Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Oversight of the Community Nursing Home Program Oklahoma City VA Medical Center Oklahoma City, Oklahoma

Report No. 08-02526-39 **December 8, 2008**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of the review was to determine the validity of allegations concerning inadequate oversight provided to veterans in the Community Nursing Home (CNH) Program at Oklahoma City VA Medical Center in Oklahoma City, Oklahoma.

We did substantiate allegations regarding the lack of a CNH Oversight Committee and a CNH Review team as required by Veterans Health Administration (VHA) Handbook 1143.2. The CNH Program was not in compliance with the VHA policy requirement that a nurse or social worker visit patients in CNH facilities on a regular basis. Further, the medical center was not in compliance regarding ongoing monitoring of exclusion criteria for nursing facilities when participating in the CNH Program.

We did not substantiate falsification of documentation in the 97 medical records we reviewed, or that limits had been placed on the number of nursing homes that could participate in the CNH Program.

We substantiated a need for CNH staff education and training; however, medical center managers were taking action to address these deficiencies.

We recommended that the Veterans Integrated Service Network (VISN) Director ensure that the Medical Center Director implements processes to establish both a CNH Oversight Committee and a CNH Review Team and require CNH Program compliance with VHA Handbook 1143.2 regarding follow-up visits every 30 days and ongoing monitoring and evaluation of exclusion criteria.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N16)

SUBJECT: Healthcare Inspection – Oversight of the Community Nursing Home Program, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted a review to determine the validity of allegations concerning inadequate oversight provided to veterans in the Community Nursing Home (CNH) Program at Oklahoma City VA Medical Center located in Oklahoma City, Oklahoma.

Background

The medical center is a tertiary care facility that provides a full range of healthcare services in medicine, surgery, mental health, and rehabilitation medicine. The medical center is also a major referral center and has contracts with 11 nursing facilities within the service area. The medical center is part of Veterans Integrated Service Network (VISN) 16.

The OIG Hotline Division received a complaint that alleged the medical center's CNH Program did not provide adequate staff supervision and that potential falsification of veteran medical records exists. According to the complainant, the medical center is not in compliance with Veterans Health Administration (VHA) Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* issued June 4, 2004, that describes specific standards and guidelines for facilities to incorporate in the CNH Program.

Scope and Methodology

We interviewed the complainant, CNH staff, and medical center staff. We reviewed CNH policies and procedures, quality management (QM) data, and CNH committee minutes. We also reviewed the medical records for 97 veterans in the CNH program during the period of Oct 1, 2006, through June 30, 2008.

On July 21–25, 2008, we conducted onsite reviews at five CNH facilities where medical center patients were residents. We observed the environment of care, communication between patients and staff, patient hygiene and physical appearance, and patient activities. We interviewed physicians and nursing staff who were involved in the care of the patients. In addition, we reviewed the Centers for Medicare and Medicaid Services (CMS) information for the five CNH facilities. This includes CMS' Nursing Home Compare database,[1] which also includes the Minimum Data Set Quality Indicator Profile.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: CNH Follow-Up Visits/ Medical Record Falsification

Medical center staff did not conduct follow-up visits every 30 days as directed in VHA Handbook 1143.2. The handbook states that a registered nurse (RN) or social worker (SW) must visit the patients in CNHs at least every 30 days, except when specific criteria apply. SWs and RNs are to alternate monthly visits unless otherwise indicated by the patient's visit plan. The purpose of these visits is to assess the overall quality of care provided in the CNH and to evaluate the medical center's patients. Accuracy and timeliness of documentation of the visits are important to monitor the patient's medical condition and coordination of care.

We reviewed the medical records of 97 CNH patients and did not find documentation of regular monthly visits by the SW or RN. We found that the SW only made 120 (37 percent) of the 323 required site visits and the RN only 52 (16 percent) of the 322 required site visits. There was no indication of falsification of medical record documentation in the 97 patient records we reviewed. However, we did find that medical record progress notes did not always contain relevant clinical updates on the patient's condition.

Issue 2: Oversight of the CNH Program

The Medical Center Director had not established two separate entities, a CNH Oversight Committee and a CNH Review Team as required by VHA Handbook 1143.2. Instead, the Director established a single committee which acted as both the CNH Oversight Committee and the CNH Review team. However, because the oversight committee is responsible for oversight of the work of the CNH Review Team, they need to be separate entities.

[1] This data is available at http://www.medicare.gov/nhcompare/home.asp.

Medical center CNH committee members did not consistently analyze Nursing Home Compare information and Minimum Data Set Quality Indicator Profile data from state survey reports.

The VHA Handbook states that the Oversight Committee should consist of multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and medical staff. The committee oversees the structure and methodology of the CNH Review Team and ensures a plan for quality monitoring is implemented. Although the medical center's CNH committee had management-level representatives from all the required entities, we found that the medical staff representative was never listed as an attendee in the 2 years of minutes we reviewed.

The CNH Review Team is responsible for the evaluations and inspections of nursing homes as well as ongoing monitoring and follow-up visits with patients who reside in the nursing homes. When making decisions for continuation of a CNH's participation with the medical center, the CNH Review Team is to consider deficiencies, staffing, and quality measure information from Nursing Home Compare; concerns from patients, families, and ombudsman offices; and findings from its own experience through the monthly monitoring process. VHA Handbook 1143.2 states that nursing facilities are to be excluded from participating in the CNH Program if the facility does not meet state requirements in four of seven CMS review standards. The medical center did not consistently analyze the most recent available information before a contract was renewed and during annual inspections to determine whether factors for exclusion from the program applied

From Oct 1, 2006, through June 30, 2008, the medical center had contracts with 11 nursing facilities. Reviews of exclusion factors were conducted on an annual basis however; quarterly reviews were stopped prior to February 2007. The CNH Review Team did not follow up on the facilities' corrective action plans to address deficiencies. Contracts with nursing facilities were continued despite noncompliance with state standards.

The CNH Review Team also approved decisions to provide additional CNHs as they became available in the service area. We found no indication that new CNHs contracts were limited.

Issue 3: CNH Program Staff Education and Training

The newly appointed CNH Coordinator identified the need for staff education and training. The CNH Coordinator and other medical center staff stated they were developing education and training programs to address staff competency deficiencies and initiating actions to strengthen the quality of the CNH patient follow-up process.

Conclusions

We concluded that the medical center had not established a CNH Oversight Committee and a CNH Review team as required by VHA Handbook 1143.2. The CNH Program was not in compliance with VHA policy requirement that a nurse or social worker visit patients in CNH facilities on a regular basis. Further, the medical center was not in compliance with VHA Handbook 1143.2 regarding ongoing monitoring of exclusion criteria for nursing facilities when participating in the CNH Program.

We did not substantiate falsification of documentation in the 97 medical records we reviewed, or that limits had been placed on the number of nursing homes that can participate in the CNH Program.

We identified a need for CNH staff education and training; however, medical center managers were taking action to address these deficiencies.

Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director establish both a CNH Oversight Committee and a CNH Review Team as required by VHA Handbook 1143.2.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires CNH Program compliance with VHA Handbook 1143.2 regarding follow-up visits every 30 days and ongoing monitoring.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires CNH Program compliance with VHA Handbook 1143.2 regarding CNH ongoing evaluation of exclusion criteria.

Comments

The VISN and Medical Center Directors concurred with the finding and recommendation of this inspection and provided acceptable improvement plans (see Appendixes A & B, pages 5─8, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 26, 2008

From: Director, Veterans Integrated Service Network (10N16)

Subject: **Healthcare Inspection – Oversight of the Community Nursing Home Program, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Office (10B5)

1. The South Central VA Health Care Network (VISN 16) has reviewed the response from the Oklahoma City VA Medical Center and concurs with the response.

2. If you have any questions, please contact Donna DeLise, Director, Office of Performance, Oklahoma City VAMC, at 405-456-3312.

(*original signed by*:)

George H. Gray, Jr.
VISN 16 Network Director

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 26, 2008

From: Director, Oklahoma City VA Medical Center (635/00)

Subject: **Healthcare Inspection – Oversight of the Community Nursing Home Program, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma**

To: Director, Veterans Integrated Service Network (10N16)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the healthcare quality for our Veterans.

2. I concur with the findings and recommendations of the Community Nursing Home Program HealthCare Inspection Team. The specific actions taken for the recommendation are on the following page.

3. If you have any questions, please contact Donna DeLise, Director. Office of Performance and Quality, at (405) 456-3312.

David Wood

David P. Wood MHA, FACHE
Medical Center Director

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Director takes action to establish a CNH Oversight Committee and CNH Review Team in compliance with VHA Handbook 1143.2.

Concur **Target Completion Date:** January 2009

Team members have been selected for the CNH Oversight Committee and the CNH Review Team in accordance with VHA Handbook 1143.2. Both teams will be up and running with the first meeting no later than January 2009.

Recommendation 2. We recommended that the Director ensure that the Medical Center Director requires CNH Program compliance with VHA Handbook 1143.2 regarding follow-up visits every 30 days and ongoing monitoring.

Concur **Target Completion Date:** October 2008

An auditing/monitoring tool to ensure follow-up visits are made every 30 days, according to VHA Handbook 1143.2 was initiated in October 2008.

Completed: October 2008

Recommendation 3. We recommended that the Director ensure that the Medical Center Director requires CNH Program compliance with VHA Handbook 1143.2 regarding CNH ongoing evaluation of exclusion criteria.

Concur **Target Completion Date:** January 2009

Chief, Social Work is designating a Social Worker (Team Lead for CNH Review Team) who will be dedicated to CNH ongoing evaluation of exclusion criteria and compliance with VHA Handbook 1143.2.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Karen Moore Dallas Office of Healthcare Inspections (214) 253-3332
Acknowledgments	Linda DeLong George Wesley, M.D.

Appendix D

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