CALIFORNIA STATE AUDITOR

Elaine M. Howle, State Auditor

FACT SHEET

Date: **April 24, 2008** **Report: 2007-121**

The California State Auditor released the following report today:

Veterans Home of California at Yountville:

It Needs Stronger Planning and Oversight in Key Operational Areas, and Some Processes for Resolving Complaints Need Improvement

BACKGROUND

Home to over 1,000 California veterans, the Veterans Home of California at Yountville (Veterans Home) is administered by the California Department of Veterans Affairs (Veterans Affairs) and has three types of accommodations—residential (independent living), licensed residential (assisted living), and hospital care. Members can receive three levels of inpatient healthcare at the hospital that is operated by and located on the grounds of the Veterans Home: intermediate, skilled nursing, and acute care. The hospital is licensed and inspected by Department of Public Health (Public Health), while the residential care facilities are licensed and inspected by the Department of Social Services.

KEY FINDINGS

In our review of the Veterans Home and its adequacy of health care and accommodation of members with disabilities, we reported the following:

- Chronic shortages in key health care positions has limited the Veterans Home's ability to serve more veterans and has resulted in excessive overtime to meet staffing requirements which could compromise patient safety. In fiscal year 2006-07, nursing positions accounted for 41.5 percent of all vacancies.
- Low salaries and the high cost of housing in the community have challenged the Veterans Home in recruiting and retaining staff in key health care positions. Likewise, it lacks a coordinated and comprehensive strategy that sufficiently addresses critical recruitment and retention needs.
- Inefficiencies in the Veterans Home's recruitment program contribute to its staffing problems — decentralized recruitment, overlapping responsibilities, limited information, and lengthy recruitment processes.
- The Veterans Home cannot ensure that medical equipment is working properly and that payments to its contractors are appropriate due to its weak contract oversight, including an inaccurate inventory of its medical equipment.
- With no assessment of compliance with the Americans with Disabilities Act (ADA) or no plan for what is needed to comply, the Veterans Home has not met the requirements specified by federal regulations since 1992.
- Public Health does not always promptly complete its investigations of complaints filed against the Veterans Home. For three of the nine complaints we reviewed, it took from 45 to 110 days to complete the investigation, and for another complaint filed more than a year ago, Public Health has not determined whether to issue a citation to theVeterans Home.
- For five complaints the Veterans Board received, neither the Veterans Board nor Veterans Affairs retained evidence that they investigated all complaints. Additionally, of the 25 alleged violations of the code of conduct we reviewed, the Veterans Home had complete documentation for only 11 cases.

KEY RECOMMENDATIONS

The report provided numerous recommendations including methods to improve filling vacancies, retaining staff, and reducing excessive overtime. Moreover, we recommended that the Veterans Home properly maintain its medical equipment and meet ADA requirements. We also made various recommendations to ensure that all complaints filed against the Veterans Home are promptly investigated and resolved and are well documented.

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