions. The OIG determined that staff followed identified processes and protocols to contain and minimize additional exposures during the outbreaks.

During the inspection, managers and staff raised concerns about having only one contracted registry agency. The registry agency was not consistently supplying the requested number of nursing assistants to the facility and the VISN and facility contract staff were aware of these deficiencies. The Resource Manager did not consistently track the number of requested and supplied registry staff.

Recommendations 1–10

1. The San Francisco VA Health Care System Director ensures that the Associate Director for Patient Care Services performs a comprehensive review of Community Living Center nurse staffing methodology, retrains the Nurse Staffing Methodology Coordinator, and develops staffing methodology processes that reflect the needs of the Community Living Center.

2. The San Francisco VA Health Care System Director continues efforts to recruit and hire for Community Living Center nursing assistants and ensures that alternate staffing strategies are consistently available to meet target nursing hours per patient day until optimal staffing is attained.

3 The San Francisco VA Health Care System Director confers with facility nursing leadership and the Office of Human Resource Management to identify and mitigate barriers to nursing assistant staff retention and recruitment and takes appropriate action.

4. The San Francisco VA Health Care System Director consults with VA Sierra Pacific Network and VA Central Office to determine the number and status of approved Community Living Center operating beds and takes action as appropriate.

5. The San Francisco VA Health Care System Director ensures a review of the episode of care related to Resident B's elopement to determine if a formal quality management review is needed and takes action accordingly.

6. The San Francisco VA Health Care System Director evaluates the requirement for Community Living Center registry nursing assistant staff access to the electronic health record system, involving the Office of General Counsel and the Network Contracting Office 21 as appropriate and takes action if needed.

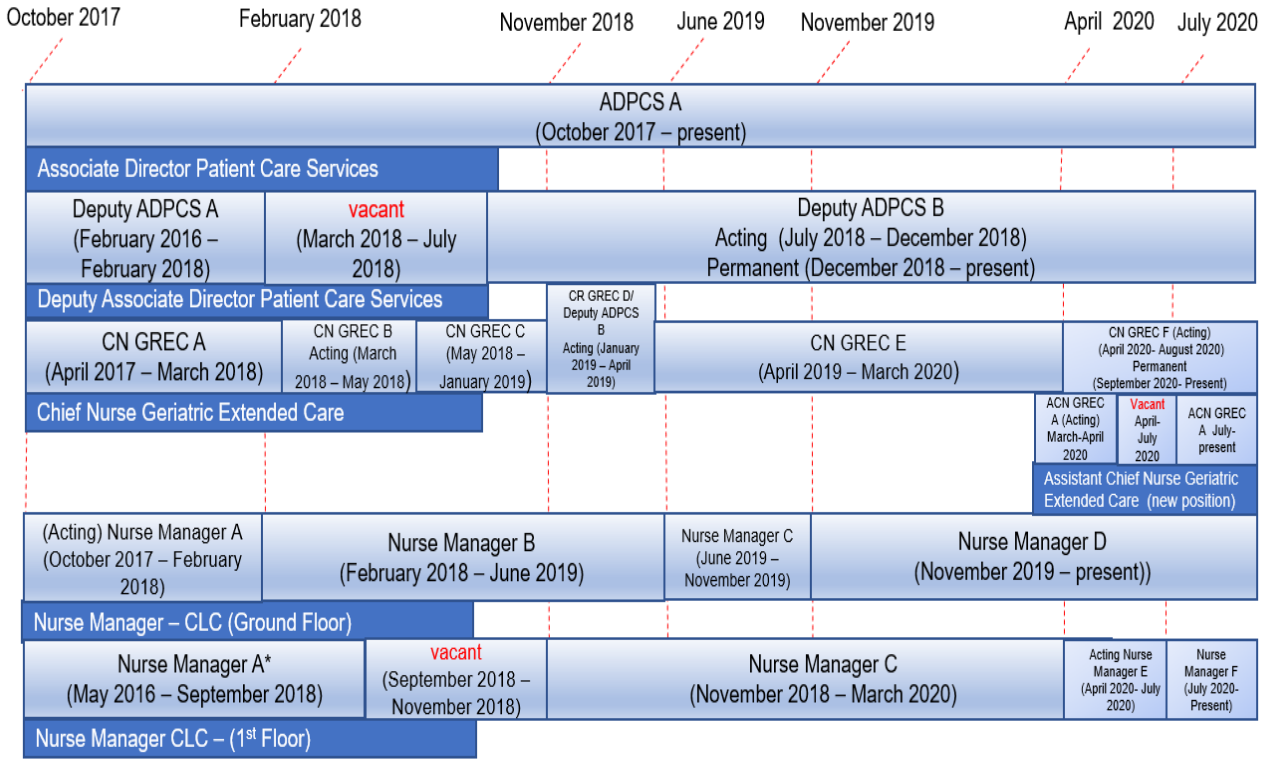
7. The San Francisco VA Health Care System Director ensures that Environmental Management Services provides Community Living Center staff a clear communication pathway to request assistance for all shifts and confirms its functionality.

8. The San Francisco VA Health Care System Director establishes comprehensive quality monitoring of the ongoing issue of the presence of flying insects in the Community Living Center, and monitors compliance.

9. The San Francisco VA Health Care System Director ensures that Community Living Center staff adhere to Veterans Health Administration hand-hygiene policies and ensures that corrective actions are initiated when hand-hygiene performance falls below established thresholds.

10. The San Francisco VA Health Care System Director ensures a comprehensive review of the registry agency agreement for performance, the provision of nursing assistants as requested, and determines if the agreement meets the needs of the Community Living Center.

Appendix A: Facility and CLC Leader Changes



Source: VA OIG analysis of facility data

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 11, 2020

From: Director, VA Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California

To: Director, Office of Healthcare Inspections, Alison Loughran (54HL07)

Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

Thank you for the opportunity to review the draft report on this hotline case. Attached is the action plan from the facility with their response to the recommendations identified in the report.

Should you have any questions please contact the Deputy Quality Manager for the Network.

(*Original signed by*:)

John A. Brandecker
Network Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 11, 2020

From: Director, San Francisco VA Health Care System, San Francisco, CA (662)

Subj: Healthcare Inspection—Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California

To: Director, VA Sierra Pacific Network (10N21)

I have reviewed and concur with the findings and recommendations made in response to the Office of the Inspector General's Healthcare Inspection of the Community Living Center within the San Francisco VA Health Care System.

Attached is the action plan in response to the recommendations submitted as a result of the healthcare inspection conducted in response to Nurse Staffing, Patient Safety, and Environment of Care Concerns at the Community Living Center within the San Francisco VA Health Care System in California.

For questions regarding this matter, please contact the Chief of Quality Management Service.

(*Original signed by*:)

Bonnie S. Graham, MBA
Health Care System Director

Facility Director's Response

Recommendation 1

The San Francisco VA Health Care System Director ensures that the Associate Director for Patient Care Services performs a comprehensive review of Community Living Center nurse staffing methodology, retrains the Nurse Staffing Methodology Coordinator, and develops staffing methodology processes that reflect the needs of the Community Living Center.

Concur.

Target date for completion: October 30, 2020

Director Comments

Immediately in January 2020, the Associate Director for Patient Care Services (ADPCS) sought counsel from the Office of Nursing Service (ONS) Staffing Methodology Coordinator Group and in February visited another Community Living Center (CLC) Chief Nurse and staffing methodology coordinator, who reviewed with the ADPCS our current staffing methodology. After this was validated, Nursing Hours Per Patient Day (NHPPD) daily monitoring of past and future 24 hours was instituted in nursing morning report for early identification of challenges. Staffing Methodology Coordinator has received monthly individual and group training and consult from the ONS Staffing Coordinator Group. All questions have been checked through ONS and Veterans Integrated Service Network (VISN) Staffing Methodology Coordinating Groups. As a result, CLC has been consistently staffed within the national 10% variance target since March of 2020. Sustaining these efforts, as CLC staffing methodology 2021 has been prepared further training needs were identified. The Staffing methodology coordinator as well as the CLC quality improvement nurse, the Minimum Data Set (MDS) nurse, and the ADPCS Executive Assistant have scheduled additional training in Resource Utilization Groups, the new ONS CLC Complexity Tool, and Staffing Methodology to be completed by October 30, 2020. As an additional step, the final CLC staffing methodology for FY2021 has also been sent to another VA for outside review.

Recommendation 2

The San Francisco VA Health Care System Director continues efforts to recruit and hire for Community Living Center nursing assistants and ensures that alternate staffing strategies are consistently available to meet target nursing hours per patient day until optimal staffing is attained.

Concur.

Target date for completion: August 25, 2020

Director Comments

The CLC and the recruitment team has been effective in reducing our vacancy rate from 45% in October 2019 to 9% as of August 2020. The average vacancy rate for the past three months has been 13.2%. Based on daily review of staffing needs, CLC Nurse Leaders have access to established hospital/CLC nursing assistant float pool, intermittent CLC nursing assistant pool, and overtime as necessary. We are meeting staffing needs and have reduced bed occupancy accordingly.

To expand recruitment channels, we have partnered with the San Francisco Office of Economic and Workforce Development to receive newly trained Nursing Assistants and offer job opportunities. Student Nursing Technician (SNT) program was instituted in December of 2019. SFVA partnered with University of San Francisco, Samuel Merritt University and San Francisco State University to recruit students currently completing BSN or MSN course of study.

OIG Comments

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

Recommendation 3

The San Francisco VA Health Care System Director confers with facility nursing leadership and the Office of Human Resource Management to identify and mitigate barriers to nursing assistant staff retention and recruitment and takes appropriate action.

Concur.

Target date for completion: March 31, 2020

Director Comments

From March 2020 to August 2020 a total of 18.2 FTE nursing assistants were hired and were granted ten percent recruitment incentives. 61.0 FTE nursing assistants currently on board receive ten percent retention incentives. The recruitment and retention incentives will be ongoing.

OIG Comments

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

Recommendation 4

The San Francisco VA Health Care System Director consults with VA Sierra Pacific Network and VA Central Office to determine the number and status of approved Community Living Center operating beds and takes action as appropriate.

Concur.

Target date for completion: November 30, 2020

Director Comments

The authorized beds remain at 120. CLC's Average Daily Census (ADC) in December 2019 was 94.5, we have capped the CLC ADC to 80 based on staffing. The CLC's ADC has maintained between 70-80 for the past 6 months. Facility leadership will discuss further with the VISN whether there is a need to submit a change in bed status to VACO.

Recommendation 5

The San Francisco VA Health Care System Director ensures a review of the episode of care related to Resident B's elopement to determine if a formal quality management review is needed and takes action accordingly.

Concur.

Target date for completion: March 31, 2020

Director Comments

A focused review of the episode of care on Resident B's elopement was immediately conducted by the Cognitive Ability Life Meaning (CALM) dementia interdisciplinary team. Specific intervention to prevent Resident B's elopement included medication readjustments, 1:1 continuous patient assistant as needed, and relocated resident to first floor. The review identified the general need to improve the CLC access control. Security officers cover the 24/7 front desk which is now the single point of entry. Since this implementation there has not been any elopement.

OIG Comments

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

Recommendation 6

The San Francisco VA Health Care System Director evaluates the requirement for Community Living Center registry nursing assistant staff access to the electronic health record system, involving the Office of General Counsel and the Network Contracting Office 21 as appropriate and takes action if needed.

Concur.

Target date for completion: August 31, 2020

Director Comments

To ensure the delivery of quality and safe care, CLC has ceased the use of registry nursing assistants. All CLC nursing assistants have full access to the electronic health record system.

OIG Comments

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

Recommendation 7

The San Francisco VA Health Care System Director ensures that Environmental Management Services provides Community Living Center staff a clear communication pathway to request assistance for all shifts and confirms its functionality.

Concur.

Target date for completion: March 31, 2020

Director Comments

To streamline the communication pathway between EMS and CLS staff, an EMS Supervisor attends the daily Nursing leadership huddle to address any housekeeping concerns in real time. The Chief of EMS meets weekly with the CLC Business Manager to ensure CLC environmental service needs are met. The Chief of CLC in the biweekly meetings with the Deputy Director has a standing item on the meeting agenda to report any outstanding environmental and/or support service issue as an escalation venue. These communication pathways allows for timely response at all levels.

OIG Comments

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

Recommendation 8

The San Francisco VA Health Care System Director establishes comprehensive quality monitoring of the ongoing issue of the presence of flying insects in the Community Living Center, and monitors compliance.

Concur.

Target date for completion: March 31, 2020

Director Comments

Upon identifying the presence of flying insects, EMS immediately initiated a daily team clean with 15 EMS staff for a two-month period to ensure thorough cleaning was completed in the CLC. Since then EMS has been fully staffed and supplemented additional contract staff to ensure all cleaning needs are met timely. Currently, 9 EMS workers and 2 contactors serving the CLC, this represents approximately a 50% increase in EMS staffing.

To monitor compliance, all CLC staff are expected to conduct daily visual inspections for the presence of items that would attract flying insects. The CLC has identified Environment of Care (EOC) Champions for each of the four wards. Environmental Management Services, when notified by CLC staff, performs a thorough bleach cleaning of non-compliant rooms. The CLC Nurse Managers and/or Assistant Nurse Managers discuss findings with staff during monthly staff meetings. No complaints of flying insects mentioned during resident council in past six months.

OIG Comments

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

Recommendation 9

The San Francisco VA Health Care System Director ensures that Community Living Center staff adhere to Veterans Health Administration hand-hygiene policies and ensures that corrective actions are initiated when hand-hygiene performance falls below established thresholds.

Concur.

Target date for completion: January 31, 2021

Director Comments

CLC hand hygiene is a focused metric that has been further monitored since January 2020. CLC's first floor has reached the 90% compliance threshold 4 out of the last 4 months. The ground floor has been averaging 83.6% for the past 5 months.

To continually improved, every floor now has 2 Champions to conduct unannounced weekly monitoring. The Nurse Managers receive the hand hygiene monitoring reports and discuss the results both in the bi-weekly CLC Survey Readiness meeting and the monthly staff meeting for sustained compliance and awareness.

Recommendation 10

The San Francisco VA Health Care System Director ensures a comprehensive review of the registry agency agreement for performance, the provision of nursing assistants as requested, and determines if the agreement meets the needs of the Community Living Center.

Concur.

Target date for completion: August 31, 2020

Director Comments

The CLC leadership has ceased registry nursing assistant usage in the CLC. Current nursing assistants are trained and expected to perform at a full performance level of their functional statements.

OIG Comments

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

OIG Contact and Staff Acknowledgments

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