Veterans Home of California at Yountville:

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

April 2008 Report 2007-121

CALIFORNIA STATE AUDITOR

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April 24, 2008 2007-121

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Veterans Home of California at Yountville (Veterans Home), with a specific emphasis on the adequacy of health care and accommodations provided for members with disabilities.

This report concludes that the Veterans Home has experienced shortages in key health care positions, such as nursing, that have limited the Veterans Home in serving the veteran community. Some nursing staff have worked substantial amounts of overtime to meet staffing guidelines for providing care to members who live in the skilled nursing and intermediate care facilities. Despite these staffing shortages, the Veterans Home has not had a coordinated and comprehensive strategy for filling chronic staff vacancies in especially important occupational areas. In addition, weak oversight of its medical equipment maintenance contract provides the Veterans Home little confidence that the equipment has received regularly scheduled testing and maintenance, thereby risking not having properly functioning equipment available when needed and making inappropriate payments to its medical equipment contractor. Moreover, the Veterans Home has not assessed its compliance with Americans with Disabilities Act requirements to ensure people with qualifying disabilities have access to the Veterans Home's programs and services, or designated a representative to respond to complaints of inaccessibility from members. Further, state agencies responsible for investigating and resolving complaints by Veterans Home members regarding the Veterans Home's programs and services, the Veterans Home, the California Veterans Board, the California Department of Veterans Affairs, and the California Department of Public Health, could improve their practices regarding those responsibilities.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Contents

Summary

Results in Brief

The Veterans Home of California at Yountville (Veterans Home) is one of three veterans homes administered by the California Department of Veterans Affairs (Veterans Affairs). As of December 2007 more than a thousand California veterans were living at the Veterans Home. Veterans Home residents (members) who are self-sufficient have independent-living accommodations if they are able to perform all the activities of daily living without assistance, or assisted-living accommodations if they need minimal assistance with daily activities. For members requiring inpatient health care, the Veterans Home provides services at three levels—intermediate, skilled nursing, and acute—at the N. M. Holderman Memorial Hospital (Holderman Hospital), which is located on the grounds of the Veterans Home. For fiscal year 2007–08 the Veterans Home has 1,037 authorized positions and a budget of $94 million.

Our review of the Veterans Home revealed that it has had difficulty filling key health care positions in recent years, especially nursing positions. During fiscal year 2006–07 about 41 percent of all vacant positions at the Veterans Home were nursing positions. As a result, the Veterans Home has been limited in its ability to serve the veterans community and some nursing staff have worked substantial amounts of overtime to meet staffing guidelines for providing care to members living in the skilled nursing and intermediate care facilities. For example, we determined that although the Veterans Home has sufficient budget-authorized nursing staff to fill 435 beds without the need for substantial overtime, its census shows that as of December 2007 it had only 357 beds filled. Moreover, 20 members of the nursing staff worked an average of more than 20 hours of overtime each week during the last three months of 2007. In addition, although we did not observe such matters at the Veterans Home, one research study we reviewed concluded that excessive overtime by health care workers can lead to medical errors and negative patient outcomes.

We also found that the veterans community has an unmet need for the services of the Veterans Home. In addition to unfilled beds, the Veterans Home maintains a waiting list of veterans seeking admittance. As of January 2008 the Veterans Home had a waiting list of 250 veterans for skilled nursing beds and 220 veterans for intermediate care beds. Although the Veterans Home does not regularly monitor the status of those waiting veterans, the mere existence of the lists indicates a certain level of demand for entry into the home. Further potentially limiting the ability of the Veterans Home to admit veterans into the level of care they need is a regulation stating that less than 75 percent of skilled nursing beds

Audit Highlights . . .

Our review of the Veterans Home of California at Yountville (Veterans Home) found that:

- *Chronic shortages in key health care positions, such as nursing, have limited the Veterans Home in serving the veteran community. Some nursing staff have worked substantial amounts of overtime to meet staffing guidelines for providing care to members who live in the skilled nursing and intermediate care facilities.*
- *Despite these staffing shortages, the Veterans Home has not had a coordinated and comprehensive strategy for filling chronic staff vacancies in especially important occupational areas.*
- *Weak oversight of its medical equipment maintenance contract provides the Veterans Home little confidence that the equipment has received regularly scheduled testing and maintenance, thereby risking not having properly functioning equipment available when needed and making inappropriate payments to its medical equipment contractor.*
- *The Veterans Home has not assessed its compliance with Americans with Disabilities Act requirements to ensure people with qualifying disabilities have access to the Veterans Home and its programs and services, or designated a representative to respond to complaints of inaccessibility from members.*

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» *State agencies responsible for investigating and resolving complaints by Veterans Home members regarding the Veterans Home and its programs and services, the Veterans Home, the California Veterans Board, the California Department of Veterans Affairs, and the California Department of Public Health, could improve their practices regarding those responsibilities.*

must be occupied before the home can admit members directly to that level of care. Veterans Affairs has suspended that regulation in the past and intends to initiate a regulatory change within six months to grant the administrators the discretion to admit veterans to this level of care while ensuring that existing members have access to skilled nursing beds.

According to the deputy administrator at the Veterans Home (deputy administrator), the home faces two major challenges in recruiting and retaining health care professionals: comparatively low salaries and the high cost of housing in the community. Salaries offered at the Veterans Home are lower than those offered at other state hospitals in the area, primarily because of the salary increases for medical and mental health positions at the California Department of Corrections and Rehabilitation facilities that resulted from recent federal court decisions. The Veterans Home must also contend with statewide shortages in several high-need health care occupations, such as registered nurses.

Despite these staffing shortages, the Veterans Home has not had a coordinated and comprehensive strategy for filling chronic staff vacancies in especially important occupational areas. Instead, individual departments within the Veterans Home have assumed important recruiting functions, without involvement from the home's human resources department. As a result, the Veterans Home has not been as effective as it could be in conducting recruiting efforts such as advertising vacant positions. It also is not as prompt as it could be in processing successful job applicants so they can start working at the Veterans Home, primarily because the home takes too much time to schedule, perform, and obtain the results of the physical examinations applicants must undergo.

To improve recruitment of health care staff, the Veterans Home has moved to centralize recruiting efforts under its human resources department. In an attempt to lessen the time between candidate job acceptances and employment start dates, the Veterans Home has identified a specific doctor and two nurse practitioners to perform physical examinations. According to the deputy administrator, the Veterans Home plans further action, such as improving the process for advertising open positions, extending outreach to nursing schools, and establishing a more effective exit interview process to gain a better understanding of why employees leave. In addition, the Veterans Home is seeking increased housing assistance for its employees.

Further, Veterans Affairs has taken action to raise salaries in several health care occupations at the Veterans Home and has performed some recruitment activities that might benefit the home. Veterans Affairs is also planning to implement a recruiting program that

will coordinate the department's recruiting efforts and require the Veterans Home to develop a local recruitment plan that addresses department-wide recruiting goals.

Our review also revealed that the Veterans Home has weak oversight of its medical equipment contract. From the medical equipment inventory provided to us by the Veterans Home, we tested 31 pieces of equipment and found that one piece of equipment had been entered into the inventory twice, leaving 30 items in our sample. Of those 30 items, six were not in use by the Veterans Home and five new items were not promptly added to the inventory. In addition, for 14 of the 19 remaining items, we could not find evidence that the contractor scheduled or performed the required maintenance within appropriate time frames. Without an accurate inventory and regularly scheduled maintenance of its medical equipment, the Veterans Home risks not having properly functioning equipment readily available when needed. Further, the Veterans Home routinely approves invoices for the contractor responsible for maintaining medical equipment but fails to verify that the contractor has met the requirements of its contract. Consequently, the Veterans Home may be making inappropriate payments to the contractor and, more importantly, it further decreases its assurance that every piece of medical equipment will function properly whenever it is needed to meet a member's health care needs.

In addition, the Veterans Home does not have a plan for fully complying with the Americans with Disabilities Act (ADA). Title II of the ADA and federal regulations require state agencies to ensure that people with disabilities are not excluded from services, programs, and activities because buildings are inaccessible. As a first step toward meeting this requirement for program accessibility, all public entities had to conduct self-evaluations of their policies and practices and correct any policies and practices that were inconsistent with the requirements of Title II. Additionally, any public entity needing to make structural changes to achieve program accessibility had to develop a transition plan. According to its equal employment opportunity/civil rights officer, Veterans Affairs has not performed a self-assessment of the Veterans Home for compliance with the ADA. Consequently, neither Veterans Affairs nor the Veterans Home can develop a plan for achieving full compliance with the ADA. The director of residential programs at the Veterans Home said that when repairs and alterations were made to the infrastructure at the Veterans Home, they were done to ADA design codes in force at the time. Nonetheless, it is not clear to what extent the Veterans Home meets the program accessibility requirements of the ADA.

Federal ADA regulations also require state agencies to develop grievance procedures and identify an employee as the agency's ADA coordinator. According to its director of residential programs, the Veterans Home has not met either of those requirements. However, the Veterans Home has made accommodations in its dining hall for members with visual impairments and provided training to dining hall workers to enable them to better serve members with visual impairments.

Our review of complaints lodged against the Veterans Home, including complaints filed with legislative staff, showed that the responsible agencies handled some complaints appropriately. However, in several cases we could not discern from the available documentation whether the proper complaint-handling procedures were followed. For example, we reviewed the nine complaints concerning the Veterans Home filed with the California Department of Public Health (Public Health) between October 2005 and October 2007 and found that in every case Public Health met the requirements to conduct an initial on-site investigation within 24 hours or 10 days of receipt of the complaint, depending on its severity. In addition, Public Health's classification of the severity of each complaint appeared appropriate. However, we noted that Public Health did not complete its investigations for three of the nine complaints within 40 business days, its recommended maximum time frame. For another of the nine complaints, Public Health has yet to make a final determination on whether to issue the Veterans Home a citation, even though the complaint was filed more than one year ago. According to the chief of the state facilities unit in Public Health's licensing and certification program, this complaint was mistakenly dropped from his pending file and not addressed again until it was discussed during our audit.

We also reviewed the 11 complaints against the Veterans Home submitted by members to Veterans Affairs from July 2005 through October 2007. From the review we found that in all 11 cases the complaints were substantively addressed and resolved in the time frame specified by Veterans Affairs policy. However, in four of the cases Veterans Affairs did not follow all its procedures designed to track the complaints and provide accountability for the resolutions. We also reviewed five complaints submitted to the California Veterans Board (Veterans Board) between June 2006 and December 2007 but were unable to determine whether they were resolved appropriately because neither the Veterans Board nor Veterans Affairs could locate documentation concerning actions they took on the complaints. Although the Veterans Board adopted a policy indicating the types of complaints it will process and those it will direct to Veterans Affairs, it did not specify a time frame for resolving the complaints it will process.

As part of our analysis of complaint-handling procedures, we reviewed documents prepared by Veterans Home staff following resident council meetings. These monthly meetings are held in Holderman Hospital and its intermediate care facility annexes to give members the opportunity to raise issues, concerns, and complaints. According to the supervisor of therapeutic activities, the hospital's therapeutic activities staff facilitate the meetings, and social services staff are responsible for taking meeting minutes. We reviewed the available meeting minutes for 2007 and memos prepared by the social services staff from May through December 2007 to communicate to Veterans Home departments the issues they needed to address. Our review revealed that 20 complaints were raised in the 2007 resident council meetings and, as of December 2007, the Veterans Home took reasonable steps to resolve 16 and had been unsuccessful in resolving two. We could not determine whether the Veterans Home had resolved the remaining two issues because no resolution was apparent in the minutes of resident council meetings or in the memos. The Veterans Home had communicated the outcomes of their investigations at subsequent resident council meetings for 14 of the 20 issues and had yet to report their findings for six. When complaints lodged by members in resident council meetings are not promptly resolved, or resolutions of the issues are not communicated to members, it can lead to dissatisfaction among the members of the Veterans Home.

When we attempted to assess the process the Veterans Home has established for handling alleged violations of its code of conduct for members, we found that the Veterans Home did not adequately document its processing of the alleged violations. The code of conduct specifies behaviors prohibited by members to preserve the tranquility of the Veterans Home and to ensure the rights and independence of each member. Our review of 25 violations alleged to have occurred in 2006 and 2007 found complete documentation in only 11 cases. For all 11 cases with complete documentation, we were able to verify that the Veterans Home followed its policies and procedures. In 12 of the 25 cases we reviewed, the Veterans Home did not maintain sufficient documentation for us to determine whether it followed all its policies and procedures. In the remaining two cases, using the limited documentation available to us, we determined that the Veterans Home did not follow appropriate policies and procedures. Without maintaining appropriate documentation, executive staff at the Veterans Home cannot be assured that alleged violations of the code of conduct receive consistent and equitable treatment.

Recommendations

To improve its ability to fill vacancies in key occupations, the Veterans Home should develop a comprehensive plan for recruitment and retention that establishes goals and strategies for reducing chronic vacancy rates and sets timelines and monitoring activities to keep recruiting efforts on track. To maximize its efforts to recruit for key health care positions, the Veterans Home should ensure that the recruitment efforts of all its departments are coordinated through a centralized position or program. In addition, the Veterans Home should implement the remaining steps it has currently identified to better recruit and retain health care staff.

To bolster recruitment efforts at the Veterans Home, Veterans Affairs should continue to develop its department-wide recruiting plan and oversee the recruiting plan the Veterans Home is implementing to ensure that it meets department-wide goals.

If Veterans Affairs is concerned that its ability to serve California veterans is limited by a regulation stating that less than 75 percent of skilled nursing beds must be occupied before it can admit new patients directly to that level of care, it should consider changing or eliminating that regulatory requirement.

To help ensure that newly hired employees at the Veterans Home can start work as soon as possible, the Veterans Home should monitor its new process for completing preemployment physicals. If the process is not resulting in new employees starting work more quickly, the Veterans Home should consider contracting with a vendor to provide the physicals.

To prevent its nursing staff from working excessive overtime, the Veterans Home should consider adopting a formal policy for distributing overtime more evenly among nurses, establishing a cap on how much overtime nursing staff can work, and monitoring overtime usage for compliance with these policies.

To ensure the Veterans Home's medical equipment is maintained as prescribed by the equipments' manufacturers, the Veterans Home should take the steps necessary to ensure the medical equipment inventory, on which maintenance activities are based, is accurate. In addition, to ensure payments to the maintenance contractor are appropriate, the Veterans Home should require the contractor to provide records of inspections and maintenance work performed prior to authorizing payments.

To meet the requirements of federal ADA regulations, the Veterans Home should develop and update as needed a plan that identifies areas of noncompliance and includes the appropriate steps and milestones for achieving full compliance. In addition, the Veterans Home should develop grievance procedures and identify a specific employee as its ADA coordinator.

To promptly resolve complaints it receives against the Veterans Home, Public Health should monitor its system for processing complaints.

To ensure that all complaints against the Veterans Home submitted to the Veterans Board are properly resolved, the Veterans Board should specify a time frame for resolving complaints in its new policy for complaint resolution and ensure it implements the policy.

To appropriately address complaints raised at resident council meetings, the Veterans Home needs to better document such issues, ensure that the relevant department resolves them, and promptly communicate their resolutions to all members.

To handle alleged violations of the code of conduct consistently and equitably, the Veterans Home should ensure that staff responsible for investigating the allegations fully document the investigations and their results.

Agency Comments

Veterans Affairs states that it generally found the report to be accurate and thorough, and expects it to be useful in its efforts to improve processes for accountability and efficiency of its organization. Veterans Affairs offers clarification on several issues we identified in the report.

Public Health agrees with our recommendation regarding its resolution of complaints against the Veterans Home.

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Introduction

Background

The Veterans Home of California at Yountville (Veterans Home) is one of three veterans homes in California administered by the California Department of Veterans Affairs (Veterans Affairs). To further serve California veterans, Veterans Affairs is building or plans to build five additional veterans homes. For fiscal year 2007–08 the Veterans Home has a budget of $94 million and 1,037 authorized positions.

According to its census for October 2007 through December 2007, the Veterans Home had 1,051 residents, whom it calls members. To be eligible for membership at the Veterans Home, individuals must be California residents, be at least age 62, and have served honorably in the armed forces. Disabled California veterans may apply for membership before reaching age 62.

On admission to the Veterans Home, members generally enter residential accommodations, also known as independent living. Members living in residential accommodations are self-sufficient and able to perform all the activities of daily living. The Veterans Home also offers licensed residential care (assisted living) for members who are self-sufficient and able to perform all the activities of daily living with minimal assistance. Finally, in N. M. Holderman Memorial Hospital (Holderman Hospital), which is operated by and located on the grounds of the Veterans Home, members can receive three levels of inpatient health care: intermediate, skilled nursing, and acute care. Table 1 shows the number of members receiving each level of care as of December 2007.

Table 1
Number of Veterans Home Members Receiving Each Level of Care at the Veterans Home
December 2007

LEVEL OF CARE	NUMBER OF RESIDENTS
Residential	648
Licensed residential	46
Intermediate	154
Skilled nursing	202
Acute	1
Total	**1,051**

Source: Veterans Home of California at Yountville census data (unaudited).

Although the Veterans Home serves primarily older veterans of past wars, it has implemented a new residential program called Pathway Home to address the challenges such as stress disorders and other disabilities that affect combat veterans as they adjust to civilian life following recent tours in Afghanistan and Iraq. The Veterans Home plans to initially work with 13 veterans in Pathway Home but will eventually expand its capacity to 40 members. The program is funded entirely by a private three-year grant of $5.62 million managed through the TIDES Center, a nonprofit entity located in the San Francisco Bay Area. At the end of the three-year grant period, the program is expected to become self-sustaining through partnerships and endowments.

Governance of the Veterans Home

The California Veterans Board (Veterans Board) is responsible for determining the policies for all operations of Veterans Affairs. It consists of seven members whose appointments by the governor are subject to the confirmation of the Senate. The Veterans Board also hears appeals by California veterans who have applied for benefits and wish to appeal any decision made by Veterans Affairs. In addition, the Veterans Board sometimes receives complaints from veterans living at the Veterans Home. Among the possible issues that a member might bring up in a complaint is a policy of the Veterans Board or some aspect of the operations of the Veterans Home.

The mission of Veterans Affairs is to serve California veterans and their families. A significant part of that mission is to provide the State's aged or disabled veterans with rehabilitative, residential, and medical care and services in a homelike environment at the California veterans homes. At Veterans Affairs the deputy secretary of veterans homes is responsible for administering all the California veterans homes and overseeing and monitoring all aspects of medical care being provided to the men and women residing at any of the veterans homes in the State. Veterans Affairs also responds to complaints about the veterans homes.

The governing body for all California veterans homes consists of the secretary of Veterans Affairs, the deputy secretary of veterans homes, and the deputy secretary for women and minority veterans affairs. According to its bylaws, the governing body has various powers to conduct, manage, and control the operations of the veterans homes. For example, the governing body has the power to provide appropriate physical resources and personnel to meet the needs of the veterans community and to participate in planning to meet the health needs of members of the veterans homes. The administrator

of each veterans home serves as the on-site representative of the governing body and is responsible for the day-to-day management of that home.

Oversight of the Veterans Home by State and Federal Agencies

The licensing and certification program of the California Department of Public Health (Public Health) licenses all health care facilities in California. Public Health has licensed Holderman Hospital at the Veterans Home as an acute care hospital with an attached skilled nursing facility. In addition to licensing health care facilities, Public Health periodically inspects the facilities for compliance with applicable laws and regulations. The inspections assess areas such as notices of rights and services for patients, grievances, and self-administration of drugs by residents. As a licensed acute care hospital that also provides skilled nursing care, Holderman Hospital is subject to various state laws and regulations that address minimum standards of nursing hours per patient day for skilled nursing and intermediate care facilities, and minimum nurse-to-patient staffing ratios in hospitals.

Until July 1, 2007, Public Health conducted inspections primarily to check compliance with federal requirements established by the Centers for Medicare and Medicaid Services. However, Chapter 895, Statutes of 2006, amended the Health and Safety Code to require Public Health to incorporate state and federal requirements into the periodic inspection process effective July 1, 2007. Included in the state requirements are staffing standards for personnel in Holderman Hospital who provide direct patient care. Public Health also responds to complaints about Holderman Hospital.

Similar to Public Health's licensing of health care facilities like Holderman Hospital, the Community Care Licensing Division (Community Care) of the California Department of Social Services (Social Services) licenses residential care facilities for the elderly and has licensed one of the residential buildings at the Veterans Home as such a facility. Community Care also conducts annual inspections at the Veterans Home to ensure compliance with applicable laws and regulations. Those inspections look into areas such as care for members with dementia, members' participation in making decisions on the care they will receive, and training of staff.

Community Care must also investigate complaints about residential care facilities for the elderly within 10 calendar days of receiving such complaints, except when the complaint involves any death of a child or a questionable death of an adult. In those cases the on-site

visit to investigate must occur within two business days. However, Community Care did not have any complaints on file dated later than 1997 regarding the facility it licenses at the Veterans Home.

The United States Department of Veterans Affairs (USVA) conducts on-site inspections of the Veterans Home annually to determine compliance with applicable statutory and regulatory requirements. These include the acute care and skilled nursing facilities of the hospital, and all residential care facilities at the Veterans Home and cover areas such as medical care and social services to meet members' social and emotional needs, staff qualifications, and medical records.

The Veterans Home is also subject to the federal Americans with Disabilities Act (ADA), which, among other things, requires that state and local government facilities ensure that their programs and services are accessible to individuals with disabilities.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the Veterans Home, with an emphasis on the adequacy of health care and accommodation of members with disabilities. Specifically, the audit committee requested that we determine the roles and responsibilities of the various entities involved in the governance of the Veterans Home and review and assess the policies and procedures for filing, investigating, and taking corrective action on complaints from members. We were also asked to determine whether any entities with governance responsibilities for the Veterans Home have evaluated staffing levels for medical personnel at the Veterans Home or identified a need for additional positions for medical personnel; identify any best practices or industry standards applicable to staffing at the Veterans Home; review the Veterans Home's staffing ratios, identify any personnel shortages, and identify actions the Veterans Home has taken to address personnel shortages; and determine whether the Veterans Home or Veterans Affairs has an authorized position of skilled nursing facility administrator. Additionally, the audit committee asked us to evaluate efforts the Veterans Home has made to ensure that its facilities and services are meeting the accessibility requirements of the ADA, assess how the Veterans Home manages its medical equipment to ensure that it is up to date and functioning properly, and review how the Veterans Home ensures compliance with its code of conduct.

To determine the roles and responsibilities of the various entities involved in the governance of the Veterans Home, we reviewed applicable laws and regulations and interviewed appropriate personnel from the following entities: the Veterans Home, Veterans Affairs, Public Health, Community Care, and the USVA. When applicable we also reviewed the policies and procedures of these entities as well as reports they completed following inspections or complaint investigations.

Public Health conducted inspections of Holderman Hospital in 2005, 2006, and 2007. Although Public Health identified deficiencies in each of the inspections it conducted at the Veterans Home since July 2005, none of the deficiencies posed immediate jeopardy or actual harm to members of the Veterans Home. The Veterans Home developed and submitted to Public Health within required time frames plans of correction to address the deficiencies identified by Public Health.

Inspections that Community Care conducted at the Veterans Home in 2005, 2006, and 2007 revealed no deficiencies in 2007 and no serious deficiencies in any of the three years. Community Care identified several type B, or lower-level, deficiencies in both 2005 and 2006. The Veterans Home submitted to Social Services proof-of-correction documentation for the identified deficiencies within the required time frame, and Community Care accepted the documentation as appropriate.

The USVA identified 34 deficiencies during its three inspections in 2005, 2006, and 2007. Of those 34 deficiencies, 22 were cases in which the Veterans Home partially met a standard and 12 instances when the Veterans Home did not meet a standard. In 2007 the Veterans Home had only three deficiencies, with only one deficiency a repeat from a previous year. Within required time frames the Veterans Home developed and submitted to the USVA plans of correction to address the deficiencies, and the USVA judged the plans for the 2005 and 2006 inspections acceptable. As of March 26, 2008, the USVA had not informed the Veterans Home whether its plan of correction for the 2007 inspection was acceptable.

To determine whether any entities with governance responsibilities for the Veterans Home have evaluated staffing levels for medical personnel at the Veterans Home or identified a need for additional positions for medical personnel, we interviewed officials at the Veterans Home and Veterans Affairs regarding staffing levels for medical personnel, reviewed human resource documents at the Veterans Home, and reviewed budget change proposals regarding staffing prepared by the Veterans Home or Veterans Affairs. We

also reviewed inspection documents prepared by the USVA and Public Health to determine whether those entities evaluated staffing levels for medical personnel.

To identify any best practices or industry standards applicable to staffing at the Veterans Home, we conducted a literature review, interviewed staff at a hospital industry association, reviewed applicable laws and regulations, and interviewed officials with governance responsibilities for the Veterans Home.

To assess staffing levels for medical personnel at the Veterans Home, we reviewed applicable laws and regulations, staffing information in the governor's budget, and staffing information maintained by the Veterans Home and Veterans Affairs. To review compliance with staffing standards for personnel in Holderman Hospital who provide direct patient care, we validated the methodology the Veterans Home uses to ensure that it meets standards for acute care, skilled nursing, and intermediate care, and we used that methodology to test whether the Veterans Home met the staffing standards in 2007.

To identify any personnel shortages at the Veterans Home, we interviewed officials at Veterans Affairs, the Veterans Home, the Department of Personnel Administration, and the Department of Finance, as well as members of the Veterans Home. Using information from the salaries and wages supplements of the governor's budgets for fiscal years 2005–06 through 2008–09, we calculated vacancy rates for occupations employed by the Veterans Home. To provide context for the vacancy rates we calculated for the Veterans Home, we also calculated vacancy rates for three other state facilities within commuting distance of the Veterans Home.

To determine actions the Veterans Home has taken to address personnel shortages, we interviewed officials at the Veterans Home and Veterans Affairs and reviewed various documents related to the issue, including staffing documents, the strategic plan developed by the Veterans Home, and budget change proposals.

To determine whether the Veterans Home or Veterans Affairs has an authorized position of skilled nursing facility administrator, whether the Veterans Home or Veterans Affairs redirected a skilled nursing facility administrator position, and the reasons for a redirection if it occurred, we interviewed officials at the Veterans Home and reviewed relevant personnel documents.

To determine the adequacy of the processes for handling complaints by members of the Veterans Home, we obtained and reviewed the policies and procedures of the entities to which complaints are generally submitted. Members of the Veterans

Home can file formal or informal complaints with various entities, including the Veterans Home, Veterans Affairs, the Veterans Board, Public Health, Community Care, and legislative members and their staff. We also interviewed responsible officials at state departments and the Veterans Home regarding their practices for processing complaints and reviewed a sample of complaints filed to determine whether the complaints were satisfactorily resolved.

To evaluate the efforts made by the Veterans Home to ensure that its facilities and services are meeting the accessibility requirements of the ADA, we interviewed officials at the Veterans Home, Veterans Affairs, and the Department of General Services. We also reviewed applicable state and federal laws and regulations as well as the ADA Title II Technical Assistance Manual, developed by the U.S. Department of Justice, covering state and local government programs and services.

To assess how the Veterans Home manages its medical equipment to ensure that it is up to date and functioning properly, we interviewed officials at the Veterans Home and a contractor hired by the Veterans Home to maintain its medical equipment, and we reviewed the medical equipment maintenance contract, inventory, maintenance schedules, and invoices and related documentation supporting payments to the contractor. In addition, we selected a sample of 31 items from the medical equipment inventory and conducted various tests to determine whether the contractor was performing appropriate maintenance on the items and otherwise fulfilling the requirements of the medical equipment contract.

To review how the Veterans Home ensures compliance with its code of conduct, we reviewed the code, interviewed officials at the Veterans Home, and reviewed a sample of cases involving code of conduct issues.

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Chapter 1

THE CALIFORNIA DEPARTMENT OF VETERANS AFFAIRS NEEDS TO STRENGTHEN PLANNING AND OVERSIGHT IN KEY OPERATIONAL AREAS AT THE VETERANS HOME OF CALIFORNIA AT YOUNTVILLE

Chapter Summary

The Veterans Home of California at Yountville (Veterans Home) has not had a comprehensive strategy for filling chronic vacancies in key staffing areas. In addition, the recruitment efforts of the Veterans Home have not been coordinated, with different departments at the Veterans Home conducting different recruitment activities without coordinating with a central organization such as the human resources department. These problems have contributed to the Veterans Home having continuing difficulty in filling key vacancies. More importantly, chronic vacancies in key health care positions limit the ability of the Veterans Home to fully utilize its existing bed capacity to serve veterans or to consider increasing its capacity to meet the demands of veterans desiring to reside at the Veterans Home. In addition, overtime is not equally distributed among nursing staff. The resulting excessive overtime for some staff might limit their ability to function optimally and thus could compromise the safety of residents at the Veterans Home (members).

Lax oversight of its medical equipment maintenance contract has had two consequences for the Veterans Home: the home has little evidence that medical equipment has been maintained as needed to best serve members, and the Veterans Home may have authorized unwarranted payments to the contractor responsible for performing the maintenance because the home did not have evidence that the work was performed. Although equipment maintenance under the contract and payments to the contractor are initially based on an inventory of the medical equipment used in N. M. Holderman Memorial Hospital (Holderman Hospital), the manager at the Veterans Home who is responsible for the medical equipment contract relies on the departments in the hospital and on the contractor to maintain an accurate equipment inventory but does not perform sufficient monitoring or testing of the inventory to ensure its accuracy. In addition, the Veterans Home does not sufficiently monitor the contractor's equipment maintenance activities to ensure that scheduled preventative maintenance was performed and payments to the contractor were appropriate.

Further, the Veterans Home does not have a plan for fully meeting the requirements of the Americans with Disabilities Act (ADA). According to the equal employment opportunity/civil rights officer

of the California Department of Veterans Affairs (Veterans Affairs), Veterans Affairs has not fully assessed the programs and services or infrastructure at the Veterans Home to identify areas where it may not be ADA compliant, nor has it or the Veterans Home developed a plan for achieving full compliance. As a result, it is not clear to what extent the Veterans Home meets the program accessibility requirements of the ADA.

Chronic Vacancies Have Limited the Ability of the Veterans Home to Serve More Veterans

The Veterans Home has had difficulty filling key health care positions in recent years. Nurses, pharmacists, and respiratory care practitioners are among the professionals most needed at the Veterans Home. According to the deputy administrator of the Veterans Home (deputy administrator), the chronic vacancies have made it difficult to meet the demand for services to veterans and have resulted in nursing staff working substantial amounts of overtime to meet staffing guidelines. Table 2 shows the vacancy rates of in-demand nursing and non-nursing health care positions for fiscal years 2004–05 through 2006–07. For our analysis we designated as in-demand all health care positions at the Veterans Home that each year had five or more full-time equivalent authorized positions and experienced vacancy rates greater than 10 percent.

The Veterans Home has had particular difficulty maintaining an adequate level of nursing employees. As indicated in Figure 1 on page 20, nursing positions, including nursing assistants, accounted for 41.5 percent of the total vacancies (66 of 159) at the Veterans Home in fiscal year 2006–07.

According to the deputy administrator of the Veterans Home, the Veterans Home has had difficulty filling its available beds for the last several years, primarily because of vacancies in key occupations such as physicians and nurses.

The mission of Veterans Affairs includes providing the State's aged or disabled veterans with rehabilitative, residential, and medical care and services in a homelike environment. To accomplish that mission, Veterans Affairs set the goal of providing the best long-term care and enhanced quality of life for all residents at the State's three veterans homes. According to the deputy administrator, part of its mission is to accommodate as many veterans as it can within its budgetary and staffing authority. He further indicated that the Veterans Home has had difficulty filling its available beds for the last several years, primarily because of vacancies in key occupations such as physicians and nurses. At Holderman Hospital, the Veterans Home must meet statutory requirements for nurse staffing levels at the intermediate care, skilled nursing, and acute care facilities. Therefore, the number of patients the hospital can accept is directly linked to the number of nursing staff employed in the hospital.

Table 2
Vacancy Rates for In-Demand Positions at the Veterans Home
Fiscal Years 2004–05 Through 2006–07

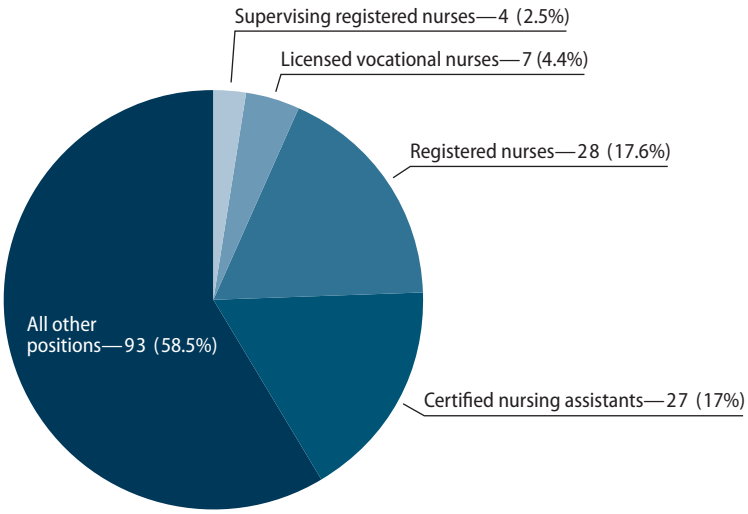
			2004–05	2005–06	2006–07
Nursing positions	Certified nursing assistant	Filled positions	177.6	173.0	170.5*
		Authorized positions	198.1	197.0	197.6*
		Vacancy rate	**10.3%**	**12.2%**	**13.7%**
	Licensed vocational nurse	Filled positions	29.1	29.1	31.5*
		Authorized positions	38.0	38.0	38.0*
		Vacancy rate	**23.4%**	**23.4%**	**17.1%**
	Registered nurse	Filled positions	77.6	72.6	68.5*
		Authorized positions	96.6	96.6	96.6*
		Vacancy rate	**19.7%**	**24.8%**	**29.1%**
	Supervising registered nurse	Filled positions	15.8	16.4	16.4*
		Authorized positions	20.0	20.0	20.0*
		Vacancy rate	**21.0%**	**18.0%**	**18.0%**
Non-nursing health care positions	Respiratory care practitioner	Filled positions	3.8	3.7	3.2
		Authorized positions	5.0	5.0	5.5
		Vacancy rate	**24.0%**	**26.0%**	**41.8%**
	Pharmacist I and II	Filled positions	4.5	3.7	3.5
		Authorized positions	5.5	5.5	6.5
		Vacancy rate	**18.2%**	**32.7%**	**46.2%**
	Clinical dietitian	Filled positions	5.4	3.9	4.5
		Authorized positions	6.0	6.0	7.0
		Vacancy rate	**10.0%**	**35.0%**	**35.7%**
	Physician and surgeon	Filled positions	11.2	11.4	12.2
		Authorized positions	13.5	14.5	14.5
		Vacancy rate	**17.0%**	**21.4%**	**15.9%**

Source: Salaries and wages supplements of the governor's budget for fiscal years 2005–06 through 2008–09 (unaudited).

* Excludes authorized positions that the Veterans Home of California at Yountville (Veterans Home) did not fill in 2006–07 as a result of delays in opening the Veterans Home's new memory care center. Positions excluded are 14.3 registered nurses, 9.5 licensed vocational nurses, 45.9 certified nursing assistants, and 2 supervising registered nurses.

The Veterans Home has authorized nursing positions to serve more veterans than it currently does. As part of our staffing review, we determined the number of beds the Veterans Home would be able to fill if it filled all its authorized nursing positions. Using the nurse staffing model developed by the Veterans Home and staffing information in the 2008–09 Governor's Budget, we estimated that with all its nursing positions filled, the Veterans Home would be able to serve approximately 435 licensed beds in Holderman Hospital without the use of significant amounts of overtime.

Figure 1
Percentage of All Veterans Home Vacancies That Occurred Among Nursing Positions
Fiscal Year 2006–07



Source: Salaries and wages supplements of the governor's budget for fiscal years 2007–08 and 2008–09 (unaudited).

Note: Excludes vacancies in authorized nursing positions that the Veterans Home of California at Yountville (Veterans Home) did not fill in fiscal year 2006–07 as a result of delays in opening the Veterans Home's new memory care center. Positions excluded are 14.3 registered nurses, 9.5 licensed vocational nurses, 45.9 certified nursing assistants, and 2 supervising registered nurses.

The current bed capacity at the Veterans Home is also sufficient to serve a greater number of veterans than it does now. As of November 15, 2007, the California Department of Public Health (Public Health) had licensed Holderman Hospital for 656 inpatient beds, including 204 intermediate care beds, 416 skilled nursing beds, six acute psychiatric beds, and 30 general acute care beds. Public Health licenses beds for occupancy when a facility shows that all aspects of its operations—the premises, management, equipment, staffing, and standards of care—comply with the requirements of the Health and Safety Code. However, the Veterans Home activates, or makes available to members, only a subset of its licensed beds. At the same time, the hospital has a largely unused third floor. The number of beds the Veterans Home chooses to activate at each level of care is driven by the needs of the residential care population, available staffing, and the constraints of the budget. The remaining beds are classified as suspended and are unused by the Veterans Home.

Table 3 displays the number of licensed inpatient beds by their status as of December 2007. The Veterans Home had activated only 418 of the 656 beds for which it was licensed, including

just 229 beds in the skilled nursing facility, 169 beds in intermediate care, and 20 beds in the acute care facility. All the Veterans Home's six licensed psychiatric acute care beds have been suspended.

Table 3
Licensed and Active Beds in Holderman Hospital
December 2007

LEVEL OF CARE	LICENSED BEDS	SUSPENDED BEDS	ACTIVE BEDS	OCCUPIED BEDS	WAITING LIST
Intermediate	204	35	169	154	220
Acute psychiatric*	6	6	0	NA	NA
Skilled nursing	416	187	229	202	250
Acute	30	10	20	1	NA
Totals	**656**	**238**	**418**	**357**	**470**

Sources: Data on *licensed*, *suspended*, and *active beds* from the California Department of Public Health (Public Health) (unaudited). Data on *occupied beds* and the *waiting list* from the Veterans Home of California at Yountville (unaudited).

NA = Not applicable.

* Effective November 2007, Public Health approved 44 skilled nursing beds being used for mentally disordered patients.

According to the deputy administrator, the Veterans Home would like to fill all beds for which it has budgetary and staffing authority. The deputy administrator further stated that the Veterans Home has had difficulty filling its active beds for several years because of staffing shortages in key occupations. Table 3 also shows the Veterans Home had 357 occupied beds in December 2007. That number represents 85 percent of the active beds and 54 percent of the licensed beds at the Veterans Home at that time.

According to Veterans Affairs' assistant deputy secretary of veterans homes, Veterans Affairs does not intend to activate the suspended beds currently in Holderman Hospital but plans to build a new long-term care facility at the Veterans Home to house a maximum of 280 skilled nursing beds. The deputy administrator stated that Holderman Hospital does not provide a sufficiently homelike environment. Built in 1932 the hospital was not designed to be a long-term care facility, and its buildings do not present the comfort and quality of life that the Veterans Home strives to provide its members. As a result, the Veterans Home would not want to expand substantially beyond the current number of active licensed beds. Further, Veterans Affairs is building five new veterans homes around the State that will, according to the deputy administrator, partially relieve demand for direct admission to licensed beds at Yountville.

Veterans Affairs also believes that California's veterans homes should be more geographically dispersed and should primarily serve veterans in the geographical region in which they are located. As such, Veterans Affairs believes that the Veterans Home is already housing veterans from a broader geographical region than it will serve in the future after the new veterans homes are open. Nonetheless, the current demand for inpatient care at the Veterans Home, combined with the demonstrated capacity of Holderman Hospital, suggests that if the Veterans Home could recruit and retain more health care staff, it could increase the number of veterans it serves.

Documents submitted by the Veterans Home to its governing body show that the demand in the veterans community for the inpatient care offered by the home is unmet. Medical administrative services maintains waiting lists for applicants to the Veterans Home who would not be able to live in the independent-living or assisted-living facilities. Those applicants are placed on waiting lists for intermediate care, skilled nursing care, or both, depending on the level of care determined by their physicians and by medical reviews conducted by the Veterans Home. Individuals admitted to the Veterans Home are subsequently removed from the waiting lists. At the January 17, 2008, governing body meeting, the Veterans Home indicated it had a waiting list of 250 veterans for skilled nursing beds and a waiting list of 220 veterans for intermediate care beds as of December 2007. Although we could not verify the accuracy of the waiting lists because the Veterans Home had not verified since October 2006 that veterans on the lists still wanted to become members, the existence of the waiting lists points to some level of unmet demand for entry into the Veterans Home. The chief of medical administrative services told us that, with few exceptions, veterans on the waiting lists do not currently live at the Veterans Home.

According to the Veterans Home, it had a waiting list of 250 veterans for skilled nursing beds and a waiting list of 220 veterans for intermediate care beds as of December 2007.

Moreover, the Veterans Home is planning to recruit more veterans as members. In the May 2007 update to its strategic plan, the Veterans Home identified a goal of expanding outreach activities to veterans and their families. Specifically, the Veterans Home plans to work with county veterans services offices and the United States Department of Veterans Affairs offices in Northern California to identify and place marginalized and homeless veterans.

The ability of the Veterans Home to fill its beds from the waiting lists is also potentially limited by a regulation stating that less than 75 percent of skilled nursing beds must be occupied before the Veterans Home can admit new members directly to that level of care. According to Veterans Affairs, when testing for compliance with this requirement it applies the 75 percent factor to the number of active beds. Veterans Affairs also stated the regulation

was put in place to protect the rights of current members of each of the State's veterans homes to have first priority in ascending to higher levels of care. However, concerned that the regulation was unnecessarily limiting the veterans homes' ability to fill their vacant beds, Veterans Affairs suspended the regulation in 2004. Although the regulation became effective again in 2006, the deputy administrator stated that the Veterans Home was not aware that it had been reinstated, and management has continued to exercise discretion in admitting patients to higher levels of care when humanitarian issues are a concern or when statutorily required to admit a veteran who is a former prisoner of war or a Medal of Honor recipient. According to Veterans Affairs, it intends to initiate a regulatory change within six months that will grant the administrators the discretion to admit veterans to skilled nursing care while ensuring that existing residents have access to that level of care. Currently, however, the regulation could limit the number of veterans the Veterans Home serves.

Unequally Distributed Overtime Could Compromise Patient Safety

The Veterans Home's inability to reach full staffing, particularly in nursing positions, has resulted in substantial amounts of overtime worked by its health care staff to meet nursing staffing requirements for current members. Although our review did not uncover any incidents when overtime had an impact on patient care, we found one study that correlated excessive overtime among nursing staff with an increased incidence of medical errors.

State law stipulates that all skilled nursing facilities without patients certified for special treatment programs must have sufficient nursing staff on duty to provide 3.2 hours of direct care daily for each patient, and that intermediate care facilities must have sufficient nursing staff on duty to provide 1.1 hours of direct care daily for each patient. State regulations also require that all acute care wards have a 1:5 ratio of nursing staff to patients at all times in facilities with beds licensed for medical or surgery care.

State regulations dictate the minimum amount of nursing care required in skilled nursing and intermediate care facilities. According to the director of nursing at the Veterans Home, the number of nurses used to provide this care must be reasonable to provide safe and appropriate care according to the individual patient's needs, assessments, planning, and quality of life. As a result, the Veterans Home staffs its wards to meet the State's staffing standards or, in wards with particular health care requirements, to exceed them. For example, the Veterans Home staffing guide calls for 1.8 hours of direct patient care daily for each patient in intermediate care wards instead of the 1.1 hours required

The Veterans Home staffs its wards to meet the State's staffing standards or, in wards with particular health care requirements, to exceed them.

by state regulations. The staffing guide also requires 3.2 hours of care daily for patients in skilled nursing wards who do not have special treatment needs. For skilled nursing wards with patients who have special treatment needs, the Veterans Home's standard is either 3.5 or 5 hours of direct patient care daily for each member based on the extent to which some members require more intensive monitoring than others. The Veterans Home further defines daily staffing requirements for the three work shifts: day, afternoon, and night. For example, for skilled nursing without special treatment programs, the day shift standard is 1.5 hours of direct patient care for each patient, 1 hour for the afternoon shift, and 0.7 hour for the night shift. For skilled nursing with special needs programs that require 5 hours of direct patient care daily, the standards are 2.5 hours for the day shift, 1.5 hours for the afternoon shift, and 1 hour for the night shift. For intermediate care, the standards are 0.8 hour for the day shift and 0.5 hour each for the afternoon and night shifts.

To test whether the Veterans Home met all staffing requirements in Holderman Hospital, we reviewed staffing records from 10 days in 2007. Our analysis revealed that although the Veterans Home met or exceeded all the staffing requirements of state regulations and substantially met its internal staffing guidelines, it did not meet its internal guidelines in six instances for the 10 days we reviewed. Table 4 shows the instances in which the Veterans Home did not meet its internal guidelines for nursing hours during the day shift. In three cases not meeting the day shift guideline resulted in the Veterans Home marginally not meeting its guideline of 1.8 nursing hours per patient per day for intermediate care wards.

According to the director of nursing, the Veterans Home prefers to staff at 1.8 hours of nursing care per patient per day to ensure the safety and security of both residents and staff. To accomplish this, the Veterans Home schedules two nurses on each intermediate care ward at all times, which nominally results in 1.8 nursing care hours daily for each patient. However, our review of the staffing schedule revealed that if all the beds in each of the intermediate care wards were fully occupied, two nurses per shift would rarely equate to the 1.8-hour guideline. Nonetheless, the Veterans Home staffing guidelines ensure that all residents receive at least the state mandated minimum nursing hours at all times.

Employees in some health care positions at the Veterans Home are working substantial amounts of overtime to meet internal staffing standards and state regulations. Units of the Veterans Home reporting to the director of nursing earned a total of $2.7 million in overtime pay and $30,000 in overtime accrued as leave in fiscal year 2006–07. To get a sense of how many hours of overtime nursing staff worked, we reviewed overtime in the skilled nursing wards of

Table 4
Wards in Holderman Hospital That Did Not Meet the Veterans Home Day Shift Staffing Guidelines
10 Days in 2007

	HOURS PER PATIENT PER DAY			TOTAL HOURS FOR THE DAY SHIFT		
WARD TYPE	REQUIRED*	WORKED	DIFFERENCE†	REQUIRED‡	WORKED	DIFFERENCE
Skilled nursing with special needs	5.0	5.26	0.26	47.5	36	(11.5)
Skilled nursing with special needs	5.0	5.05	0.05	47.5	40	(7.5)
Intermediate	1.8	1.71	(0.09)	22.4	16	(6.4)
Intermediate	1.8	1.85	0.05	20.8	16	(4.8)
Intermediate	1.8	1.73	(0.07)	24.0	16	(8.0)
Intermediate	1.8	1.66	(0.14)	23.2	16	(7.2)

Sources: N. M. Holderman Memorial Hospital patient census, daily shift assignments, and ward sign-in sheets (unaudited); Veterans Home of California at Yountville payroll forms (unaudited).

* Based on Veterans Home staffing guidelines.

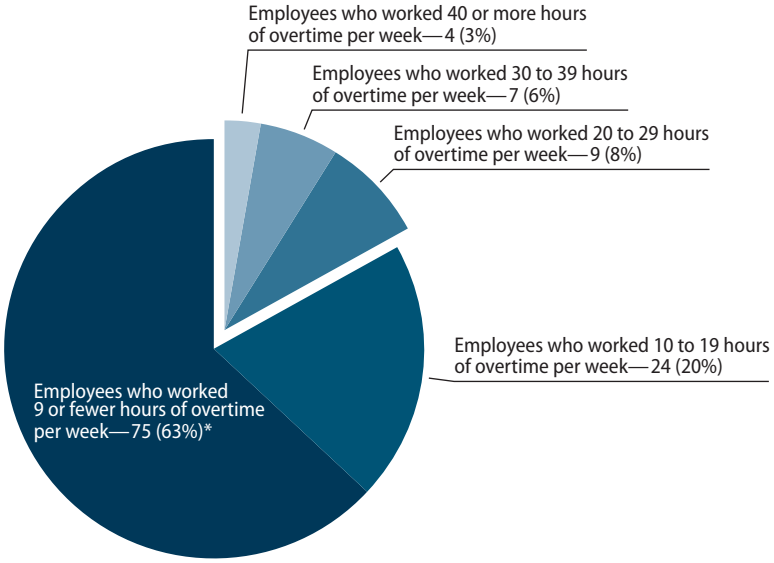
† All daily nursing hour guidelines are in excess of the minimum number of nursing hours per patient required by state law.

‡ Based on ward occupancy and Veterans Home staffing guidelines.

Holderman Hospital for October through December 2007. Those wards employ approximately 86 percent of the total nursing staff in Holderman Hospital. We determined that 28 registered nurses, 16 licensed vocational nurses, and 75 certified nurse assistants worked a total of more than 16,000 overtime hours in the last three months of 2007. Although this might sound extreme, not all nurses worked overtime. As indicated in Figure 2 on the following page, 20 members of the nursing staff worked an average of more than 20 hours of overtime each week. However, if the overtime had been equally distributed among all registered nurses, licensed vocational nurses, and certified nursing assistants, nursing staff would have averaged 5.4, 6.3, and 6.5 hours per week, respectively, from October through December 2007. In comparison, according to the 2004 National Sample Survey of Registered Nurses, the typical full-time registered nurse works an average of 7.5 hours overtime each week.

The director of nursing told us that the Veterans Home does not have an explicit policy that limits the amount of overtime an individual can work. In addition, the contract between the Veterans Home and the union representing nursing staff strongly encourages the use of volunteer rather than mandatory overtime. However, as shown in Figure 2, overtime is not distributed equally across individuals. The director of nursing told us that the Veterans Home is implementing changes to address the overtime imbalance by creating a process to monitor overtime usage and assign overtime more equitably among all nursing staff.

Figure 2
Average Weekly Overtime in the Holderman Hospital Skilled Nursing Wards October Through December 2007



Source: State Controller's Office blanket expenditure reports (unaudited).

* Fifty-six nursing staff members worked 5 or fewer hours of overtime on average per week.

Although nothing came to our attention indicating that the overtime worked at the Veterans Home has affected the quality of care provided to patients, one research study we reviewed suggested that working substantial amounts of overtime could increase the risk of medical errors. Specifically, the study found a higher incidence of errors in administering medication, charting, and transcription as a result of excessive overtime. Errors in medication administration constituted the majority of errors reported by nurses in the study. Researchers found that when a nurse worked more than 12.5 hours, regardless of scheduled shift length, the incidence of medical errors tripled. The risk of errors also increased when a nurse worked more than 40 or 50 hours in a week. In addition to compromising patient safety, the use of excessive overtime can negatively affect morale among the nursing staff. The deputy administrator expressed concerns that the use of mandatory overtime could also be a detriment to morale and have a negative impact on the ability of the Veterans Home to recruit and retain nurses.

The Veterans Home Faces External and Internal Challenges in Recruiting and Retaining Health Care Staff

According to the deputy administrator, recruiting and retaining health care professionals are problems at the Veterans Home, particularly for positions requiring specialized skills. He identified two primary external challenges to filling all available positions: low salaries and the high cost of housing in the community. In addition, its lack of a comprehensive recruitment plan and the decentralized structure of its efforts to meet recruiting goals are among the internal factors hampering the ability of the Veterans Home to meet its staffing requirements.

Low Salaries and High Housing Costs Make It Difficult for the Veterans Home to Compete With Other Hospitals for High-Demand Positions

A major factor in recruiting and retaining critical staff is the competition the Veterans Home faces with other state and private hospitals in the area, including the California Department of Corrections and Rehabilitation's (Corrections and Rehabilitation) California Medical Facility in Vacaville, the Sonoma Developmental Center, Napa State Hospital, and the privately run Queen of the Valley Medical Center in Napa. As shown in Table 5 on the following page, state facilities had high vacancy rates in several key positions.

Salaries and benefits offered for many of the high-demand positions are lower at the Veterans Home than in some other state hospitals. For example, in January 2008 the entry-level monthly salary, including recruitment and retention differentials, for registered nurses at the Veterans Home was $4,854 compared with $7,591 at the California Medical Facility and $5,813 at Napa State Hospital. Other critical health care positions for which salaries at the Veterans Home lag those at other state and local facilities include licensed vocational nurses, pharmacists, and physicians and surgeons. Moreover, the maximum salaries for high-demand positions are lower at the Veterans Home than at some other local facilities. For example, the maximum salary, including recruitment and retention differentials, for registered nurses at the Veterans Home was $6,439 in January 2008 compared with $8,737 at the California Medical Facility and $7,261 at Napa State Hospital. The primary reason for the differences in salaries at state government hospitals is the increases in the salaries for medical and mental health positions at Corrections and Rehabilitation facilities that resulted from recent federal court decisions.

The primary reason for the differences in salaries at state government hospitals is the increases in the salaries for medical and mental health positions at the California Department of Corrections and Rehabilitation facilities that resulted from recent federal court decisions.

Table 5
Vacancy Rates for High-Demand Positions at the Veterans Home and Comparison Institutions
Fiscal Year 2006–07

	VETERANS HOME*	NAPA STATE HOSPITAL	SONOMA DEVELOPMENTAL CENTER	CALIFORNIA MEDICAL FACILITY
Nursing Positions†				
Registered nurses	29.1%	0.0%	32.9%	15.3%
Supervising registered nurses	18.0	0.0	20.0	7.5
Licensed vocational nurses	17.1	3.9	23.0	‡
Non-nursing Health Care Positions				
Clinical dietitians	35.7	45.6	26.7	‡
Physicians and surgeons	15.9	23.2	18.3	37.8
Respiratory care practitioners	41.8	0.0	46.7	24.0
Pharmacists I and II	46.2	45.8	25.7	48.9

Source: Salaries and wages supplements of the governor's budgets for fiscal years 2006–07 and 2007–08 (unaudited).

Note: A zero percent vacancy rate indicates that actual full-time equivalents worked exceeded authorized positions.

* Excludes vacancies in authorized positions that the Veterans Home of California at Yountville (Veterans Home) did not fill in fiscal year 2006–07 as a result of delays in opening the Veterans Home's new memory care center. Excluded positions are 14.3 registered nurses, 9.5 licensed vocational nurses, 45.9 certified nursing assistants, and 2 supervising registered nurses.

† Does not include certified nursing assistants (CNAs), because the Veterans Home was the only facility with authorized CNA positions in fiscal year 2006–07.

‡ This facility did not have any authorized positions for this classification in fiscal year 2006–07.

The Veterans Home must also contend with statewide shortages in several high-demand health care occupations. According to a report published by the California Center for Health Workforce Studies, the shortage of registered nurses in California in 2007 was estimated to be between 10,294 and 59,027 full-time equivalent positions. In addition, the California Hospital Association, a trade organization with more than 400 hospital and health system members, reported that a 2007 statewide survey revealed problems filling several non-nursing health care positions, including clinical laboratory scientists, pharmacists, respiratory therapists, and physical therapists.

The deputy administrator noted another reason the Veterans Home has difficulty recruiting and retaining key health care staff: homes in the Napa Valley and the surrounding area are expensive. According to the California Association of Realtors, the median price of homes sold in Napa County in December 2007 was $570,750, whereas the median price of homes sold in California in the same month was $475,460. Together, the problems of relatively low salaries for health care occupations at the Veterans Home and relatively high housing

costs near the Veterans Home underscore the importance of the Veterans Home developing a thorough plan for recruiting and retaining staff.

Insufficient Strategic Planning and a Decentralized Recruitment Program Are Among the Internal Problems the Veterans Home Needs to Resolve

Although aware of the challenges in recruiting and retaining staff in key nursing and other professional health care positions, Veterans Affairs and the Veterans Home have been slow to develop a comprehensive recruitment plan to address the issues. In its 2007 strategic plan, the Veterans Home lists the goal of attracting and retaining qualified and caring staff. Objectives noted in the strategic plan include enhancing in-service training, expanding recruitment outreach to health care professionals, promoting staff recognition and reward systems, strengthening staffs' job skill sets, standardizing individual development plans and performance appraisals for employees, and obtaining staff input in assessing the workplace environment. However, the strategic plan does not provide a sufficiently detailed blueprint for addressing the critical recruitment and retention needs of the Veterans Home.

Specifically, the activities designed to further the objectives listed in the strategic plan are frequently too vague to determine how they will be achieved. For example, the plan requires the Veterans Home to "provide additional transitional housing benefits to assist employees relocating to this high-cost area." However, the plan does not specify a process for meeting that target or designate the person or department responsible for monitoring the process. In addition, key areas of improvement that the Veterans Home has separately identified as important, including the centralization of recruiting functions that we discuss next, are not addressed in the plan. Finally, the strategic plan does not tie the objectives of the plan to specific measurable outcomes, does not list responsibilities or timelines for several tasks, and does not provide specific monitoring steps or guidelines to ensure that the plan remains on track.

The Veterans Home also has not developed a centralized program to support its recruiting goals and activities. Although not required, we believe a centralized program would be a good management practice that would clarify responsibilities and increase accountability. According to the deputy administrator, there has been no evidence of a concerted recruitment program or an advertising budget available to start one at the Veterans Home at any time during the past 20 years. The reason for the lack of recruiting efforts is that at one time the Veterans Home was well known in the area as an employer and could hire entry-level personnel whom it would develop through their careers. The deputy

administrator further stated that over many years the human resources department at the Veterans Home has decentralized several key human resources functions to various departments at the Veterans Home—including training and development, and recruitment and retention—which the Veterans Home is now beginning to restore. He also told us that the training function was lost when the former training officer position was transferred to nursing and then lost in a subsequent budget reduction.

The decentralized recruiting structure currently in use at the Veterans Home has resulted in overlapping responsibilities and reduced accountability.

The decentralized recruiting structure currently in use at the Veterans Home has resulted in overlapping responsibilities and reduced accountability. According to the deputy administrator, the individual department chiefs have largely picked up training and recruitment functions at the Veterans Home. He further stated that until mid-2007, the entire annual budget for recruiting totaled between $7,000 and $12,000 and was made available solely to the nursing department at the Veterans Home rather than centrally to the human resources department. Other departments at the Veterans Home use their own staff and funds to advertise vacancies, and departments generally perform their own recruiting activities. For example, the chief of rehabilitative services said that her department has been independently posting rehabilitative services job vacancies on private recruiting Web sites and has sent letters and job announcements to education and training programs for physical therapists, physical therapy assistants, and speech therapists nationwide.

Further, the chief of human resources at the Veterans Home told us that some departments have been performing certain functions that typically are also done by the human resources department, such as scheduling applicants for physicals and fingerprinting. Although departments at the Veterans Home may have a role in performing independent outreach and recruiting activities, the current redundancy of functions has resulted in a patchwork of recruiting efforts that makes it difficult for the Veterans Home to meet its health care staffing needs.

Although certain recruitment functions have been assumed by the individual department chiefs, the Veterans Home has not collected or shared important recruitment information with department managers. According to the chief of human resources at the Veterans Home, until November 2007 the home maintained only the current month's position vacancy data, which made it difficult to monitor changes in vacancies from prior months and measure the impacts of any recruitment efforts. The chief of human resources further stated that because exit interview forms are not always completed, useful data that might be collected are not captured or tracked by the Veterans Home and therefore are not provided to department managers. For confidentiality reasons, department managers are not

permitted to view the exit interview forms of departing employees. Further, the deputy administrator stated that the Veterans Home does not conduct regular employee surveys that would enable department managers to gauge job satisfaction among their staff. As a result, both the administration and individual departments are limited in their ability to address employees' concerns with their jobs, identify the reasons for those concerns (beyond high housing costs and low salaries), and devise methods for fostering recruitment and retention.

Despite persistent vacancies in key health care positions, the Veterans Home has had limited success in its efforts to expand the pool of potential employees. While some department chiefs may perform certain recruiting and outreach functions for their own departments, the human resources department posts vacancies and bulletins for all positions on the State Personnel Board's Vacant Positions Database, the Veterans Affairs Web site, and private employment Web sites that focus on veterans and military employees leaving active service. The Veterans Home also sends out bulletins for all vacant positions to a list of state agencies, medical centers, local junior colleges, and nonprofit entities. According to the chief of human resources at the Veterans Home, however, there is no formal process to update the list, and all vacancy announcements are sent to the same list, regardless of the classification. Further, important sources of potential employees, such as local nursing education programs, are not included on the list. Although to fill vacancies in certain specialized or hard-to-fill positions in the physician and surgeon job classification, the human resources department does send job announcements to hospitals and medical centers around the country; that step is not taken for any other job classification.

Finally, the Veterans Home has been slow to clear successful applicants to start working at the Veterans Home. Data provided by the chief of human resources at the Veterans Home show that between January and September 2007 it took an average of 43 days for the applicants hired to be notified that they could begin work.[1] The primary reason for this lengthy notification period is the amount of time involved in scheduling, performing, and obtaining the results of physical examinations. Human resources' documents at the Veterans Home show that an average of 36 days elapsed between requests for physicals and the date that the results of physicals were reported to the human resources

Between January and September 2007 it took an average of 43 days for the applicants hired to be notified that they could begin work.

[1] This does not include nursing applicants; because the nursing department at the Veterans Home handles the scheduling of its new hires, nursing statistics were not added until October 2007.

department. According to the deputy administrator, those delays have occasionally resulted in the Veterans Home losing newly hired employees who tired of waiting and found other jobs.

Some Steps Have Been Taken to Improve Recruitment and Retention Efforts

The deputy administrator told us that, spurred by a crisis in staffing prompted by the anticipated opening in July 2007 of its new memory care center (a ward for members with Alzheimer disease or dementia), the Veterans Home chartered two committees to look at recruiting. The Recruitment and Retention Committee, assembled in February 2006 and composed of employees nominated by each department, met five or six times during the year to analyze recruitment and staffing issues in the nursing unit. In May 2007 the deputy administrator chartered a second committee to look at recruiting for all positions, not just nursing.

According to the deputy administrator, following some of the committees' recommendations, the Veterans Home moved the advertising and recruiting budget from nursing to human resources and expanded its efforts to publicize vacancies by posting them on additional Web sites. The deputy administrator further stated that, because of concerns about the length of time involved in completing preemployment physicals, in October 2007 the Veterans Home moved responsibility for completing all preemployment physicals to a single doctor and redirected two nurse practitioners to assist. Previously, nurse practitioners did not perform preemployment physicals, and various doctors would complete the physicals when they had time.

The deputy administrator further noted that the Veterans Home plans to take several steps in the near future to coordinate the recruiting and outreach efforts. For example, the human resources department will use the recruiting budget that was reallocated from the nursing unit to the human resources department to create and release newspaper advertisements that will list all vacant positions. This will allow the Veterans Home to standardize recruiting materials and establish a brand for the Veterans Home in the community. The Veterans Home also plans to implement a more effective exit interview process and create a yearly survey of employee satisfaction that will highlight areas of concern for current staff. Further, according to the deputy administrator, the Veterans Home is working to establish a training partnership with the School of Nursing at the University of California at San Francisco that will improve the level of practice at the Veterans Home, increase its visibility and prestige, and provide an additional source of nursing applicants.

According to the deputy administrator, the Veterans Home is working to establish a training partnership with the School of Nursing at the University of California at San Francisco that will improve the level of practice at the Veterans Home, increase its visibility and prestige, and provide an additional source of nursing applicants.

The Veterans Home has made various attempts to improve the housing options available to employees, according to the deputy administrator. For example, to partially offset the high cost of housing nearby, the Veterans Home submitted to Veterans Affairs two budget change concepts for fiscal years 2007–08 and 2008–09 to increase the number of housing units available for employee rental on the Veterans Home campus. Veterans Affairs did not approve those requests. The fiscal year 2007–08 proposal was not approved, according to Veterans Affairs, because it believed the proposal's costs—$2.2 million—should have been spread over five years instead of being incurred in one year. According to Veterans Affairs, the fiscal year 2008–09 proposal was for the same issue, except the cost was $2.5 million. The deputy administrator of the Veterans Home indicated that the Veterans Home no longer planned to seek state funds for employee housing. Instead, it is seeking a public-private partnership to pursue development of workforce housing. Currently, the Veterans Home has 22 residential houses available on its campus for employees, and three or four houses become available every year for new employees who need transitional housing.

The deputy administrator also told us that the Veterans Home offers a "20/20" program that allows a nurse or certified nurse assistant to pursue a master's degree or additional credential, with the Veterans Home paying a full salary and a significant part of the tuition. A participant in the 20/20 program works 20 hours a week, with another 20 hours set aside for school and study.

According to Veterans Affairs, it is in the process of developing a department-wide recruitment program as a result of concerns about vacancies in several positions.

According to Veterans Affairs, the department is also in the process of developing a department-wide recruitment program as a result of concerns about vacancies in several positions. According to the draft version of the recruitment program, successful recruitment cannot take place without the development of comprehensive recruitment plans. When implemented the recruitment program will designate a recruitment program officer responsible for, among other things, coordinating the department's recruiting efforts, providing recruitment assistance and training to offices and divisions, monitoring costs and preparing reports regarding recruitment goal attainment, and developing the department's annual recruitment plan. Specific strategies the program identifies as important to recruitment success include developing relations with community-based organizations, advertising in the media or at career fairs, and presenting at school-related programs.

The plan stipulates that although the recruitment program officer will be responsible for coordinating Veterans Affairs' recruitment efforts, actual supervision of local recruitment efforts will be vested in the veterans homes. Consequently, the program will ask the administrators of each veterans home to designate a local

recruitment coordinator responsible for conducting recruitment activities at each home and developing a local recruitment plan that will fit into the overall program organized by the recruitment program officer. However, the specific timelines and objectives for the program are still being developed, and the program is not scheduled for implementation until December 2008. In the interim, according to Veterans Affairs' chief of human resources, Veterans Affairs has performed some recruitment and outreach activities that may benefit the Veterans Home; for example, Veterans Affairs staff have attended various job fairs in Northern California, and Veterans Affairs has purchased a list containing the names and addresses of all licensed nurses in California and plans to send recruitment letters and brochures to everyone on that list.

Veterans Affairs has also attempted to increase the salaries for several health care job classifications at the Veterans Home. For fiscal years 2006–07 through 2008–09, Veterans Affairs submitted five budget change proposals to the Department of Finance (Finance) concerning recruitment and retention of high-demand staff at the Veterans Home. Of those five proposals, two were not approved by Finance, one was not approved by the Legislature, and two were approved by the Legislature. The two budget change proposals that were approved increased salaries for health care workers at the Veterans Home, including respiratory care practitioners, physical therapists, and certain mental health positions, such as psychiatrists and psychologists. In addition, staff at the Department of Personnel Administration (Personnel Administration) told us that the Legislature is currently considering an additional proposal to increase the salaries of several additional health care positions at Veterans Affairs, the Department of Developmental Services, and the Department of Mental Health that have been adversely affected by the increased salaries ordered by the court for similar positions at Corrections and Rehabilitation. If approved, the funding will bring the salaries for several positions—including licensed vocational nurses, physicians, and pharmacists—to within 10 percent of the salaries for those positions at Corrections and Rehabilitation.

Veterans Affairs has also worked with other departments facing similar staffing problems to increase recruitment outreach. The 2007–08 Governor's Budget included up to $1.85 million to hire a private-sector recruiting contractor to assist several state departments, including Veterans Affairs, in filling their vacant high-demand health care positions. According to its contracts unit, Personnel Administration had selected the consultant and was in the process of executing the contract as of February 2008.

With Weak Oversight of Its Medical Equipment Maintenance Contract, the Veterans Home Cannot Ensure That Equipment Is Working Properly and Payments to Its Contractor Are Appropriate

Oversight by the Veterans Home of its $327,000 medical equipment maintenance contract (contract) is not sufficient to ensure that all medical equipment used at the home is being maintained as prescribed by the manufacturers and that the Veterans Home is only authorizing payments to its contractor that are supported by evidence that work was performed. Specifically, we found that the Veterans Home does not adequately monitor its medical equipment inventory, ensure that the payments it makes to its contractor are supported by evidence of work performed, or require the contractor to provide the inspection and maintenance records required under the contract.

The contract specifies that the timely and proper maintenance of medical equipment in accordance with manufacturer specifications is an extremely important aspect of the overall health and safety requirements of the Veterans Home. According to the chief of the plant operations department (plant operations) at the Veterans Home (plant operations chief), as the contract manager he relies on the contractor and the departments that use the equipment to ensure the accuracy of the medical equipment inventory. The deputy administrator stated that although management at the Veterans Home was aware of some structural problems with the way the contract was overseen, contract oversight had not surfaced as a significant problem in the past and management did not know about the specific conditions we identified during our audit.

According to the medical equipment maintenance contract, the timely and proper maintenance of medical equipment is an extremely important aspect of the overall health and safety requirements of the Veterans Home.

The Veterans Home Relies on Its Contractor to Maintain Much of Its Medical Equipment

The Veterans Home has a wide variety of medical equipment in the departments of Holderman Hospital (hospital departments), such as nursing, central supply, audiology, podiatry, dental, and acute care. Equipment still under warranty is often serviced by the manufacturer's representative. Service on the remaining medical equipment is the responsibility of the Veterans Home. Because maintaining certain pieces of medical equipment, such as defibrillators and X-ray equipment, requires highly specialized skills and training not available through civil service, the Veterans Home contracts for the maintenance, repair, certification, calibration, and inspection of those pieces of equipment as needed to comply with all code requirements and manufacturer specifications. Each contract runs for two years, with an option for a third. Medi-Tek, Inc. (Medi-Tek) has been the medical equipment contractor at

the Veterans Home under two contracts since fiscal year 2004–05. In September 2007 Medi-Tek was selected to continue as the service provider through December 2009.

In his role as contract manager, the plant operations chief is responsible for monitoring the terms of the contract. According to the contract analyst at Veterans Affairs who is responsible for the current contract, the Veterans Affairs contracts office in Sacramento receives monthly invoices from Medi-Tek and faxes them to the plant operations chief for approval. The plant operations chief signs and faxes the invoices back to the Veterans Affairs contracts office. That signature affirms that the requirements of the contract were fulfilled to the satisfaction of the plant operations chief. Veterans Affairs then authorizes payment to the contractor.

The Veterans Home Does Not Ensure the Accuracy of Its Medical Equipment Inventory

Because the Veterans Home pays the contractor monthly installments to maintain the medical equipment, as identified in the equipment inventory, the inventory is critical to ensuring that the payments to the contractor are appropriate for the work performed.

Because the equipment maintenance performed by the contractor is supposed to be based on the inventory of medical equipment used at the Veterans Home, that inventory is key to scheduling maintenance activities and the proper inspection, service, and maintenance of the equipment. In addition, the Veterans Home pays the contractor monthly installments of the agreed-on annual charges to maintain the items identified in the medical equipment inventory; therefore, the inventory is critical to ensuring that payments to the contractor are appropriate for the work performed. According to its chief, plant operations maintains a central medical equipment inventory to determine what should be included in the medical equipment maintenance contract. The central medical equipment inventory is compiled from inventories maintained by each hospital department and Medi-Tek. Before the approval of each new contract every two or three years, plant operations requests that Medi-Tek and each hospital department update their medical equipment inventories and submit them to plant operations. Those inventories are used as the basis for the new contract.

Although the update process at the end of the contract's term is intended to be the only official and complete update process for the medical equipment inventory, plant operations staff will update the inventory on occasion during the term of the contract if they receive notices of additions or deletions to the inventory from the hospital departments or from Medi-Tek. The plant operations chief noted that although typically his staff discuss any inventory discrepancies with Medi-Tek and the hospital departments and

make necessary adjustments, for the 2007 contract plant operations did not check to ensure that updates submitted by Medi-Tek and the hospital departments were accurate and supportable.

The process the Veterans Home has for updating the medical equipment inventory does not ensure that important pieces of medical equipment are receiving maintenance. For example, of the 31 items on the medical equipment inventory that we reviewed, five were placed in service at the Veterans Home between the signings of the 2004 and 2007 contracts. However, according to the plant operations chief, no amendments to the contract were made between 2004 and 2007 to ensure that additional equipment items were listed in the medical equipment inventory and serviced by the contractor.

Insufficient inventory monitoring could also result in the State paying Medi-Tek to maintain equipment that is no longer in use.

Insufficient inventory monitoring could also result in the Veterans Home paying Medi-Tek to maintain equipment that it does not use. For example, of the 31 items in our sample, one piece of equipment had been entered into the inventory twice, thereby overstating the work to be performed under the contract. In addition, six of the items in our sample had been disposed of by the Veterans Home or were on-site but not in use. None of the six items had received servicing from Medi-Tek in the last two years, but they remained part of the contract and Medi-Tek continued to receive payments for all the items on the medical equipment inventory. Those items also remained on the medical equipment inventory included with the contract released for bid in September 2007, even after the Veterans Home updated its inventory in the same year.

According to the plant operations chief, although new items may come into service over the course of the contract, generally they are replacements for old or damaged equipment that are already on the list, and Medi-Tek will service them without any contract changes. The plant operations chief relies on each hospital department to inform him of any significant decreases in the inventory and on Medi-Tek to inform him if there are any substantial increases to the inventory. However, without implementing a strong inventory-monitoring process, the Veterans Home cannot determine if the inventory is being kept up to date, that all equipment is receiving scheduled maintenance, and that the State is paying to maintain only equipment that Veterans Home staff are using.

Ineffective monitoring by the Veterans Home of its medical equipment inventory might also provide the current contractor with an unfair advantage in open bidding for subsequent contracts. Although the Veterans Home performs inventory updates before each new contract, it does not perform monitoring of the inventory in the interim and uses the current contractor's inventory to assemble the inventory released for bid. Further, the Veterans Home

does not perform any testing to ensure that this final inventory is accurate. The errors that could result from a weak monitoring system give the current contractor an unfair advantage, because the contractor has firsthand knowledge of the accuracy of the inventory and the amount of work necessary to maintain the equipment listed. As previously noted, six of the 31 items we reviewed from the medical equipment inventory were not in use but were still listed in the inventory released for bid in September 2007. The current contractor would be the only bidder aware that a potentially significant number of the items listed in the medical equipment inventory would not require maintenance and could adjust its bid accordingly.

Weak Contract Oversight Does Not Ensure That the Contractor Fulfills the Terms of the Equipment Maintenance Contract

When plant operations staff hear nothing from the departments, they assume that Medi-Tek is fulfilling its obligations.

The Veterans Home has not developed a reliable system for ensuring that the medical equipment contractor has performed all work required by the contract. Specifically, the plant operations chief told us that plant operations relies on input from the hospital departments to monitor Medi-Tek compliance with the contract. When plant operations staff are informed of a problem, they follow up to resolve it. When plant operations staff hear nothing from the hospital departments, they assume that Medi-Tek is fulfilling its obligations. Plant operations typically does not check that the work listed on the invoice was performed or documented in the service records unless it has a concern. However, according to the deputy administrator, neither plant operations nor the hospital departments that use most of the medical equipment are sufficiently staffed to monitor the contract.

The Veterans Home does not require Medi-Tek to follow key terms of the contract designed to help the Veterans Home monitor contractor performance. For example, the contract requires that Medi-Tek provide records of all services performed and submit to the Veterans Home quarterly reports of maintenance activities. However, rather than submitting the documentation to plant operations, the contractor stores the documents in its office at the Veterans Home in a disorganized manner that does not permit efficient retrieval or usage. Moreover, for six of the 31 sample items for which Medi-Tek retained service records in its office, we found no evidence that any had been reviewed by plant operations before payment to the contractor was approved.

Weak oversight by the Veterans Home of the contract has led to multiple violations of the contract's terms by Medi-Tek. Specifically, in our review of 19 items from the most recently approved medical equipment inventory included with the contract

(contract inventory), we did not find sufficient evidence that in 2007 Medi-Tek performed preventative maintenance inspections for two items, and for 12 items we found that the contractor scheduled preventative maintenance less frequently than required by the contract and did not adequately document inspection procedures and outcomes.

One of the contractor's primary responsibilities is performing scheduled preventative maintenance of all medical equipment listed on the contract inventory. For each piece of equipment on the contract inventory, the contractor should perform a specified number of preventative maintenance inspections each year. Medi-Tek is required to add a maintenance sticker to each piece of equipment, listing the date of the last preventative maintenance inspection, the next scheduled date of service, and the signature of the technician that serviced the equipment. In addition, for each item serviced, Medi-Tek must submit to plant operations documentation showing the location where the equipment was serviced, the type of repairs required, actions taken or recommendations of the repair technician, and the signature of the appropriate department representative to confirm that the work was performed. In addition, Medi-Tek is required to submit a list of all equipment it could not locate.

Our review of maintenance performed on 19 items for which the contractor was responsible found no evidence that the contractor appropriately scheduled, performed, or documented maintenance for 74 percent of the sampled equipment.

In our review of a sample of items the contractor was responsible for maintaining, we found no evidence that the contractor appropriately scheduled, performed, or documented maintenance for 74 percent of the pieces of medical equipment. We initially selected 31 items from the inventory approved as part of the December 2007 contract to review for proper maintenance activities. As discussed earlier, one of the items in our sample is a duplicate of another item in our sample, five items were placed in service during the 2004 contract period but not added to the contract inventory to track maintenance until the December 2007 contract became effective; and six items were no longer in use by the Veterans Home. Of the 19 items in our sample that were in use by the Veterans Home and included in the contract inventory between 2004 and 2007, according to the maintenance stickers Medi-Tek placed on the equipment, two items did not show evidence of having been inspected by Medi-Tek since 2003. In addition, 12 of the 19 items were scheduled to receive inspections less frequently than required by the contract. Because of the incorrect inspection schedules, six of the 12 actually did not receive required maintenance inspections in 2007 within the required time frame. Therefore, Medi-Tek did not correctly schedule or perform required maintenance on 14 of the 19 items that appeared on both the 2004 and 2007 contract inventories.

According to the contractor, its failure to perform timely preventative maintenance is the result of the technician not using the contract inventory when performing preventative maintenance inspections in each hospital department over the last year. Instead, the technician performed maintenance on whatever medical equipment was readily available at the time in each hospital department. As a result, some pieces of medical equipment may not have received maintenance, particularly if the equipment items were off premises with residents and would therefore be difficult to track down. Further, without using the contract inventory, the technician could not be sure when the next scheduled maintenance was due and so would sometimes incorrectly indicate on the maintenance stickers that inspections were annual instead of semiannual or quarterly. As a result, some pieces of medical equipment were serviced less frequently than required by the contract. According to the contractor, one reason for the technician not using the contract inventory to perform maintenance is that the inventory was three years old and was therefore not an accurate list of medical equipment used at the Veterans Home. However, the contract requires that the contractor maintain its own inventory of medical equipment as part of its computer-based documentation system.

In addition to maintenance stickers, we also used supporting service records, where available, to determine Medi-Tek's compliance in performing required preventative maintenance inspections. As previously mentioned, the contract requires that Medi-Tek complete records detailing all services performed on each piece of equipment. Because Medi-Tek keeps these records in its office at the Veterans Home rather than submitting them to plant operations, as the contract requires, we relied on service records stored in the Medi-Tek office. However, we located recent service records for only six of the 19 items in our sample. Without the missing records, we could not confirm that any services had been performed, nor could we determine what actions, if any, had been taken by the Medi-Tek technician. Further, the dates on two of the six service records we could find did not agree with the dates listed on the maintenance stickers.

The contractor stated that it considers service records a lower priority than emergency repairs and maintenance inspections; therefore, the records may not be completed when the technician is busy with those activities.

The contractor stated that it considers service records a lower priority than emergency repairs and maintenance inspections; therefore, the records may not be completed when the technician is busy with those activities. The contractor added that the technician has been completing most service records by hand because the company's laptop was stolen more than a year before our testing, which has slowed the completion of service records. However, the contract specifically states that timely and proper maintenance of the medical equipment, in accordance with the specifications of the contract, is an extremely important aspect of the overall health and

safety requirements of the Veterans Home. Without the necessary documents to monitor the contractor's performance, the Veterans Home cannot be certain that these important maintenance activities are carried out.

We also found that for the six equipment items for which we found service records, Medi-Tek did not obtain signatures from hospital department representatives verifying that the maintenance work for the six pieces of equipment had actually been performed. Although the contract requires that the signatures be obtained, the contractor stated that he and his staff do not obtain signatures from hospital department representatives because Veterans Home staff are reluctant to do so and it would be time-consuming and not feasible to obtain signatures on the volume of service records generated by maintenance inspections. Moreover, plant operations does not enforce the contract provision requiring signatures and, as indicated earlier, does not require the contractor to submit any documentation on its maintenance activities.

Finally, the contract also requires that the contractor provide a proven computer-based documentation system that will process work orders, schedule preventative maintenance, track equipment warranty status, maintain inventory, and generate monthly report summaries. Medi-Tek's current process of scheduling and performing maintenance, which relies on the technician to remember the service schedules of each piece of equipment without the use of an inventory and then to manually complete all service records, violates that provision. According to the contractor, Medi-Tek is currently implementing a new computerized system at the Veterans Home to schedule and document all maintenance inspections.

The Veterans Home Does Not Have a Plan to Comply With the Americans with Disabilities Act but Has Made Accommodations for Members With Visual Impairments

The Veterans Home does not have a plan to ensure that it fully complies with Title II of the Americans with Disabilities Act (ADA), which along with federal regulations requires that individuals with disabilities not be excluded from services, programs, and activities as a result of their disabilities because existing buildings are inaccessible. This standard is known as program accessibility. As a first step toward ensuring program accessibility, all public entities are required by federal ADA regulations to conduct a self-evaluation of their policies and practices to identify those inconsistent with the requirements of Title II. Additionally, the regulations require public entities to develop a transition plan if structural changes are necessary for achieving program accessibility.

However, according to the equal employment opportunity/civil rights officer at Veterans Affairs (civil rights officer), it has not performed a self-assessment of the Veterans Home for compliance with the ADA. In addition, neither Veterans Affairs nor the Veterans Home could provide us with a plan for achieving full compliance. Although the Veterans Home does not appear to be in full compliance with the ADA, it has taken steps in its dining hall to accommodate members with visual impairments.

Veterans Affairs Could Not Provide an Assessment of the Veterans Home for Compliance With the ADA

According to the ADA Title II Technical Assistance Manual published by the U.S. Department of Justice as part of a program to help entities with ADA compliance, effective January 26, 1992, all public entities were required to comply with the requirements of Title II. Subsequently, public entities were to complete a self-evaluation for compliance with the accessibility requirements of the ADA, develop a transition plan if structural changes were necessary for achieving program accessibility, and retain the self-evaluation for three years. Federal ADA regulations require that certain design standards be followed for any new construction or alteration of facilities subject to the ADA. In general, individuals with disabilities must be able to readily access and use all facilities constructed or altered after January 26, 1992. In addition, federal ADA regulations require that public entities develop grievance procedures for resolving complaints concerning alleged noncompliance with the ADA and designate a staff member to coordinate efforts to comply with the ADA.

Veterans Affairs has not performed a self-assessment of the Veterans Home for compliance with the Americans with Disabilities Act; therefore the Veterans Home has been out of compliance with federal regulations since 1992.

According to the civil rights officer, Veterans Affairs has not performed a self-assessment of the Veterans Home for compliance with the ADA. Consequently, neither Veterans Affairs nor the Veterans Home has developed a transition plan for achieving ADA compliance. Therefore, the Veterans Home has been out of compliance with federal ADA regulations since 1992.

According to the director of the Capital Development and Construction Division of Veterans Affairs, the department is currently working on a facilities master plan for the Veterans Home that should be completed by mid-spring of 2008 and will include an accessibility review. The director of residential programs at the Veterans Home stated that additions and remodeling of existing infrastructure, such as sidewalks or buildings, are made so the areas are ADA compliant. Further, the chief of the Design Services Section (design services chief) of the Department of General Services (General Services) said that the Veterans Home works with General Services when it needs to make significant

changes or alterations to facilities—that is, changes costing more than $131,000. The Veterans Home must obtain the approval of General Services to make facility changes costing from $131,000 to $400,000, and General Services must manage all work costing more than $400,000. According to the design services chief, when significant changes are required, General Services oversees the design and construction of the changes to ensure compliance with the ADA and all other relevant codes.

We also asked whether the Veterans Home had developed the grievance procedures and designated an individual as its ADA coordinator as required by federal ADA regulations. The director of residential programs at the Veterans Home informed us that the home has not developed grievance procedures specific to the ADA and was not aware it was required to do so. In addition, neither the Veterans Home nor Veterans Affairs has designated a specific employee to coordinate the efforts to comply with the ADA. The civil rights officer told us that she normally processes all complaints related to the ADA at headquarters but was unaware of how the Veterans Home handled such issues.

According to the director of development and construction, Veterans Affairs is taking steps to ensure that it complies with Title II. The governor's proposed budget for fiscal year 2008–09 includes $3.2 million and 18.3 positions for Veterans Affairs to establish a facilities maintenance and management unit and a deferred maintenance program. The unit will be responsible for implementing a program for maintenance and repairs at the State's three existing veterans homes, the five veterans homes under construction, and the state cemetery for veterans. The director further stated that the unit will assess the current level of ADA compliance at the Veterans Home and ensure continuing compliance.

The governor's proposed budget for fiscal year 2008–09 includes $3.2 million and 18.3 positions for Veterans Affairs to establish a facilities maintenance and management unit that would assess the current level of compliance with the Americans with Disabilities Act at the Veterans Home and ensure continuing compliance, among other things.

The Veterans Home Has Taken Steps to Ensure That Visually Impaired Members Can Access the Home's Dining Facilities

Title II of the ADA is intended to protect every qualified disabled individual from discrimination on the basis of disability in the services, programs, or activities of all state and local governments. An individual with a visual impairment may be a qualified individual with a disability under the ADA. We reviewed a complaint lodged against the Veterans Home by a member with a visual impairment who stated that he could not ascertain his food choices in the dining hall at the Veterans Home. The member submitted the complaint after the Veterans Home had taken several steps to improve services in the dining hall for visually impaired members.

The first of those improvements occurred in April 2007, when the senior occupational therapist at the Veterans Home provided training to dining hall staff on methods of providing quality services to visually impaired members. In addition, 20 tables were set aside in the dining hall for members with disabilities, including visual impairments, to sit and be served their meals by dining hall staff, rather than going through a serving line as do most members. The tables have individual menus with enlarged print. According to the chief of dietary and food services, the member fills out the menu and gives it to the server, or the server will assist the member with making and writing a menu selection. Also, a large-print menu is posted on the wall as members enter the serving area.

When we spoke with the visually impaired member who had filed the complaint about the dining hall, he told us that he was not satisfied with the level of assistance the Veterans Home provided visually impaired members. However, we also spoke with another visually impaired member of the Veterans Home who indicated she has had no problems in the dining hall related to her limited vision. She said that whenever she cannot read a table menu, a member of the dining hall staff reads the selections to her. Moreover, from our review of the changes made in the dining hall to accommodate members with visual impairments, we concluded that the Veterans Home had taken reasonable steps to accommodate members with visual impairments.

The Veterans Home No Longer Has the Position of Skilled Nursing Facility Administrator

The Veterans Home established the position of skilled nursing facility administrator by reclassifying a staff services manager II position, and the position was filled on April 1, 2003. When the position became vacant on September 16, 2004, after the incumbent transferred to the Veterans Home of California at Barstow, the Veterans Home decided it did not need a skilled nursing facility administrator. On February 1, 2005, the Veterans Home reclassified the position as an associate governmental program analyst. According to the deputy administrator of the Veterans Home, the skilled nursing facility administrator position was essentially too narrow in scope to address the larger systemic issues associated with managing health care services for the Veterans Home. In addition, the position's duties overlapped with the scope of the director of nursing, and to a certain extent, with the chief medical officer.

However, in November 2007 the Veterans Home rewrote the duties for the skilled nursing facility administrator position to broaden the scope to address managed care, case management, and related

issues, and reclassified a registered nurse position to establish the renamed position of hospital and health services administrator. As of January 2008 the Veterans Home was actively seeking to fill the position.

Recommendations

If Veterans Affairs is concerned that its ability to serve California veterans is limited by a regulation stating that less than 75 percent of skilled nursing beds must be occupied before it can admit new patients directly to that level of care, it should consider changing or eliminating that regulatory requirement.

To improve its ability to fill vacancies in key occupations, the Veterans Home should develop a comprehensive plan for recruitment and retention that establishes goals and strategies for reducing chronic vacancy rates and sets timelines and monitoring activities to keep recruiting efforts on track. To maximize its efforts to recruit high-need staff, the Veterans Home should ensure that the recruitment efforts of all its departments are coordinated through a centralized position or program. In addition, the Veterans Home should implement the remaining steps it has currently identified to better recruit and retain health care staff.

To bolster recruitment efforts at the Veterans Home, Veterans Affairs should continue to develop its department-wide recruiting plan and oversee the recruiting plan the Veterans Home is implementing to ensure that it meets department-wide goals.

To help ensure that newly hired employees at the Veterans Home can start work as soon as possible, the Veterans Home should monitor its new process for completing preemployment physicals. If the process is not resulting in new employees starting work more quickly, the Veterans Home should consider contracting with a vendor to provide the physicals.

To prevent its nursing staff from working excessive overtime, the Veterans Home should consider adopting a formal policy for distributing overtime more evenly among nurses, establishing a cap on how much overtime nursing staff may work, and monitoring overtime usage for compliance with these policies.

To ensure the Veterans Home's medical equipment is maintained as prescribed by the equipments' manufacturers, the Veterans Home should take the steps necessary to ensure the medical equipment inventory, on which maintenance activities are based, is accurate. In addition, to ensure payments to the maintenance contractor are

appropriate, the Veterans Home should require the contractor to provide records of inspections and maintenance work performed prior to authorizing these payments.

To meet the requirements of federal ADA regulations, the Veterans Home should develop and update as needed a plan that identifies areas of noncompliance and includes the appropriate steps and milestones for achieving full compliance. In addition, the Veterans Home should develop grievance procedures and identify a specific employee as its ADA coordinator.

Chapter 2

AGENCIES RESPONSIBLE FOR HANDLING COMPLAINTS AGAINST THE VETERANS HOME OF CALIFORNIA AT YOUNTVILLE COULD BETTER MEET THAT RESPONSIBILITY

Chapter Summary

At the Veterans Home of California at Yountville (Veterans Home), residents (referred to as members) have several avenues they can follow to raise concerns about the care they are receiving and file complaints. Members, as well as their families and other interested parties, can submit complaints to external entities like the California Veterans Board (Veterans Board), the California Department of Veterans Affairs (Veterans Affairs), the California Department of Public Health (Public Health), and members of the Legislature or their staff. Additionally, members of the Veterans Home can raise issues and concerns internally through resident council meetings held in the N. M. Holderman Memorial Hospital (Holderman Hospital) and its intermediate care facility annexes.

Our review of complaints against the Veterans Home that members filed with various external agencies and legislative staff showed that the agencies did not always handle the complaints appropriately. We also found cases in which insufficient documentation prevented us from determining whether the complaints had been handled appropriately.

State Agencies That Resolve Complaints Concerning the Veterans Home Could Improve Their Resolution Efforts

The state agencies we reviewed that receive and resolve complaints from Veterans Home members could strengthen their efforts to resolve those complaints. Public Health is responsible for responding to complaints regarding the care provided in the licensed care units of the Veterans Home; and the Veterans Board, Veterans Affairs, and the Veterans Home are responsible for responding to various complaints from members in all units. Members or their families or advocates can file complaints directly to the Veterans Home, the Veterans Board, or Veterans Affairs. Moreover, the governor's office and members of the Legislature review complaints against the Veterans Home submitted to them and then forward those complaints to Veterans Affairs for resolution.

Public Health Has Not Always Promptly Completed Its Investigations of Complaints

In responding to each of the nine complaints it received from October 27, 2005, to October 5, 2007, Public Health met the requirements to conduct an initial on-site investigation within 24 hours or 10 days of receipt of the complaint, depending on severity.

According to its system for tracking complaints and incidents, or unusual events that occur at the Veterans Home, Public Health received nine complaints against the Veterans Home and 129 unusual events reported by the Veterans Home from October 27, 2005, to October 5, 2007. In responding to each of the nine complaints, Public Health met the requirements to conduct an initial on-site investigation within 24 hours or 10 days of receipt of the complaint, depending on its severity. Based on applicable criteria, we concluded that Public Health correctly classified the severity of all nine complaints. Public Health substantiated five of the nine complaints, which resulted in five deficiencies for the Veterans Home. Deficiencies are notices of noncompliance with state requirements for which the Veterans Home must take corrective action. For one of the five deficiencies, Public Health is considering issuing the Veterans Home a class A citation, the second most serious level of citation. According to state law, Public Health must issue class A citations when it determines that violations of state or federal requirements present imminent danger that could cause death or serious harm to residents or patients of long-term care facilities, or present substantial probability that death or serious harm to residents or patients could result. In the deficiency resulting in the potential citation, a patient at Holderman Hospital fell and broke his hip. Through a series of errors, the patient's X-ray was not read for approximately 23 days, according to Public Health. The Veterans Home submitted plans of correction for each of the five deficiencies that were identified by Public Health.

Public Health did not complete its investigation of three of the nine complaints within 40 days of their receipt, as recommended by its policy and procedures manual. Instead, it took from 45 to 110 days to complete the investigations for those three complaints. For another of the nine complaints, the potential citation described in the previous paragraph, is more than one year old, but Public Health still had not decided as of January 1, 2008, whether to issue a citation. According to the chief of the state facilities unit in the licensing and certification program (licensing chief) at the Public Health headquarters in Sacramento, it was mistakenly dropped from his pending file and not addressed again until it was discovered during our audit. The licensing chief also indicated that Public Health will take steps to ensure that complaints are tracked appropriately in the future.

In addition to investigating complaints about the Veterans Home, Public Health also reviews unusual events reported by the Veterans Home. State regulations require the Veterans Home to report to

Public Health any unusual event, such as an epidemic outbreak, poisoning, major accident, or any unusual occurrence that threatens the welfare, safety, or health of the members. According to its system for tracking complaints and incidents, Public Health received 129 reports of unusual events from the Veterans Home from October 27, 2005, to October 5, 2007. For example, reported unusual events include allegations of verbal abuse of a resident by another resident and inaccurate information documented in a member's record. We reviewed a sample of 10 unusual events reported by the Veterans Home and found that only one resulted in a deficiency. In that case Public Health determined that a certified nursing assistant failed to treat a resident with consideration, respect, and full recognition of the member's dignity and individuality. As corrective action the Veterans Home provided the certified nursing assistant with mandatory remedial training on resident's rights, communication, and professional conduct.

The Veterans Board Has Not Always Maintained Evidence of Complaint Resolutions

According to its executive officer, the Veterans Board received five complaints against the Veterans Home filed by members from the beginning of her tenure, June 2006, through the time of our fieldwork, December 2007. However, we were unable to determine whether the complaints were resolved because neither the Veterans Board nor Veterans Affairs could locate documentation concerning actions they took in response to the complaints.

We were unable to determine whether the complaints submitted to the Veterans Board were resolved because neither the Veterans Board nor Veterans Affairs could locate documentation concerning actions they took in response to the complaints.

The executive officer explained that in the past the chair of the Veterans Board reviewed complaints and then worked with the deputy secretary of veterans homes at Veterans Affairs (deputy secretary) to investigate and resolve them. However, the Veterans Board could not locate documentation on any complaints it received through December 2007. The executive officer further stated that the Veterans Board did not track the complaints it received and did not report on them at Veterans Board meetings. Rather, the complaints were handled informally through telephone conversations and e-mail messages between the chair and the deputy secretary. Additionally, the executive officer told us that while in Yountville for a meeting, the chair of the Veterans Board spoke with several members who filed complaints to personally address their issues.

We also reviewed Veterans Affairs' correspondence files and logs for 2006 and 2007 and found no entries regarding the complaints received by the Veterans Board. The assistant deputy secretary for veterans homes told us that the secretary of Veterans Affairs has recommended to the Veterans Board that they work together

to develop a structured policy to handle complaints submitted directly to the Veterans Board. According to the executive officer, in February 2008 the Veterans Board approved a new policy for addressing complaints received from members, their families, or other interested parties. Under the new policy, on receiving complaints related to Veterans Affairs policies or operations (including the Veterans Home), the Veterans Board must direct the complaints to Veterans Affairs for tracking and resolution. Complaints that pertain solely to the activities of the Veterans Board will be addressed by its chair or executive officer as appropriate. Within 10 days of receiving the complaint, Veterans Affairs must provide a written response to the complainant and send a copy to the Veterans Board. The new policy also requires the executive officer to update the Veterans Board on the complaints received and their status or disposition at each Veterans Board meeting. Although the Veterans Board adopted a policy indicating the types of complaints it will process and those it will direct to Veterans Affairs, it did not specify a time frame for resolving the complaints it will process.

Veterans Affairs Has Generally Followed Its Procedures for Tracking Complaints

In all 11 complaint cases it received between July 1, 2005, and October 5, 2007, Veterans Affairs addressed and resolved the complaints in the time frame specified by its policy.

Veterans Affairs received 11 complaints from members between July 1, 2005, and October 5, 2007. The complaints had been submitted to Veterans Affairs through the governor's office or through legislators, sent directly to the secretary of Veterans Affairs by members, or forwarded to Veterans Affairs by the administration at the Veterans Home. Complainants in the 11 cases expressed concerns about residence fees, health care received, general well-being, or the conditions of some of the buildings at the Veterans Home. Veterans Affairs addressed and resolved each complaint in the time frame specified by its policy, which is 10 working days or the number of days related to the due date requested by the referring party. The policy governs only the paper-handling process as the complaint moves through Veterans Affairs. Investigation procedures vary by complaint and are determined by the responsible deputy secretary.

In seven cases Veterans Affairs closely followed its established policies and procedures for resolving complaints. Each complainant received written notification of Veterans Affairs' response, and final resolution of each complaint was documented and filed with the original communication. Four complaints were not processed entirely according to Veterans Affairs' policies governing written communication, which is its basic policy for handling written complaints. Specifically, Veterans Affairs did not prepare routing slips for the four complaints; according to the assistant deputy

secretary of veterans homes, these were clerical errors. A routing slip is intended to identify and record on the official file all staff who contribute to the completion of a written communication, including staff who investigate and those who sign or approve the final product, thereby providing accountability to the complaint resolution process. Although lacking routing slips, the four complaints were addressed within a reasonable period by Veterans Affairs, given full consideration by the responsible parties, and documented according to Veterans Affairs' policies.

The Veterans Home Does Not Always Maintain Evidence It Resolved Issues Raised at Resident Council Meetings

As a condition of receiving federal funds to help pay for the care of veterans, the Veterans Home must establish a council of members (resident council) that meets at least quarterly, document any concerns the resident council submits to Veterans Home management, and act on the concerns of members and the resident council regarding policy and operational decisions affecting members' health care and living conditions.

In 2007 the Veterans Home held monthly resident council meetings for the members living in Holderman Hospital, including its intermediate care facility annexes. According to the supervisor of therapeutic activities (supervisor), staff from the therapeutic activities office (therapeutic activities staff) facilitate the resident council meetings. Veterans Home social services staff record meeting minutes, including any complaints, issues, or concerns that members voice. As of May 2007, according to the supervisor, social services staff are also responsible for preparing issue memos, which are addressed to the Veterans Home departments that will be involved in resolving the issues raised during resident council meetings, and ensuring that the issue memos are given to the therapeutic activities staff. The supervisor stated that before May 2007 social services staff did not have to prepare issue memos, but therapeutic activities staff were responsible for communicating members' issues and concerns to the appropriate Veterans Home departments. According to the supervisor, with or without issue memos, therapeutic activities staff should report at each resident council meeting on the status of issues raised at prior meetings, including whether or not the issues have been resolved.

The minutes for resident council meetings held in Holderman Hospital and the intermediate care facility annexes from January through December 2007 indicate that members raised 20 issues at the meetings. Further, the minutes show that of the 20 issues raised, the Veterans Home took reasonable steps to resolve 16 and had not successfully resolved two. We could not determine whether

The minutes show that of the 20 issues raised, the Veterans Home took reasonable steps to resolve 16 and had not successfully resolved two, but we could not determine whether the Veterans Home had resolved the remaining two issues because no resolution was apparent in the minutes of resident council meetings or in issue memos.

the Veterans Home had resolved the remaining two issues because no resolution was apparent in the minutes of resident council meetings or in issue memos. The issues that were not resolved or for which we could not determine whether they were resolved related primarily to complaints from members regarding the facilities, such as towel dispensers that dispense too many towels, room temperatures, leaking shower heads, and a broken soda machine. The Veterans Home had communicated the outcomes of their investigations at subsequent resident council meetings for 14 of the 20 issues and had not reported their findings for six.

When an issue raised in a resident council meeting is not resolved promptly or a resolution is not communicated to members, it can lead to member dissatisfaction with the Veterans Home. According to the supervisor, part of the lack of response seems to be department heads not understanding the need to pay attention to issue memos. Administrative staff at the Veterans Home sent an e-mail to department chiefs informing them of the purpose and importance of the memos as well as the need for timely responses.

The Veterans Home Needs to Better Document the Resolution of Code of Conduct Violations

Because the Veterans Home did not maintain documentation of the resolution of allegations of misconduct by residents for 12 of the 25 violation reports we reviewed, we could not determine whether the Veterans Home consistently and equitably enforces its code of conduct.

The Veterans Home established a code of conduct for members to preserve the tranquility of the Veterans Home and ensure the rights and independence of each member.

The Veterans Home established a code of conduct for members to preserve the tranquility of the Veterans Home and ensure the rights and independence of each member. Under the code of conduct, members are expected to cooperate with facility staff and abide by the code of conduct as well as local, state, and federal laws. In addition, members are expected to comply with Veterans Home policies related to members' health and safety and housekeeping. Among the activities prohibited by the code of conduct are insulting or harassing language or behavior, elder abuse, and threats of violence or acts of violence against another member or Veterans Home employee. Prohibited possessions while on Veterans Home grounds include illegal drugs and drug paraphernalia, alcohol in unauthorized areas, weapons, and hazardous materials, among others.

According to its administrative manual, the Veterans Home enforces the code of conduct and intervenes when violations are reported, using a multidisciplinary approach that includes counseling, mediation, and progressive discipline to resolve

conflicts and correct behavior. Failure by members to follow the code of conduct can result in verbal or written warnings or possible discharge from the facility. Members or Veterans Home staff can report alleged violations of the code of conduct.

The Veterans Home policies and procedures concerning its code of conduct are contained in its administrative manual. The policies and procedures specify that only certain Veterans Home staff can review an alleged violation of the code of conduct with the member who committed the violation and that for certain substantiated violations, such as alcohol or drug use issues, the member should be referred to an assistance program offered at the Veterans Home. When followed, the policies and procedures help ensure that alleged violations of the code of conduct are treated consistently and equitably.

According to the admissions officer at the Veterans Home, every new member entering the Veterans Home receives a copy of the code of conduct and must agree, in writing, to abide by the rules to the best of his or her ability. The admissions officer noted that copies of the signed agreement are kept in administrative records and in the member's medical record.

The chief of residential care service and residential care for the elderly at the Veterans Home (residential care chief) maintains a file of code of conduct violation reports (violation reports). We reviewed that file, selected a sample of 25 violation reports—12 from 2006 and 13 from 2007—and tested them against the established policies and procedures of the Veterans Home. Of the 25 alleged violations of the code of conduct we reviewed, we found complete documentation in 11 cases. In those 11 cases we were able to verify that the Veterans Home staff investigating the allegations followed appropriate policies and procedures. For example, in one of the 11 cases, one member accused another member of using profanity and directing it at her. We found that this allegation was handled appropriately by a residential care unit leader at the Veterans Home, who met with the member alleged to have used profanity and told him such behavior was inappropriate and would not be tolerated. In another case, a member was found by a residential care unit leader to have alcohol in an unauthorized area (his refrigerator). The residential care unit leader confiscated the alcohol, took the member to the Ambulatory Care Clinic at Holderman Hospital for a breathalyzer test, and scheduled a residential care treatment meeting for the next day.

Of the 25 alleged violations of the code of conduct we reviewed, we found complete documentation in only 11 cases.

In two of the 25 cases we reviewed, using the limited documentation available, we determined that the Veterans Home did not follow appropriate policies and procedures in processing the allegations. Both cases involved members who had been caught

using illegal drugs but had not been referred to the drug treatment program offered by the Veterans Home and required by Veterans Home policy. The residential care chief told us that she could not remember why the two members were not referred to the drug treatment program. When Veterans Home staff do not refer members using illegal drugs to the drug treatment program, abuses go untreated and other members may have to endure behavior that violates the tranquility of the Veterans Home.

In the remaining 12 cases in our sample, the Veterans Home did not maintain sufficient documentation for us to determine whether the home followed its policies and procedures. Without maintaining appropriate documentation, Veterans Home management cannot ensure that staff are handling alleged violations of the code of conduct consistently and equitably.

Recommendations

To promptly resolve complaints it receives against the Veterans Home, Public Health should monitor its system for processing complaints.

To ensure that all complaints against the Veterans Home submitted to the Veterans Board are promptly resolved, the Veterans Board should specify a time frame for resolving complaints in its new policy for complaint resolution and ensure it implements the policy.

To ensure that complaints against the Veterans Home are processed so there is accountability in the complaint resolution process, Veterans Affairs should enforce its policy of using routing slips with complaints.

To appropriately address issues raised at resident council meetings, the Veterans Home needs to better document such issues, ensure that the relevant department resolves them, and promptly communicate resolutions to all members.

To handle alleged violations of the code of conduct consistently and equitably, the Veterans Home should ensure that staff responsible for investigating the allegations completely document the investigations and their results.

To ensure that members of the Veterans Home receive treatment for drug abuse when necessary, staff of the Veterans Home should follow its policy to refer members who use illegal drugs to the drug treatment program.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: April 24, 2008

Staff: Norm Calloway, CPA, Project Manager
John Billington
Chuck Kocher, CIA
Julien Kreuze
Maya Wallace

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at (916) 445-0255.

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(Agency response provided as text only.)

Department of Veterans Affairs
Office of the Secretary
Post Office Box 942895
Sacramento, California 94295-0001

April 10, 2008

Elaine M. Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle,

The Veterans Home of California, Yountville and California Department of Veterans Affairs staff have reviewed your draft audit report, *Veterans Home of California at Yountville: It Needs Stronger Planning and Oversight in Key Operational Areas and Some Processes for Resolving Complaints Need Improvement* (Report 2007-121). We generally found the report to be accurate and thorough, and expect it to be useful to us in our efforts to improve processes for accountability and efficiency of our organization. There are several clarifications we would like to offer, as set forth in the enclosure to this letter.

One of the concerns of the Joint Legislative Audit Committee was the adequacy of health care for our veterans. We were pleased to note that the audit found no quality of care issues related to the findings. We particularly appreciate the report's acknowledgement of some of our efforts to improve facility operations, and the strong support we have received from the Legislature and the Schwarzenegger Administration to date to address a number of longstanding material and personnel issues.

We have an outstanding team of health care professionals and support staff whose commitment is to provide all veterans with the highest quality of health care and service. This audit will be another tool in helping us carry out that mission. Please contact Stan Oppegard, Deputy Secretary for Veterans Homes at (916) 653-2293 should you have further questions or require additional input from us.

Sincerely,

(Signed by: Tom Johnson)

THOMAS JOHNSON, FACHE
Secretary

* California State Auditor's comments begin on page 63.

Summary of Comments

Vacant Positions - Reference: Page 3[1]

The report notes that "41% of the Veterans Home total vacant positions can be accounted for by nursing position".

(1) The Department would point out that over 39% of the positions at the Home are in the Nursing Department. Thus, the vacancy rate for nurses closely mirrors its percentage of the overall home staff.

Overtime – Reference: Page 10 and 28-31

The report cites what it has called "excessive overtime" and recommends "a policy for distributing overtime more evenly among nurses, establishing a cap on how much overtime nursing staff may work…".

The Department wishes to commend the staff for their commitment to serve all veterans and would point out that overtime has been reduced by 7.5% in the first two months of this year, compared to the same time period last year, with no mandatory overtime being requested. Attached are two charts depicting the reduction of overtime in hours and dollars for that time period. Nevertheless, overtime is something the Department is committed to continue to reduce as it does impinge on the lifestyle of those staff members
(2) not wanting overtime. The Department would further point out that overtime is desired by some nurses more than others and a policy for even distribution of overtime would work against these desires and may impose undue hardship on those not desiring overtime. Finally, it is important to note that overtime may fluctuate greatly as acuity or census changes with residents or sick leave usage varies with staff. Overtime is not only affected by vacancies. The Department would point out that vacancy rates have been reduced in 75% of the categories cited in table 2 of the report.

ADA – Reference: Page 11

The report notes that the Department should develop and update a plan regarding ADA compliance.

The Department notes that the newest building in the campus was built in 1955. As remodeling occurs, such as in the Memory Care Center, the building is brought up to current ADA standards. A new $12 million dollar project, to remodel the Member Services Building, is about to begin. It too will be brought up to current ADA standards. A strategic plan for the campus is being developed and the ADA issue is being addressed with that plan.

Governing Body – Reference: Page 15

The report notes that "the governing body has the power to provide appropriate physical resources and personnel to meet the needs of the veterans community and to participate in planning to meet the health needs of members of the veterans homes".

(3) The Department would point out that these powers are all subject to state and federal law, budget appropriations and control agency oversight. There is no independent fiduciary authority by this governing body.

[1] While preparing our draft report for publication, page numbers shifted. Therefore, the page numbers that Veterans Affairs cites in its response do not correspond to the page numbers in our final report.

Home Capacity – Reference: Page 21 and 25

The report states that "…chronic vacancies in key health care positions limit the ability of the Veterans Home to fully utilize its existing bed capacity to serve veterans…". The report further discusses this issue on pages 24-25 when licensed capacity is discussed.

The Department would point out that regardless of licensed capacity the budget is predicated on an operating capacity of 1085. With 1073 residents as members, this is 97.6% occupancy. The average occupancy for nursing homes in California according to OSHPD Data in 2006 was 88.1%. The Home is caring for virtually all of the veterans it is authorized to care for based upon the budget allocation. There is no direct nexus between the vacancy rate for staff and the census. The Home is operating virtually at capacity. (4)

Vacancies – Reference: Page 22

The report states that there are "chronic vacancies" in the Department.

The Department would point out that the word "chronic" is subject to constant change as the aggressive recruitment efforts of the Department bear fruit, despite the challenges noted in the following paragraphs on recruitment. The chart prepared by the auditors, labeled "Table 2" highlights the vacancy rates of high need positions at the Veterans Home for 3 consecutive fiscal years, 2004-05, through 2006-07. The current data, dated March 31, 2008, shows reduced vacancies in all categories except CNAs and Physicians. In Physicians, the vacancy rate is slightly less than 2005-06 but slightly more than 2006-07. In RN's, the vacancy rate is 15.9%, dramatically less than the previous years and in Respiratory Therapy the rate has dropped to 18%, from 41.8%. (5)

Bed Utilization – Reference: Page 24

The report states that "the Veterans Homes activates, or makes available to members, only a subset of its licensed beds".

The Department would point out that there are normally 3 categories of beds: licensed beds, available bed (staffed and physically compliant) and budgeted beds. Most licensed health care facilities do not have all of their licensed beds available. Furthermore, the report correctly points out that the use of beds is subject to the "constraints of the budget". This constraint could be direct, in terms of authorizing a specific number of residents (as in 1085 at Yountville) or indirect, as in limiting the salaries or recruitment tools available to the Department as pointed out on page 32 of the report.

Recruitment – Reference: Page 33

The report states: "Although aware of the challenges in recruiting and retaining staff in key nursing and other professional health care positions, Veterans Affairs and the Veterans Home have been slow to develop a comprehensive recruitment plan to address the issues".

The Department would point out that in virtually every Governing Body meeting, held quarterly, some aspect of personnel recruitment and retention is discussed. For example, the April 2007 meeting had a focus on Respiratory Therapy recruitment. The July 2007 meeting had a discussion of RN recruitment. In most meetings there is a discussion of specific recruitment issues under the Administrator's report.

(6) The Department would further point out that at the Joint Conference Committee meeting in January 2007 there was a lengthy discussion and decision planning process regarding hospital clinical staff recruitment and in the January 2008 Joint Conference Committee meeting the discussion focused on Physician recruitment.

The Department would further point out recruitment and retention of clinical staff is a top priority for the home. A shortage of health care professionals statewide, such as registered nurses, pharmacists, radiology technologists and therapists (RT, OT, PT, Speech) is hampering all health care organizations in the goal of maintaining a full compliment of staff and reducing overtime.

In recognition of this the Department has consistently promoted innovative recruitment and retention plans, however, a successful recruitment plan is contingent on an available labor pool, an affordable housing market and a competitive salary and benefit package as referenced in other portions of this report.

Strategic Plan – Reference: Page 34

The report says that the Department "Strategic Plan does not provide a sufficiently detailed blueprint for addressing the critical recruitment and retention needs at Veterans Home".

(7) The Department has a Strategic Plan and on page 24 of the Goals and Objectives of the plan there is a deliverable date of July 2008 regarding specific recruitment goals. Again, however, achievement of these goals cannot be obtained without a salary structure appropriate to the marketplace.

Staff Housing – Reference: Page 34 and 39

The report refers to the Strategic Plan relative to additional housing for Yountville staff members.

The Department is developing a proposal for staff housing at Yountville, which will be released before the end of the year.

Educational Incentives – Reference: Page 40

The report refers to the 20/20 program allowing staff to advance their nursing education while remaining employed.

The Department would point out that through its efforts, starting in 2005, legislation was finally passed to allow loan forgiveness to be given as a recruitment tool to attract newly graduated nurses to state service. This legislation was spawned by a BCP submitted by the Department in October 2005 for an Accelerated Baccalaureate RN Degree Program. The Department has been very aggressive over the past 4 years in pursuing every avenue, in concert with other state agencies, to enhance the recruitment tools available for health care professionals.

Biomedical Equipment – Reference: Pages 46-51

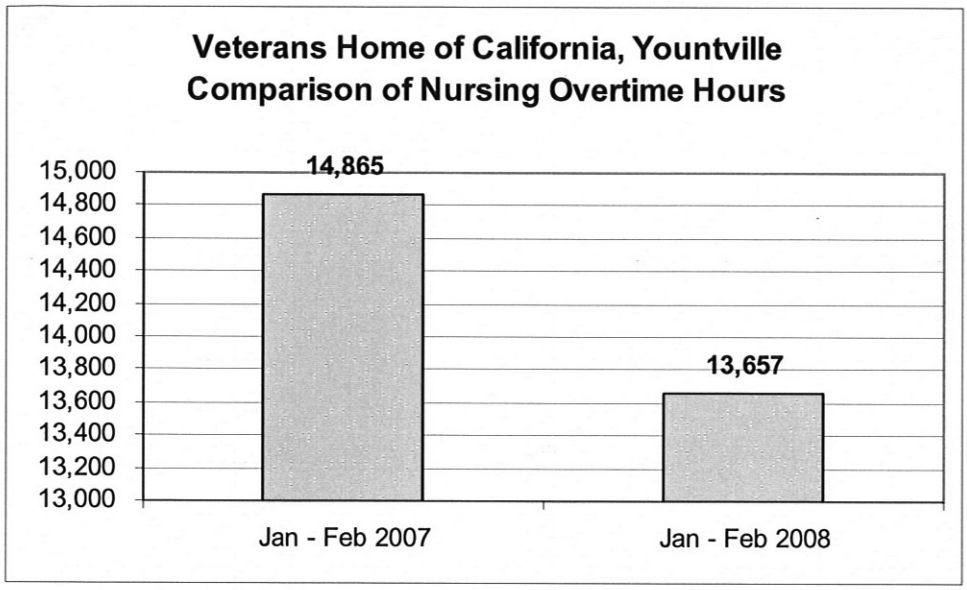
(8) The audit report finds that there was a lack of good oversight of the biomedical equipment maintenance program. However, it did not find any evidence that the health and safety of residents at the Veterans Home was compromised.

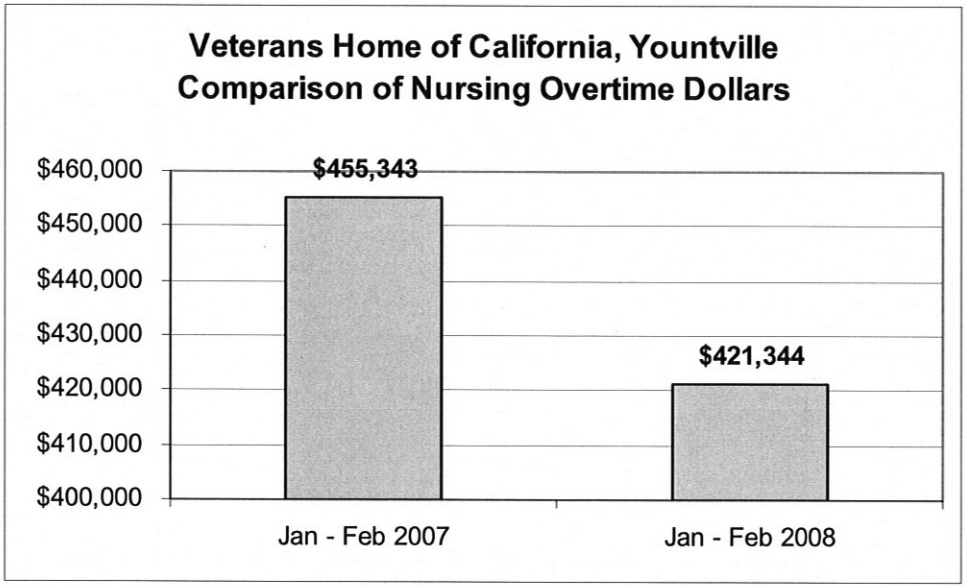
The Department notes that the $327,000 biomedical equipment maintenance contract referenced in the audit report is a 2-year contract (annual dollar value $163,500) with an inventory of 1300+ items owned by 16 different departments. The overwhelming majority of "equipment" in this inventory does not meet the definition of equipment as defined in State Administrative Manual 8602 but are instruments or apparatus that require annual maintenance or calibration. The majority of items (700+) are controlled by Central Supply and Respiratory Care and the average yearly maintenance cost is under $100 ($90.43) per item.

Oversight of the equipment maintenance is delegated to 16 service areas. Each service area designates a representative who is responsible for updating their inventory and notifying Contract Manager of new and no longer useable items. The services area representative is responsible for tracking location of each item. The Veterans Home believes that delegating responsibilities to the individual service area is appropriate; however, good inventory management also requires oversight by the Contract Manager to ensure that the service area representatives are fulfilling their responsibility. Improvement can be made with additional staffing resources that can monitor by performing periodic physical inventories to ensure accurate records. The Veterans Home is currently reviewing two Asset Management systems that will allow us to tag and locate medical equipment using RFID technology.

The Veterans Home acknowledges that the Contract Manager does not receive service records or regular reports on maintenance performed by the contractor. As mentioned in the audit findings, the Contractor is implementing a new computerized system at the Veterans Home to schedule and document all maintenance inspections. Once implemented, monthly reports will be generated automatically. Service records shall be kept in the responsible service area. Veterans Home Contract Manager will institute periodic audits of contractor's service records.

The Department acknowledges that the oversight if this maintenance program will need to change and will take appropriate action to do so.





With regard to bed occupancy, (*see* page 25 of the report), regardless of licensed capacity, the Home's budget is predicated on an operating capacity of 1085. With 1073 residents, this represents an occupancy of 97.6%. By way of comparison, the average occupancy for all nursing homes in California is 93%.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF VETERANS AFFAIRS

To provide clarity and perspective, we are commenting on the response to our audit report from the Department of Veterans Affairs (Veterans Affairs). The numbers below correspond with the numbers we have placed in the margins of Veterans Affairs' response.

Veterans Affairs downplays the importance of high vacancy rates for nurses and other health care staff at the Veterans Home. As we state on page 21 of our report, the deputy administrator for the Veterans Home told us that the home has had difficulty filling active beds for several years because of staffing shortages in key occupations. In addition, as we point out on page 23 of our report, these staffing shortages have led to excessive overtime for some staff that could compromise the safety of residents at the Veterans Home. (1)

Veterans Affairs comments concerning excessive overtime addresses its nursing staff's satisfaction or dissatisfaction with levels of overtime worked, but is silent as to the potential impacts of excessive overtime on the quality of care for the Veterans Home's members. As we state on pages 1 and 26 of our report, although nothing came to our attention indicating that overtime worked at the Veterans Home has affected the quality of care provided to patients, one research study we reviewed suggested that working substantial amounts of overtime might increase the risk of medical errors. Moreover, as we show in Figure 2 on page 26, 20 members of the nursing staff worked an average of more than 20 hours of overtime each week in the last three months of 2007. (2)

Our comments on pages 10 and 11 in the Introduction section of our report regarding the powers of the governing body for the Veterans Home are taken directly from the bylaws of the governing body. As a state government entity, the governing body is of course subject to applicable federal and state laws, as well as budgetary oversight by the governor and the Legislature. (3)

Veterans Affairs' comments do not directly relate to our discussion of occupied beds in its N. M. Holderman Memorial Hospital (Holderman Hospital). In stating an operating capacity of 1,085, Veterans Affairs is referring to the capacity of the entire Veterans Home, including over 700 beds in the residential areas of the home. Our discussion on pages 18 through 23 in our report is about the capacity and occupancy in the Veterans Home's Holderman (4)

Hospital. As we state on page 21 of our report, in December 2007 only 85 percent of the active beds and 54 percent of the licensed beds in Holderman Hospital were filled. Moreover, the Veterans Home's deputy administrator's statement on page 21 of the report that the home has had difficulty filling active beds for several years because of staffing shortages in key occupations indicates a nexus between staff vacancy rates and occupancy at the Veterans Home.

(5) The vacancy data referenced by Veterans Affairs, dated March 31, 2008, were not available to us during our fieldwork and therefore we cannot comment on their accuracy. Moreover, even if the data were available and were accurate, they would not have altered our recommendation that the Veterans Home develop a comprehensive recruitment and retention plan.

(6) Although we observed evidence of some of the meetings and discussions Veterans Affairs describes, these activities do not provide an adequate substitute for a comprehensive recruitment plan, which, as we describe on pages 29 through 32, the Veterans Home has lacked.

(7) Veterans Affairs' statement is misleading. Veterans Affairs indicates our report refers to the department's strategic plan; however, our discussion relates to the Veterans Home's strategic plan. On page 29 and 30 we discuss shortcomings of the strategic plan for the Veterans Home regarding recruiting and retaining qualified staff. Veterans Affairs did not offer its department-wide strategic plan. It did, however, provide its draft department-wide recruitment plan, which it stated is not scheduled for implementation until December 2008.

(8) Veterans Affairs is correct that we did not find any evidence that the health and safety of residents was compromised by the weaknesses we found in the Veterans Home's oversight of its medical equipment contract. However, the potential for such compromise was certainly present as a result of the Veterans Home's weak oversight of the equipment maintenance contract. As we state on page 35 of the report, language in the Veterans Home's medical equipment maintenance contract underscores the importance of our finding by stating that the timely and proper maintenance of medical equipment in accordance with manufacturer specifications is an extremely important aspect of the overall health and safety requirements of the Veterans Home.

(Agency response provided as text only.)

California Department of Public Health
MS 2500
P.O. Box 997377
Sacramento, CA 95899-7377

April 9, 2008

Elaine M. Howle
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Public Health (CDPH) has prepared its response to one recommendation contained in the Bureau of State Audits (BSA) draft report, as it relates to CDPH, pertaining to the Veteran's Home of California in Yountville. The CDPH appreciates the opportunity to provide the BSA with its response to the draft report.

Please contact Kathleen Billingsley, Deputy Director, Licensing and Certification, at (916) 440-7360 if you have any questions.

Sincerely,

(Signed by: Mary Winkley for)

Mark Horton, M.D. M.S.P.H.
Director

Enclosure

Veterans Home of California at Yountville
BSA Audit Report
Licensing and Certification Response

RECOMMENDATION

To help ensure it promptly resolves complaints it receives against the Veterans Home, Public Health should monitor its system for processing complaints.

RESPONSE

The CDPH concurs with the audit recommendation. The State Facilities Unit (SFU) of the Licensing and Certification Program is responsible for the General Acute Care Hospital and Distinct Part Skilled Nursing Facility at the Veterans Home in Yountville. The SFU has developed a report generated from the complaint and incident tracking system that will identify complaints pending closure at 30 business days from receipt. Supervisors will review the report each week to follow-up with the assigned evaluator for timely completion. When timely completion is not appropriate due to missing components of the investigation [i.e. coroner's report, police reports, etc.], proper documentation to support completion dates beyond the policy and procedure recommended 40 business days will be verified. Documentation will be entered in the complaint and incident tracking system under the "Investigation" tab, "View Investigation Notes" selection. This will be monitored by the field Supervisors and the SFU Chief.

For the timely completion of the citation process, the Outlook Calendar feature will be utilized to provide a weekly meeting/reminder with supervisors for review of pending citation approval process. This will be monitored by the Chief of Field Operations.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press