VA Canâ€™t Say Definitively Its Nursing Homes Have Bucked Deficiencies: GAO

By Greg T. Rinckey

The U.S. Department of Veterans Affairs still cannot provide assurances that patient care problems identified years ago at some of its 132 nursing homes have been resolved, according to the federal government's watchdog agency.

In a new report

, the Government Accountability Office (GAO) stated there are "weaknesses" in the VA's process for responding to deficiencies at its nursing homes, also referred to as community living centers (CLCs). The GAO warned that such administrative problems "may compromise the quality of care and quality of life of veterans in CLCs." The GAO reached this conclusion after evaluating the VA's process for responding to CLC care deficiencies identified by a federal contractor in 2007 and 2008.

Following reports about sub-par care at CLCs that made headlines in 2004, the VA over the next three years conducted unannounced reviews of certain CLCs. It hired Long Term Care, Inc. (LTCI) in 2007 to conduct a more expansive, two-year investigation of 116 VA-operated nursing homes. LTCI uncovered a host of deficiencies at many CLCs, some relating to a dearth of competent skilled nurses and unsanitary and unsafe conditions. For example, 90 percent of the 116 investigated CLCs were found to have dignity deficiencies, meaning veterans in their care had poor hygiene and lacked privacy. Fifty-nine percent of the CLCs had infection control deficiencies caused by staff who skirted proper isolation procedures and hand washing requirements, according to the GAO report.

In response to these findings, the VA required CLCs to establish corrective action plans to address the LTCI-identified deficiencies. The VA also rolled out a national training and education initiative to address care concerns. Additionally, it ordered another LTCI investigation of all agency-operated nursing homes in 2010 and 2011.

However, the GAO found the VA lacks a "clear and complete" process for documenting the feedback it provides to CLCs on their corrective action plans. Due to lax reporting requirements to VA regional networks, the GAO said, "VA headquarters does not know whether CLCs fully implemented their plans and corrected all LTCI-identified deficiencies." Insufficient verification requirements for the training and education initiative were also cited. The GAO said VA officials want to wait until LTCI delivers the findings of its 2010-2011 investigation to learn how well CLCs addressed deficiencies identified in the 2007-2008 report.

This wait-and-see strategy is unacceptable. It unnecessarily puts some of the 46,000 disabled veterans who receive care at VA nursing homes at risk of medical malpractice.

While the VA seems content to wait to see its CLC employees have kicked the deficient

practices that put disabled veterans at risk, veterans should not delay in consulting with a VA medical malpractice attorney about filing an administrative claim with the agency if they have suffered from an employee’s negligent or wrongful act or omission. There is a two-year deadline for filing such claims.

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