US DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Improvements in Patient Safety, but Concerns Identified with Staffing Shortages Affecting Quality of Care at the VA Community Living Center in Miles City, Montana

Healthcare Inspection | **24-01751-39** | **January 28, 2025**

BE A

VOICE FOR VETERANS

REPORT WRONGDOING

vaoig.gov/hotline | **800.488.8244**

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Visit our website to view more publications.
vaoig.gov

Executive Summary

The VA Office of Inspector General (OIG) conducted a follow-up healthcare inspection in response to a 2023 OIG report regarding mistreatment of a resident at the Miles City VA Community Living Center (CLC) and the Fort Harrison VA Medical Center (facility), part of the Montana VA Healthcare System (system).[1] The OIG did not receive new allegations but initiated the inspection to review the current state of the CLC, including corrective actions and sustainability of changes implemented by system leaders. During the inspection, the OIG found staffing shortages affecting the quality of care for CLC residents.

The 2023 OIG report substantiated an allegation of resident mistreatment. Specifically, the OIG found that on two occasions, the CLC physical therapist obtained assistance from CLC nursing staff to force the resident to participate in physical therapy after the resident refused. The OIG determined that CLC staff did not report the incidents, as required, and identified issues related to facility oversight processes regarding the incidents and a pattern of resident mistreatment in the CLC, and facility leaders' noncompliance with state licensing board reporting requirements. The OIG made seven recommendations and all recommendations were considered closed as of May 9, 2024.[2]

1. Sustained Actions in Response to Patient Safety Concerns

Due to the severity of the concerns identified in the prior report, the OIG initiated this follow-up inspection to review the areas of concern in the CLC specific to rights of residents to refuse treatment, patient safety reporting, screening and admissions, physician care oversight and documentation, and nursing care operations. The OIG determined system leaders' actions to address CLC deficiencies were sustained; therefore, the OIG does not have recommendations related to these issues.

Residents' Right to Refuse Treatment

The OIG confirmed that Veterans Integrated Service Network (VISN) and facility staff provided oversight and patient safety training.[3] During interviews, CLC staff confirmed receiving this training and relayed knowledge to the OIG regarding residents' right to refuse treatments.

---

[1] VA OIG, *Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison*, Report No. 22-01341-43, January 26, 2023.

[2] VA OIG, *Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison*.

[3] A VHA and VISN review, after the OIG's March 2022 on-site inspection identified quality of care concerns and resulted in a temporary closure of the CLC in mid-April 2022. During the closure, VISN and facility staff provided oversight and training to CLC staff, including abuse reporting and environment of care, and the CLC reopened in September 2022.

Patient Safety Reporting

Staff indicated knowledge and use of patient safety reporting mechanisms and cited no concerns of retaliation for reporting events. The OIG reviewed patient safety reports from September 1, 2022, through April 4, 2024, and identified one incident of suspected abuse. The OIG found facility leaders followed applicable processes and actions to address the allegation. In addition, all 14 CLC residents reported having no concerns or complaints related to mistreatment, feeling they were being treated with respect and receiving the care they needed.

Screening and Admissions

The Veterans Health Administration (VHA) VHA requires that the CLC medical director, in collaboration with the CLC nurse leader, oversees "the CLC admissions process and facilitating appropriate admissions into the CLC."[4] The CLC physician told the OIG that the interdisciplinary team discusses and finalizes admissions. The OIG reviewed CLC admission screening evaluations and observed a weekly interdisciplinary team meeting. The interdisciplinary team meeting allowed for staff, including the medical director, nurse manager, nursing assistant, and social worker, to discuss concerns with each other as well as with the patient and family.[5]

Physician Care Oversight and Documentation

The Chief of Staff reported, and the OIG confirmed through document review, that the CLC physician's ongoing professional practice evaluations were completed as required. The OIG also reviewed the electronic health records of CLC residents from September 2022 through April 2024, and determined that the CLC physician had entered all required assessments and documented the evaluation and care plans for residents outside of the required assessments.[6]

---

[4] VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023; VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024. Unless otherwise indicated, the directives contain similar language related to requirements for CLCs.

[5] VHA Directive 1142; VHA Directive 1142(1). The directive states that interdisciplinary teams, including the CLC medical director, nurse, psychologist, social worker, dietitian, nursing assistant, and other ancillary members as needed, work collaboratively to "create and revise every CLC resident's care plan." The directive includes a recreational therapist as a core member of the interdisciplinary team.

[6] The OIG reviewed the frequency of the CLC Medical Director's required electronic health record documentation, including admission notes, life-sustaining treatment orders, and periodic notes (30, 60, 90 days); VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. The amended policy contains similar language related to ongoing professional practice evaluation processes; Montana VA Health Care System, Policy 11-25-232, *Documentation Standards for Licensed Independent Practitioners*, August 14, 2020.

Nursing Care Operations

The OIG learned that prior to and after reopening the CLC in September 2022, VISN and system leaders provided in-person patient safety training to CLC staff on abuse reporting, environment of care, abnormal vital signs, mentation, and disruptive behavior. In addition, the OIG learned that system leaders hired a nurse manager in August 2022 and an assistant nurse manager in February 2023, each of whom have long-term care experience. The OIG determined that VISN, system, and CLC leaders implemented and sustained changes and related actions to ensure the rights of residents to refuse treatments, and processes for patient safety reporting, screening and admissions, physician care oversight and documentation, and nursing care operations.

2. CLC Staffing Shortages Affecting Quality of Care

During this review, the OIG identified gaps in CLC physician coverage and staffing shortages for the CLC physical therapist and social work positions, affecting quality of care for CLC residents.

The CLC physician reported serving as the sole physician to provide direct care for residents, the CLC medical director to oversee administrative matters, and being integral to resident care. The system policy requires the physician to evaluate residents "at least every 30 days after admission for the first 90 days of admission and then every 60 days thereafter."[7] Further, for required visits, the Centers for Medicare and Medicaid Services standards stipulate that "the physician must make actual face-to-face contact with the resident."[8]

The OIG learned that the CLC physician was on extended leave twice—for about five weeks and three weeks—and there was no scheduled face-to-face coverage during the time of the physician's leave.[9] In interviews with the OIG, VISN, system, and CLC leaders reported that when the CLC physician was not available, medical coverage for residents was by phone to the facility medical officer of the day, who is located over 300 miles away at the facility. When asked about the CLC physician coverage, the System Director reported the coverage was not sufficient, due to lack of continuity. The OIG is concerned the coverage plan does not meet the requirement for a covering provider to have face-to-face resident contact while the CLC physician is on extended leave. The OIG made one recommendation to the System Director to review CLC physician coverage and ensure residents' care and staff's needs are met when the physician is not available for extended periods.

---

[7] Montana VA Health Care System, Policy 11-25-232.

[8] Centers for Medicare and Medicaid Services*, F387 §483.40(c) Frequency of Physician Visits*, accessed September 18, 2024. The guidelines allow for intermittent coverage by "a qualified nurse practitioner (NP), clinical nurse specialist or physician assistant (PA)s" after the initial physician visit; VHA Directive 1142; VHA Directive 1142(1). VHA requires CLCs to adhere to Centers for Medicare and Medicaid Services standards.

[9] The physician was on leave in September and October 2023, and in December 2023 and January 2024.

VHA requires that all veterans eligible for CLC care have access to a clinically appropriate level of rehabilitative services, to include physical therapy. The OIG learned that the CLC physical therapist left the position in December 2023, and physical therapy coverage, at the time of the inspection, was accomplished through video or telephone, as well as having a physical therapist from the facility provide care to CLC residents as needed. The VISN geriatric extended care lead reported that consistent physical therapy engagement with the interdisciplinary team would be instrumental in ensuring that residents' care needs are being addressed. The System Director reported that, as of September 11, 2024, the CLC physical therapy needs were still being covered by existing system staff.

VHA mandates that CLCs have a social worker as a core member of the CLC interdisciplinary team.[10] The system standard operating procedure states that the social worker ensures referrals to the CLC meet administrative and clinical eligibility, address residents' psychosocial needs, and coordinate discharge planning.[11] At the time of the OIG site visit, coverage was shared by patient aligned care team social workers (10 staff members from multiple sites) providing on-site CLC services one to three days per week.[12] Despite efforts to ensure communication and engagement with the covering social worker, VISN, system, and CLC staff expressed concerns regarding the management of resident-specific issues given the limited social work coverage. The System Director reported that the newly hired CLC social worker was on-site, as of September 11, 2024; therefore, the OIG does not have a recommendation.

The OIG found that in the face of the staffing shortages, system and CLC leaders established limited coverage. While the OIG did not find that the CLC staffing shortages resulted in resident harm, the physician coverage and the physical therapist shortage may limit access and continuity of care for CLC residents.

VA Comments and OIG Response

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

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

---

[10] VHA Directive 1142; VHA Directive 1142(1).

[11] Montana VA Health Care System, "Community Living Center (CLC) – Long-Stay Services Admission Criteria and Process" (standard operating procedure) 1000, July 2022.

[12] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 24, 2024. The handbook states that the patient aligned care team provides comprehensive primary care.

Contents

Executive Summary i

Abbreviations vi

Introduction 1

Scope and Methodology 3

Inspection Results 4

1. Sustained Actions in Response to Patient Safety Concerns 4

2. CLC Staffing Shortages Affecting Quality of Care 7

Conclusion 10

Recommendations 1–2 11

Appendix A: VISN Director Memorandum 12

Appendix B: Facility Director Memorandum 13

OIG Contact and Staff Acknowledgments 16

Report Distribution 17

Abbreviations

ADPCS	Associate Director for Patient Care Services
CLC	community living center
EHR	electronic health record
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a follow-up healthcare inspection in response to a 2023 OIG report regarding mistreatment of a resident at the Miles City VA Community Living Center (CLC) and the Fort Harrison VA Medical Center (facility), part of the Montana VA Healthcare System (system).[1] The purpose of the inspection was to review corrective actions and evaluate the sustainability of changes implemented by system leaders. In addition, the OIG reviewed staffing shortages affecting the quality of care for CLC residents. The OIG did not receive new allegations.

Background

The system is part of Veterans Integrated Service Network (VISN) 19 and includes the facility, a Health Care Center in Billings, five community-based outpatient clinics, 11 other outpatient services locations, and the CLC. The Veterans Health Administration (VHA) classifies the system as low complexity level 3.[2] The facility has 18 operational hospital beds including 6 intensive care unit beds, 24 residential rehabilitation beds, and 12 operating CLC beds located in Miles City.[3] From October 1, 2022, through September 30, 2023, the facility served 40,434 patients.

The Miles City CLC is in southeastern Montana, over 300 miles from the facility; see figure 1.

[1] VA OIG, *Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison*, Report No. 22-01341-43, January 26, 2023.

[2] VHA Office of Productivity, Efficiency and Staffing, “Fact Sheet: Facility Complexity Model,” January 28, 2021. VHA categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with level 1a facilities being the most complex and level 3 facilities being the least complex. A level 3 facility has “low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs.”

[3] Facility leaders told the OIG that the CLC census gradually increased from 10 residents at the time of the reopening in September 2022, to 14 residents at the time of the OIG site visit, with an anticipated maximum of 17 residents.

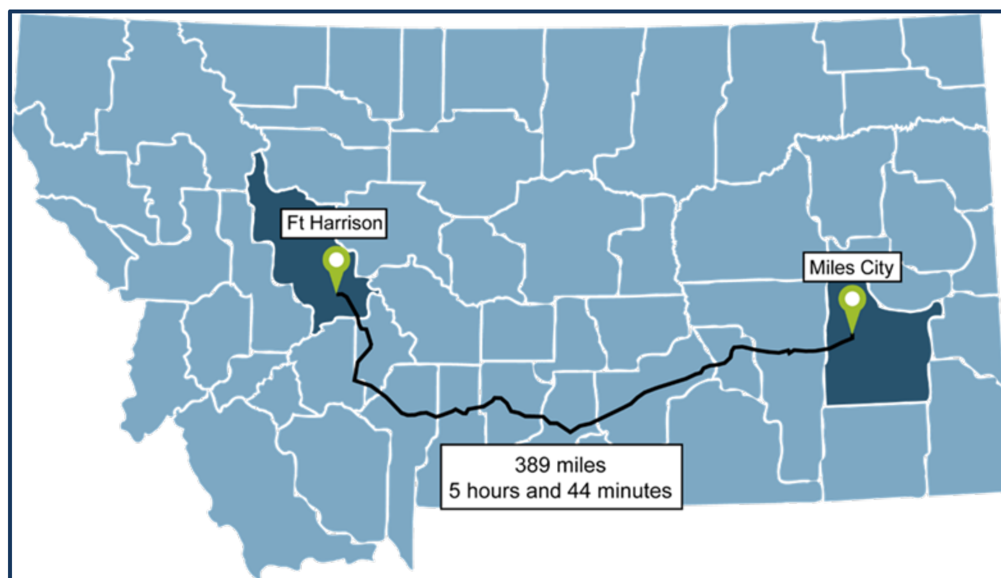

Figure 1. *Fort Harrison to Miles City, Montana.*
Source: "VA Montana health care locations," VA, accessed August 26, 2024, https://www.va.gov/montana-health-care/locations/.

Summary of the Prior OIG Report

An OIG report, published January 26, 2023, substantiated an allegation of resident mistreatment. Specifically, the OIG found that on two occasions, the CLC physical therapist obtained assistance from CLC nursing staff to force a resident to participate in physical therapy after the resident refused. The OIG determined that CLC staff did not report the incidents, as required, and identified issues related to facility oversight processes regarding the incident and a pattern of resident mistreatment in the CLC, and facility leaders' noncompliance with state licensing board reporting requirements.[4] The OIG made seven recommendations and all recommendations were considered closed as of May 9, 2024.

Areas of Review

Due to the severity of the concerns identified in the prior report, the OIG initiated this follow-up inspection to review the actions taken by system leaders and evaluate the sustainability of changes made, specific to

- rights of residents to refuse treatment,
- patient safety reporting,

[4] VA OIG, *Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison*. The final open recommendation was closed following the on-site Miles City inspection for this review.

- screening and admissions,
- physician care oversight and documentation, and
- nursing care operations.[5]

In addition, the OIG identified concerns with staffing coverage for the CLC physician, physical therapist, and social worker affecting the quality of care.

Scope and Methodology

The OIG initiated the review on March 27, 2024, and conducted on-site inspections at the Miles City CLC April 30–May 1, 2024, and the facility June 4–5, 2024. The OIG team conducted virtual and in-person interviews with facility and CLC leaders and staff from April 30, 2024, through June 12, 2024.

The OIG reviewed patient safety reports from September 1, 2022, through April 4, 2024; CLC residents' electronic health records (EHR) from September 2022 through April 2024; and the CLC physician's ongoing professional practice evaluations, from January 2021 through December 2023.

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, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] To determine whether implemented actions were sustained, the OIG interviewed staff and reviewed facility documentation. Some issues in the 2023 OIG report were related to a specific deceased patient and were not re-reviewed during this inspection.

Inspection Results

1. Sustained Actions in Response to Patient Safety Concerns

During this inspection, the OIG reviewed system leaders' actions in response to the areas of concern identified in the 2023 report specific to rights of residents to refuse treatment, patient safety reporting, screening and admissions, physician care oversight and documentation, and nursing care operations. The OIG determined system leaders' actions to address CLC patient safety concerns and deficiencies were sustained. Therefore, the OIG does not have recommendations related to these issues.

VHA provides guidance on the CLC delivery-of-care framework that supports cultural transformation to "a philosophy that puts the needs, interests, and lifestyle choices of individuals at the center of care giving."[6] Further, VHA utilizes resident-centered care, an approach to providing health care where the treatment plan reflects the needs of the resident and decisions are driven by the wishes and preferences of the resident.[7] The actions taken in response to deficiencies identified in the 2023 OIG report were paramount to establishing and maintaining this cultural transformation.

Residents' Right to Refuse Treatment

VHA states that patients have "the right to accept or refuse any medical treatment or procedure recommended to them" and providers are not permitted to "unduly pressure or coerce the patient (or surrogate) into consenting to a particular treatment or procedure."[8]

The OIG learned that VISN and facility staff provided oversight and patient safety training.[9] During interviews, CLC staff confirmed receiving this training and relayed knowledge to the OIG regarding the residents' right to refuse treatment.

---

[6] "Holistic Approach to Transformational Change (HATCh): An Overview," New Mexico Medical Review Association, accessed August 7, 2024, https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/CulturalTransformation/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FCulturalTransformation%2FShared%20Documents%2FHATCh%20Overview%2Epdf&parent=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FCulturalTransformation%2FShared%20Documents. (This site is not publicly accessible.)

[7] VHA Directive 1142, *Standards for Community Living Centers*, October 5, 2023; VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024. Unless otherwise indicated, the directives contain similar language related to requirements for CLCs.

[8] VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended May 1, 2024. The amended policy contains similar language related to patient rights to refuse treatment.

[9] A VHA and VISN review, after the OIG's March 2022 on-site inspection identified quality of care concerns and resulted in a temporary closure of the CLC in mid-April 2022. During the closure, VISN and facility staff provided oversight and training to CLC staff, including abuse reporting and environment of care. The CLC reopened in September 2022.

Patient Safety Reporting

VHA policy establishes procedures for reporting, analyzing, and addressing patient safety events, which include quality of care concerns, and instruct facility staff to report any unsafe conditions to the patient safety manager.[10]

In interviews with the OIG, staff indicated knowledge and use of patient safety reporting mechanisms, such as the joint patient safety reporting system, and cited no concerns of retaliation for reporting events. The OIG reviewed patient safety reports, from September 1, 2022, through April 4, 2024, and identified one incident of suspected abuse. The OIG found facility leaders followed applicable processes and actions to address the allegation. In addition, during interviews, all 14 CLC residents reported having no concerns or complaints related to mistreatment, feeling they were being treated with respect and receiving the care they needed. Relatedly, nursing leaders reported to the OIG implementing actions to improve culture and safety reporting, and a nurse and a nursing assistant reported an improved ability to report concerns or issues.

Screening and Admissions

VHA policy states that the CLC medical director, in collaboration with the CLC nurse leader, is responsible for overseeing "the CLC admissions process and facilitating appropriate admissions into the CLC."[11]

The CLC physician told the OIG that the interdisciplinary team discusses and finalizes admissions. During the on-site visit, the OIG reviewed CLC admission screening evaluations, and observed a weekly interdisciplinary team meeting.[12] The OIG found that the interdisciplinary team meeting allowed for staff, including the medical director, nurse manager, nursing assistant, and social worker, to discuss concerns with each other as well as with the patient and family. The meeting included a summary of the patient's current medical status and plans for addressing ongoing issues.

Physician Care Oversight and Documentation

According to VHA, oversight of providers who are permitted to practice independently is accomplished, in part, by the ongoing professional practice evaluation, a defined process that

[10] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023. "A patient safety event is an event, incident or condition, directly associated with care or services provided to a patient, that could have resulted or did result in unintentional harm."

[11] VHA Directive 1142; VHA Directive 1142(1).

[12] VHA Directive 1142; VHA Directive 1142(1). The directive states that interdisciplinary teams, including the CLC medical director, nurse, psychologist, social worker, dietitian, nursing assistant, and other ancillary members as needed, work collaboratively to "create and revise every CLC resident's care plan."

"may include, but is not limited to, periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients."[13] System policy sets forth documentation standards that providers must adhere to, including maintaining complete, accurate, and timely EHR documentation.[14] The system requires a physician to document a history and physical upon resident admission as well as ongoing evaluations during a resident's stay in the CLC.[15]

The Chief of Staff reported ongoing professional practice evaluations were completed for the CLC physician by another physician in the VISN with a similar practice. Through document review, the OIG confirmed that the required ongoing professional practice evaluations were completed. The OIG also reviewed the EHRs of CLC residents from September 2022 through April 2024, and determined that the CLC physician had entered all required assessments and documented the evaluation and care plans for residents.[16]

Nursing Care Operations

VHA states that "for CLCs to provide resident-centered care, all CLC Interdisciplinary Team members [including nurses] must work collaboratively to . . . help the resident achieve goals for care."[17] The OIG observed that day-to-day CLC care coverage is provided by registered nurses and nursing assistants, forming the cornerstone of resident care. According to VHA "restorative care is a critical component of the nursing care."[18]

The OIG learned that prior to and after reopening the CLC in September 2022, VISN and system leaders provided in-person patient safety training to CLC staff on abuse reporting, environment of care, abnormal vital signs, mentation, and disruptive behavior. In addition, the OIG learned that system leaders hired a nurse manager in August 2022 and an assistant nurse manager in February 2023, each of whom have long-term care experience.

VISN, system, and CLC leaders supported corrective actions related to nursing care processes for resident-centered care. The VISN geriatric extended care lead told the OIG that a CLC process improvement workgroup was developed to support veteran-centric care initiatives and to enhance CLC quality measures. The VISN Director reported that VISN staff would continue to

---

[13] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. The amended policy contains similar language related to ongoing professional practice evaluation processes.

[14] Montana VA Health Care System, Policy 11-25-232, *Documentation Standards for Licensed Independent Practitioners*, August 14, 2020.

[15] Montana VA Health Care System, Policy 11-25-232.

[16] The OIG reviewed the frequency of the CLC Medical Director's required EHR documentation, including admission notes and periodic notes (30, 60, 90 days); VHA Directive 1100.21(1); Montana VA Health Care System, Policy 11-25-232.

[17] VHA Directive 1142; VHA Directive 1142(1).

[18] VHA Directive 1142; VHA Directive 1142(1).

provide support in the form of quarterly visits, along with oversight as needed. The acting Associate Director of Patient Care Services (ADPCS) reported providing continued guidance and oversight to CLC staff starting in November 2023, and started monthly site visits in January 2024. CLC leaders reported support from VISN and system leaders for corrective actions. CLC nursing staff also reported the use of watchlist huddles to monitor residents with acute ongoing needs.[19] In addition, several leaders and staff reported a strong emphasis on restorative nursing care to support the physical, mental, and psychosocial well-being of the residents.[20]

The System Director and CLC nurse manager reported no concerns regarding nurse staffing. The acting ADPCS told the OIG that coverage needs were addressed through support from other system facilities as well as the implementation of incentives, which improved staff morale and retention. The Chief of Staff reported that hiring for a permanent ADPCS was in process.[21]

The OIG determined that VISN, system, and CLC leaders implemented and sustained changes to ensure the rights of residents to refuse treatments. In addition, leaders implemented and sustained processes for patient safety reporting, screening and admissions, physician care oversight and documentation, and nursing care operations.

2. CLC Staffing Shortages Affecting Quality of Care

During this review, the OIG identified gaps in CLC physician coverage and staffing shortages for the CLC physical therapist and social worker positions, affecting quality of care for CLC residents. System leaders told the OIG that recruitment challenges contributed to the gaps in coverage and staffing shortages.

Quality of care "is the degree to which health services . . . increase the likelihood of desired health outcomes."[22] A crucial component of quality of care is continuity of care. According to the World Health Organization, continuity of care "reflects the extent to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences." Without good continuity of care, patients may "experience fragmented, poorly integrated care from multiple providers," often with poor

---

[19] "CONCERT: CLCs' Ongoing National Center for Enhancing Resources & Training," VA, accessed July 16, 2024, https://dvagov.sharepoint.com/sites/VHAConcert/SitePages/CONCERT%20Home%20Page.aspx. (This site is not publicly accessible.) VA defines a watchlist huddle as a 5 to 15-minute gathering of the care team to communicate and problem-solve about residents who are at high-risk for an adverse event.

[20] Montana VA Health Care System Policy 11-27-530, *Community Living Center Restorative Nursing Program*, June 14, 2022. "Restorative Nursing consists of nursing interventions that promote the Resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial wellbeing."

[21] The System Director confirmed that, as of September 4, 2024, the ADPCS hiring was still in process.

[22] "Fact Sheet: Quality health services," World Health Organization, accessed August 5, 2024, https://www.who.int/news-room/fact-sheets/detail/quality-health-services.

outcomes and "risk of harm due to failures of communication [and] inadequate sharing of clinical information."[23]

VHA requires that CLCs have an interdisciplinary team that consists of the medical director, a nurse who is not the CLC nurse leader, a psychologist, a social worker, a dietitian, and a nursing assistant. VHA also recommends that additional staff, including a physical therapist, participate as needed with the interdisciplinary team to ensure the needs of residents are being met.[24]

CLC Physician Coverage Gaps

The CLC physician reported serving as the sole physician to provide direct care for residents in the CLC and as the medical director to oversee administrative matters. VHA states that the CLC medical director is integral, as a core member of the interdisciplinary team, to developing residents' care plans and goals of care.[25] The system policy states that the physician is to evaluate residents "at least every 30 days after admission for the first 90 days of admission and then every 60 days thereafter."[26] Further, for required visits, the Centers for Medicare and Medicaid Services standards stipulate that "the physician must make actual face-to-face contact with the resident."[27]

The OIG learned that the CLC physician was on extended leave twice—for about five weeks and three weeks—and staff reported there was no scheduled face-to-face coverage while the physician was on leave.[28] In interviews with the OIG, VISN, system, and CLC leaders reported that when the CLC physician was not available, medical coverage for residents was by phone to the facility medical officer of the day, who is located over 300 miles away at the facility. When asked about CLC physician coverage, the VISN Director told the OIG of a need for on-site physician coverage. The System Director also reported the current CLC physician coverage was not sufficient, due to lack of continuity. Leaders told the OIG that the CLC was recently set up to utilize telehealth, where a physician can see and evaluate a resident virtually, but as of September 18, 2024, the CLC had not utilized telehealth for residents when the physician was on

---

[23] "Continuity and coordination of care—A practice brief to support implementation of the WHO Framework on integrated people-centered health services," World Health Organization, accessed July 3, 2024, https://iris.who.int/bitstream/handle/10665/274628/9789241514033-eng.pdf?ua=1.

[24] VHA Directive 1142; VHA Directive 1142(1).

[25] VHA Directive 1142; VHA Directive 1142(1).

[26] Montana VA Health Care System, Policy 11-25-232.

[27] Centers for Medicare and Medicaid Services, *F387 §483.40(c) Frequency of Physician Visits*, accessed September 18, 2024. The guidelines allow for intermittent coverage by "a qualified nurse practitioner (NP), clinical nurse specialist or physician assistant (PA)s" after the initial physician visit; VHA Directive 1142; VHA Directive 1142(1). VHA requires CLCs to adhere to Centers for Medicare and Medicaid Services standards.

[28] The physician was on leave in September and October 2023, and in December 2023 and January 2024.

leave.[29] The OIG is concerned the current plan does not meet the requirement for a covering provider to have face-to-face resident contact while the CLC physician is on extended leave.

Physical Therapist Staffing Shortage

VHA requires that all veterans eligible for CLC care have access to a clinically appropriate level of rehabilitative services, to include physical therapy. Physical therapists utilize evaluation and treatment techniques to address a patient's strength, balance, flexibility, transfers, and gait.[30] VHA guidance also recommends that staffing for the CLC interdisciplinary team includes a physical medicine and rehabilitation specialist.[31]

The OIG learned the CLC physical therapist left the position in December 2023. The chief of physical medicine and rehabilitation told the OIG that CLC physical therapy coverage is currently accomplished through video or telephone, as well as having a physical therapist from the facility provide care to CLC residents on an as-needed basis. The Chief of Staff reported that the plan for future coverage is to create a new physical therapist position that will provide in-person CLC physical therapy services as needed. The System Director and the chief of physical medicine and rehabilitation reported as of June 2024, approval to recruit for a physical therapist who will work part-time in the CLC and part-time at the Billings Health Care Center located 153 miles from the CLC. The chief of physical medicine and rehabilitation stated that even with incentives, "it's a hard place to recruit." The System Director reported that, as of September 11, 2024, the CLC physical therapy needs were still being covered by existing system staff.

During interviews with the OIG, CLC leaders expressed concerns that the lack of a physical therapist may limit a resident's timely access to durable medical equipment and the implementation of fall-prevention strategies.[32] A CLC staff member reported that the limited involvement of all members of the interdisciplinary team effects the continuity of care that the residents require. The VISN geriatric extended care lead reported that consistent physical therapy engagement with the interdisciplinary team would be instrumental in ensuring that residents' care needs are being addressed.

---

[29] *Merriam-Webster.com Dictionary*, "telehealth," accessed September 17, 2024, https://www.merriam-webster.com/dictionary/telehealth. Telehealth is "health care provided remotely to a patient in a separate location using two-way voice and visual communication."

[30] VHA Directive 1170.03(1), *Physical Medicine and Rehabilitation Service*, November 5, 2019.

[31] Assistant Under Secretary for Health for Patient Care Services / Chief Nursing Officer (12), "Informational Memorandum: Community Living Center Interdisciplinary Team Staffing Guidelines (VIEWS 10770213)," memorandum to the Veterans Integrated Service Network Directors (10N1-23), September 19, 2023.

[32] "Durable medical equipment (DME)," HealthCare.gov, accessed August 6, 2024, https://www.healthcare.gov/glossary/durable-medical-quipment-dme/. Durable medical equipment includes "equipment and supplies ordered by a health care provider for everyday or extended use" and "may include: oxygen equipment, wheelchairs, crutches, or blood testing strips."

Social Worker Staffing Shortage

VHA mandates that CLCs have a social worker as a core member of the interdisciplinary team [33] The system standard operating procedure states that the social worker ensures referrals to the CLC meet administrative and clinical eligibility, address residents' psychosocial needs through a detailed initial assessment, and coordinate discharge planning.[34]

The chief of social work reported that the former CLC social worker left for another position in November 2023. During an interview with the OIG, the chief of social work reported that the social work position was vacant, and recruitment was in process. The chief of social work also reported requesting other social work staff to cover the CLC temporarily. The OIG learned that, at the time of the OIG site visit, coverage was provided by rotating patient aligned care team social workers (10 staff from multiple sites) providing on-site CLC services one to three days per week.[35]

Multiple staff reported communicating residents' social work needs to covering social workers using electronic messaging, interdisciplinary team meetings, and discussions or emails between staff. However, despite efforts to ensure communication and engagement with the covering social worker, VISN, system, and CLC staff expressed concerns regarding the management of resident-specific issues given the limited social work coverage.

The System Director reported that, as of September 11, 2024, the CLC social worker was hired and on-site; therefore, the OIG does not have a recommendation.

The OIG found that, in the face of staffing shortages, system and CLC leaders established limited coverage. While the OIG did not find that the CLC staffing shortages resulted in resident harm, current physician coverage and the physical therapist shortage may limit access and continuity of care for CLC residents. Therefore, the OIG concluded that a better coordinated coverage and hiring plan is warranted.

Conclusion

During this inspection, the OIG reviewed rights of residents to refuse treatment, patient safety reporting, screening and admissions, physician care oversight and documentation, and nursing care operations. The OIG determined the actions to address CLC deficiencies were sustained and, therefore, the OIG does not have recommendations related to these issues. VHA provides guidance on the framework for CLC delivery-of-care that supports cultural transformation. The

---

[33] VHA Directive 1142; VHA Directive 1142(1).

[34] Montana VA Health Care System, "Community Living Center (CLC) – Long-Stay Services Admission Criteria and Process" (standard operating procedure) 1000, July 2022.

[35] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 24, 2024. The handbook states that the patient aligned care team provides comprehensive primary care.

actions taken by system leaders in response to deficiencies identified in the 2023 OIG report were paramount to establishing and maintaining this cultural transformation.

The OIG identified gaps in CLC physician coverage and staffing shortages for the CLC physical therapist and social worker positions affecting quality of care for CLC residents. System leaders told the OIG that recruitment challenges contributed to the coverage issues and staffing shortages.

Although system and CLC leaders established limited coverage for staffing shortages, the OIG is concerned the plan does not meet the requirement for a covering provider to have face-to-face resident contact while the CLC physician is on extended leave.

VHA requires that all veterans eligible for CLC care have access to a clinically appropriate level of rehabilitative services, to include physical therapy. The chief of physical medicine and rehabilitation told the OIG that CLC physical therapy coverage is currently accomplished through video or telephone, as well as by having a physical therapist from the facility provide care to CLC residents as needed.

While the OIG did not find that the current CLC staffing resulted in resident harm, the OIG determined that the shortages may put residents at risk for quality of care issues and potentially lead to adverse clinical outcomes. Therefore, the OIG concluded that a better coordinated and prioritized review and hiring plan by facility leaders is needed to ensure physician coverage and physical therapist staffing to avoid delays in care and mitigate potential adverse clinical outcomes. The newly hired CLC social worker was on-site as of September 11, 2024; therefore, the OIG does not have a recommendation.

Recommendations 1–2

1. The VA Montana Healthcare System Director reviews Community Living Center physician coverage to identify barriers and gaps, determines options for resolution, and completes and executes a coverage plan to ensure residents' care and staff's needs are met when the physician is not available for extended periods.

2. The VA Montana Healthcare System Director reviews Community Living Center physical therapy staffing to identify barriers and gaps, determines options for resolution, and completes and executes a hiring plan to ensure residents' care and staff's needs are met.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 26, 2024

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Improvements in Patient Safety, but Concerns Identified with Staffing Shortages Affecting Quality of Care at the VA Community Living Center in Miles City, Montana

To: Director, Office of Healthcare Inspections (54HL02)
Director, GAO/OIG Accountability Liaison Office (VHA 10OICGOAL Action)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values.

2. We concur with the report findings and recommendations.

3. Should you need further information, please contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

[OIG comment: The OIG received the above memorandum from VHA on December 2, 2024.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 26, 2024

From: Director, Fort Harrison VA Medical Center (436)

Subj: Healthcare Inspection—Improvements in Patient Safety, but Concerns Identified with Staffing Shortages Affecting Quality of Care at the VA Community Living Center in Miles City, Montana

To: Director, Rocky Mountain Network (10N19)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Inspection—Improvements in Patient Safety, but Concerns Identified with Staffing Shortages Affecting Quality of Care at the VA Community Living Center in Miles City, Montana.
2. VA Montana Healthcare System concurs with the findings and will take appropriate actions as recommended.
3. If there are any questions regarding responses or additional information required, please contact Chief of Quality Management for the Montana VA Health Care System.

(*Original signed by*:)

Duane B. Gill, FACHE
Executive Director, Montana VA Health Care System

[OIG comment: The OIG received the above memorandum from VHA on December 2, 2024.]

Facility Director Response

Recommendation 1

The VA Montana Healthcare System Director reviews Community Living Center physician coverage to identify barriers and gaps, determines options for resolution, and completes and executes a coverage plan to ensure residents’ care and staffs’ needs are met when the physician is not available for extended periods of time.

_X _Concur

____Nonconcur

Target date for completion: February 2025

Director Comments

The Montana VA Healthcare System recognizes the importance of following the system policy and ensuring adequate face-to-face coverage for Veterans within the Community Living Center (CLC) system. The Montana VA Healthcare System is in recruitment for a second physician as the Deputy Medical Director for the CLC to ensure regular, uninterrupted physician coverage. The Montana VA Healthcare System will also ensure that a telehealth coverage plan with the Medical Officer of the Day is instituted to cover the CLC during weekend, holiday, evening, and night hours and continue recruitment. Additionally, a provider will be identified for coverage should the CLC provider be out of the office for an extended period to ensure face-to-face provider availability for those residents requiring physician visits every 30 days.

Recommendation 2

The VA Montana Healthcare System Director reviews Community Living Center physical therapy staffing to identify barriers and gaps, determines options for resolution, and completes and executes a hiring plan to ensure resident’s care and staffs’ needs are met.

_X _Concur

____Nonconcur

Target date for completion: May 2025

Director Comments

The Montana VA Healthcare System and Community Living Center (CLC) leadership recognize the importance of physical therapy (PT) availability to Veterans within the CLC. To meet this need, the Montana VA Healthcare System is currently in recruitment for a physical therapist who will provide care and coverage up to 50%. The physical therapy team will provide routine coverage and participation in interdisciplinary team meetings, until recruitment is completed.

During inclement weather, telehealth visits will be implemented for those residents' requiring PT with assistance of nursing services.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Sami Cave, MA, Director Erin Butler, LCSW Jonathan Ginsberg, JD James McMahon, MPT, AT Glenn Schubert, MPH Robert Yang, MD, MHA
Other Contributors	Sheyla Desir, MSN, RN Reynelda Garoutte, MHA, BSN Natalie Sadow, MBA April Terenzi BA, BS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Rocky Mountain Network (10N19)
Director, Fort Harrison VA Medical Center (436)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
Steve Daines, Tim Sheehy
US House of Representatives
Troy Downing, Ryan Zinke

OIG reports are available at www.vaoig.gov.