# LOUISIANA DEPARTMENT OF VETERANS AFFAIRS

# OVERSIGHT OF QUALITY OF CARE IN LOUISIANA'S WAR VETERANS HOMES

PERFORMANCE AUDIT
AUGUST 12, 2015

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LOUISIANA LEGISLATIVE AUDITOR
**DARYL G. PURPERA, CPA, CFE**

August 12, 2015

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Charles E. "Chuck" Kleckley,
Speaker of the House of Representatives

Dear Senator Alario and Representative Kleckley:

This report provides the results of our performance audit on the Louisiana Department of Veterans Affairs (LDVA). The purpose of this audit was to evaluate LDVA's oversight of quality of care in Louisiana's War Veterans Homes. The report contains our findings, conclusions, and recommendations. Appendix A contains LDVA's response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of LDVA for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/aa

LDVA 2015

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# Louisiana Legislative Auditor

**Daryl G. Purpera, CPA, CFE**

## Louisiana Department of Veterans Affairs

***Oversight of Quality of Care in Louisiana's War Veterans Homes***

August 2015

*Audit Control # 40140013*

## Introduction

This report provides the results of our performance audit of the Louisiana Department of Veterans Affairs (LDVA). The purpose of this audit was to evaluate LDVA's oversight of quality of care in Louisiana's five War Veterans Homes (Veteran homes). As shown in Exhibit 1, Louisiana has five Veteran homes that can house up to 785 residents. As of May 2015, there were 723 residents in these homes.

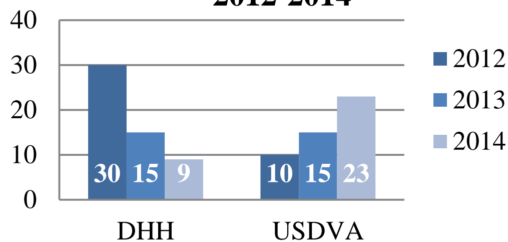
**Exhibit 1: Location of Veteran Homes**

**Source:** Prepared by legislative auditor's staff using information provided by LDVA.

Federal regulation[1] gives LDVA the responsibility for ensuring quality of care for veterans in the Veteran homes. The goal of each Veteran home is to provide high-quality nursing care to eligible Louisiana veterans to meet their health care needs, maximize their quality of life, and return them to the highest possible level of physical and mental function.

To evaluate quality of care in Veteran homes, the United States Department of Veterans Affairs (USDVA), and the Louisiana Department of Health and Hospitals (DHH) annually conduct external reviews. From calendar years 2012 through 2014, USDVA cited 48 deficiencies, and DHH cited 54 deficiencies, as summarized in Exhibit 2.

**Exhibit 2: External Survey Results for Veteran Homes 2012-2014**




**Source:** Prepared by legislative auditor's staff using information provided by LDVA.

In addition to these external reviews, LDVA has also established internal processes to ensure the quality of care in the Veteran homes. These processes include conducting quarterly internal quality assurance reviews and addressing resident grievances (complaints) and incidents at each Veteran home. This audit focused on LDVA management's oversight of these internal processes. Appendix C summarizes LDVA's processes for ensuring quality of care in Louisiana Veteran homes, and Appendix E contains statistical quality data on each Veteran home and the deficiencies cited by USDVA and DHH.

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[1] 38 CFR § 51.120

# Objective: To evaluate LDVA's oversight of quality of care in Louisiana's War Veterans Homes.

While LDVA has maintained applicable state and federal licenses to operate its five Veteran homes, we found that management could strengthen its oversight of the homes by centrally collecting and using data to monitor whether Veteran homes are complying with processes designed to ensure quality of care. LDVA management's current oversight consists of developing policies and procedures and conducting periodic site visits to the homes to review operations. LDVA currently has two staff members to oversee all five Veteran homes across Louisiana.[2] Because of LDVA's limited staffing resources, LDVA could improve both the effectiveness and efficiency of its oversight over Veteran homes if it used data to proactively evaluate quality and assess compliance with its policies.

Starting in October 2014, the USDVA established the Quality Assurance and Performance Improvement (QAPI) which requires that LDVA take a more proactive and data-driven approach to measuring quality of care. However, LDVA currently does not collect electronic data on all of its processes. Because LDVA management does not collect electronic data, we obtained various forms and documents used in its processes related to quality of care and developed data sets to evaluate quality and compliance with policies. As a result of our procedures, we found the following:

- **Veteran homes did not always examine high-risk areas on quality assurance reviews, as required by policy.** We identified instances when deficiencies cited on USDVA surveys or incident reports were not reviewed in the quality assurance process. For example, Monroe, Jennings, Reserve, and Bossier City all had incidents related to scalding temperatures, but Bossier City was the only home that reviewed this area as part of the quality assurance process.

- **Veteran homes did not always address deficiencies identified during internal quality assurance reviews.** Of the 1,995 quality assurance reviews, 531 (27%) identified areas of noncompliance. However, 286 (54%) of these did not have an action plan for correcting the problem identified during the internal quality assurance review, as required by policy.

- **Veteran homes did not always resolve grievances in a timely manner.** Of the 231 resolved grievances, 42 (18%) were not resolved within the required five-day time period.

- **Veteran homes did not consistently update care plans when incidents occurred, as required by policy.** In calendar year 2014, there were 3,874 incidents reported, with 2,051 (53%) related to falls. However, not all Veteran homes consistently updated care plans when incidents occurred, as required by policy.

- **Veteran homes did not monitor whether contract providers provided quality services.** During fiscal years 2012 through 2014, Veteran homes entered into 87 contracts with 26 providers totaling $7.7 million related to delivery of health services. Most of these contracts required reports, progress notes, or statistical data as evidence

[2] Appendix D shows the organizational chart of LDVA.

of services provided. However, Veteran homes did not request any of these reports from contract providers in order to monitor the contract requirements.

These findings are summarized in more detail below.

## Veteran homes did not always examine high-risk areas on quality assurance reviews, as required by policy.

Federal regulation[3] requires that Veteran homes identify quality issues and develop and implement appropriate plans of action to correct internally-identified deficiencies. To meet this requirement, each Veteran home department[4] conducts quality assurance reviews to evaluate compliance with federal standards of care such as infection control, residents' rights, dignity issues, pressure sores, and use of restraints. The purpose of these reviews is to assure the provisions of appropriate optimal resident care and services are consistent with the quality care objectives of the home.

LDVA's quality assurance policy requires that Veteran homes review high-risk, high-volume, or problem-prone areas and, although it does not specifically define "high-risk," it asks the Veteran home to consider including incident reports and results of USDVA surveys as areas to review.

We reviewed 1,995 quality assurance reviews Veteran homes conducted from calendar years 2012 to 2014 and found areas that did not appear to be high-risk that were reviewed multiple times. For example, Exhibit 3 shows a review that evaluated whether or not dishes were dry. The home evaluated this area six times within the same year even though no deficiencies were cited during these reviews, and this area was not cited as a deficiency on previous USDVA surveys. Appendices E-1 to E-5 show the different areas reviewed, by each Veteran home.

**Exhibit 3**
**Quality Assurance Review Example**

LWVH - Adm - 060
Revised 09/06

QUALITY ASSURANCE MONITORING CHECKLIST

DEPARTMENT: Dietary [redacted] /13

STANDARD: To prohibit bacteria growth, dishware will be washed, rinsed, sanitized and must be allowed to air dry prior to usage.

LIST SUBJECTS TO BE MONITORED BY THE AUDITOR

1. SUBJECT MONITORED Cups
2. SUBJECT MONITORED bowls
3. SUBJECT MONITORED Trays
4. SUBJECT MONITORED Plates
5. SUBJECT MONITORED glasses

| CRITERIA –Use the following codes to answer the criteria. YES = Y NO = N NOT APPLICABLE = N/A | | | | | | | |
|---|---|---|---|---|---|---|---|
| List different aspects of standard to be monitored | 1 | 2 | 3 | 4 | 5 | | |
| Was the dishware dry? | Y | Y | Y | Y | Y | | |

Total "yes" answers 5 divided by total responses excluding N/A's 5 equals 100 compliance percentage. This percentage will be entered on the Internal Compliance Tool LWVH – Adm - 061.

**Source**: Prepared by legislative auditor's staff using information provided by LDVA.

We also identified instances when deficiencies cited on incident reports and USDVA surveys were not reviewed in the quality assurance process. For example, Monroe, Jennings, Reserve, and Bossier City all had incidents related to scalding temperatures, but Bossier City was the only home that reviewed this area as part of the quality assurance process. In addition, one home was cited by USDVA for failure to provide care relating to incontinence issues. However, this issue was never reviewed as part of quality assurance. To help ensure that Veteran homes consistently review areas of high risk, LDVA should specifically define

[3] 38 CFR § 51.210
[4] Departments include accounting, housekeeping, human resources, maintenance, medical, medical records, nursing, nutrition, recreation, social services, and pharmacy.

what constitutes a high-risk area and track the results of these reviews to ensure that Veteran homes are reviewing these areas.

As of October 2014, LDVA adopted the Quality Assurance and Program Improvement (QAPI) model required by the Centers for Medicaid Services (CMS), which increases the frequency of reviews from quarterly to monthly and requires a more proactive and data-driven approach to quality assurance. According to the QAPI policy, Veteran homes are tasked with incorporating external survey outcomes (deficiencies incurred) with the internal quality assurance reviews when identifying areas of risk. Overall, QAPI is designed to involve all levels of the organization to identify opportunities for improvement and continuously monitor the effectiveness of interventions. Therefore, collecting data from Veteran homes' quality assurance reviews would help ensure that LDVA effectively oversees this process.

**Recommendation 1:** LDVA should develop more specific guidance on high-risk areas for quality assurance reviews.

**Recommendation 2:** LDVA should track the results of quality assurance reviews in order to more effectively oversee the quality assurance process and identify areas that need improvement.

**Summary of Management's Response:** LDVA partially agrees with these recommendations. According to LDVA, Veterans homes implemented a new quality assurance process (Quality Assurance and Program Improvement-QAPI) in October 2014. LDVA believes this new program successfully addresses the concerns raised by LLA in its Performance Audit and stated that as the QAPI is still being fully implemented, LDVA will take LLA recommendations under advisement and will consider expanding QAPI as deemed necessary. See Appendix A, pages 2-3, for LDVA's complete response.

**LLA Additional Comments:** In management's response, LDVA provides examples of high-risk areas, such as repeat falls and restraint reduction as areas that could be reviewed as part of the new QAPI process. However, LDVA's new QAPI policy does not provide specific guidance on high-risk areas for quality assurance reviews as the report recommends. Instead, the new QAPI's "Review and Evaluation" section, which gives guidance on selecting review topics, contains exactly the same wording as LDVA's prior quality assurance policy.

## Veteran homes did not always address deficiencies identified during internal quality assurance reviews.

To evaluate compliance with federal standards of care, LDVA's quality assurance policy requires that each Veteran home determine acceptable levels of performance for each standard of care. For example, if a home designates 100% as an acceptable level of performance for the treatment of pressure sores, then anything below 100% is considered noncompliant. LDVA's quality assurance policy also requires that each department establish a plan of correction to identify the problem's cause, scope, and severity that includes follow-up procedures for correcting the problem. However, Veteran homes did not develop action plans for more than half of the quality assurance reviews that identified

areas of noncompliance, as required by policy. Of the 1,995 quality assurance reviews, 531 (27%) identified areas of noncompliance. However, 286 (54%) did not have an action plan for correcting the problem identified during the internal quality assurance review. Exhibit 4 summarizes each Veteran home's quality assurance reviews and the number of noncompliant reviews each home had.

**Exhibit 4**
**Quality Assurance Reviews**
**Calendar Years 2012 to 2014**

| Veteran Home | Total Reviews | Total Noncompliant | Percent Noncompliant | Total Noncompliant Reviews Without Action Plan | Percent Without Action Plan |
|---|---|---|---|---|---|
| Bossier City | 454 | 100 | 22.0% | 79 | 79.0% |
| Jackson | 242 | 57 | 23.6% | 49 | 86.0% |
| Jennings | 364 | 113 | 31.0% | 73 | 64.6% |
| Monroe | 731 | 205 | 28.0% | 60 | 29.3% |
| Reserve | 204 | 56 | 27.5% | 25 | 44.6% |
| **Total** | **1,995** | **531** | **26.6%** | **286** | **53.9%** |

**Source:** Prepared by legislative auditor's staff using information obtained from LDVA Veteran homes.

**Recommendation 3:** LDVA should ensure all noncompliant quality assurance reviews have an action plan to correct the problems identified, as required by policy.

**Summary of Management's Response:** LDVA partially agrees with this recommendation. According to LDVA, Veterans homes implemented a new quality assurance process (Quality Assurance and Program Improvement-QAPI) in October 2014. LDVA believes this new program successfully addresses the concerns raised by LLA in its Performance Audit and stated that as the QAPI is still being fully implemented, LDVA will take LLA recommendations under advisement and will consider expanding QAPI as deemed necessary. See Appendix A, page 3, for LDVA's complete response.

**LLA Additional Comments:** The new QAPI's "Review and Evaluation" section states that LDVA should establish a plan of correction by completing the Quality Assurance Action Plan form. This requirement is exactly the same as LDVA's prior quality assurance policy. Therefore, it is unclear how the new QAPI will ensure that Veteran homes address deficiencies identified during internal quality assurance reviews, as recommended in the report.

## Veteran homes did not always resolve grievances in a timely manner.

According to LDVA policy, all Veteran home residents are encouraged and assisted, if necessary, to file a grievance if they have a concern. Reported grievances are directed to the appropriate department and/or home administrator for investigation and follow-up and are required to be resolved within five days. From calendar years 2012 through 2014, Veteran homes received 307 grievances and resolved 231 of them. The remaining 76 grievances were either ongoing or not

resolved. Of the 231 resolved grievances, 42 (18%) were not resolved within the required five-day time period. In addition, 69 (29%) of the 231 grievances that Veteran homes indicated had been resolved did not have a resolved date.

It is important for Veteran homes to resolve grievances in a timely manner because the most common grievances were related to missing or allegedly stolen property, resident care, and staff members. Specific examples of grievances included missing money, jewelry, and clothes; not receiving adequate assistance from staff resulting in accidents; and staff not treating residents with dignity or respect. Exhibit 5 summarizes the number and type of grievances by Veteran home. Appendices E-1 to E-5 contain a list of the top grievances, by Veteran home.

**Exhibit 5**
**Grievances by Type and Veteran Home**
**Calendar Years 2012 to 2014**

| Grievance Category* | Bossier City | Jackson | Jennings | Monroe | Reserve | Total |
|---|---|---|---|---|---|---|
| Resident Property | 17 | 4 | 37 | 30 | 7 | 95 |
| Resident Care | 19 | 1 | 10 | 4 | 10 | 44 |
| Grievance on Staff | 11 | 16 | 4 | 4 | 1 | 36 |
| Resident Concern | 3 | 17 | 2 | 4 | 1 | 27 |
| Facility | | 15 | | | 1 | 16 |
| Maintenance | | 12 | | 1 | | 13 |
| Dietary | 1 | 9 | | | 1 | 11 |
| Family Member Concern | 4 | 1 | | 5 | | 10 |
| Unknown | | | | 1 | 9 | 10 |
| Housekeeping | | 7 | | 1 | | 8 |
| Fiscal | | 6 | | | | 6 |
| Activities | | 5 | | | | 5 |
| Abuse | 3 | | | 1 | | 4 |
| Parking | | 4 | | | | 4 |
| Pests | | 4 | | | | 4 |
| Resident Behavior | | | | | 3 | 3 |
| Laundry | | | | 2 | | 2 |
| Medical Records | | 1 | | | 1 | 2 |
| Medication | | | | | 2 | 2 |
| Visitor Grievance | | 2 | | | | 2 |
| Communication | | | | | 1 | 1 |
| Other | | 1 | | | | 1 |
| Physical Contact by Other Resident | | | 1 | | | 1 |
| **Total** | **58** | **105** | **54** | **53** | **37** | **307** |

*We created the grievance categories using the grievance forms submitted by each Veteran home.
**Source:** Prepared by legislative auditor's staff using grievance logs and forms submitted by each Veteran home.

Although each Veteran home keeps a log of grievances and reviews each one to ensure they are resolved, LDVA management does not currently collect or track grievance information that would help it assess trends among the homes and evaluate compliance with its policies.

**Recommendation 4:** LDVA should track grievances electronically in order to compare grievances among homes and determine whether grievances were addressed timely.

**Summary of Management's Response:** LDVA partially agrees with this recommendation. According to LDVA, it strives to resolve grievances quickly and to the full satisfaction of residents. To improve in areas of timely documentation of grievances with resolution, LDVA has revised the grievance policy to provide more time for a resolution and facilities now provide LDVA headquarters with a copy of the monthly grievance log for review and monitoring. See Appendix A, pages 3-4, for LDVA's complete response.

## Veteran homes did not consistently update care plans when incidents occurred, as required by policy.

If a Veteran home resident is involved in any type of incident that causes or could cause physical injury, LDVA's Incident/Accident policy requires that the home enter an incident report into its Pioneer system, LDVA's current electronic system, to track each resident's care. However, LDVA does not routinely analyze data from this system to evaluate trends in incidents among Veteran homes. In calendar year 2014, there were 3,874 incidents reported, with 2,051 (53%) related to falls. Exhibit 6 summarizes incidents, by type and Veteran home. Appendices E-1 to E-5 outline the top incidents, by Veteran home.

An **incident** is defined as an event or series of unplanned events, such as a fall or skin tear, that cause or could have caused personal injury or property damage.

**Exhibit 6**
**Incidents by Type and Veteran Home**
**Calendar Year 2014**

| Incident Type | Bossier City | Jackson | Jennings | Monroe | Reserve | Total | Percent |
|---|---|---|---|---|---|---|---|
| Fall | 478 | 241 | 500 | 439 | 393 | 2,051 | 52.9% |
| Skin Tear | 24 | 457 | 301 | 161 | 129 | 1,072 | 27.7% |
| Other* | 23 | 1 | 155 | 44 | 79 | 302 | 7.8% |
| Bruise | 5 | 44 | 39 | 17 | 40 | 145 | 3.7% |
| Physical Contact | 30 | 13 | 17 | 29 | 22 | 111 | 2.9% |
| Pressure Ulcer | | | 68 | | | 68 | 1.8% |
| Scalded-Spillage Hot | 6 | | 6 | 9 | 1 | 22 | 0.6% |
| Head Injury | 6 | | 5 | 2 | 7 | 20 | 0.5% |
| Wander from Grounds | 4 | 1 | 6 | 5 | 2 | 18 | 0.5% |
| Verbal Contact | 5 | | 7 | 3 | 2 | 17 | 0.4% |
| Patient Contact-Object | 4 | | 5 | 2 | 3 | 14 | 0.4% |
| Choking Episode | 2 | | 9 | 2 | | 13 | 0.3% |
| Puncture/Laceration | | | 5 | 3 | 2 | 10 | 0.3% |
| Failure to Administer Medication | 1 | | 1 | | 1 | 3 | 0.1% |
| Burn-Direct Heat Exposure | | | 1 | 2 | | 3 | 0.1% |
| Missing Property | 2 | | | | 1 | 3 | 0.1% |
| Temperature Exposure-Heat | 1 | | | | | 1 | 0.0% |
| Ingestion of Harmful Substance | | | 1 | | | 1 | 0.0% |
| **Total** | **591** | **757** | **1,126** | **718** | **682** | **3,874** | |

*The other category is not defined in policy, so we are unsure what types of incidents are included in this category.
**Source:** Prepared by legislative auditor's staff using information obtained from LDVA Veteran homes.

LDVA policy also requires that the Director of Nursing update a resident's care plan when an incident occurs. According to LDVA management, updating the care plan could potentially mitigate the risk of the incident recurring. We reviewed 2,046 incident reports for 100 residents with the most incidents and found that Veteran homes did not consistently update care plans, as required by policy. For example, we found a resident that had 14 reported incidents during calendar year 2014 either related to a fall or skin tear, but did not have a corresponding update to their care plan for 12 of the 14 incidents. In addition, DHH and USDVA surveys cited care plan updates and revisions as a deficiency 17 times from 2012 to 2014.

According to LDVA management, although the policy requires that care plans be updated after incidents occur, every incident may not warrant an update to the care plan. Since LDVA does not always update care plans after incidents occur, it should consider developing criteria that outlines the circumstances under which care plans must be updated and revise its policy accordingly. For example, 25 residents in our sample of 100 were identified as high-risk for falls and skin tears and accounted for 40% of all incidents because of multiple recurring incidents. Therefore, developing specific risk-based criteria for when care plans must be updated, such as residents with a high number of recurring incidents or residents with certain types of incidents, would help ensure LDVA targets its resources to those residents most at risk.

**Recommendation 5:** LDVA should consider developing risk-based criteria for when care plans should be updated and revise its current policy accordingly. Risk-based criteria could consider factors such as the frequency of incidents for each resident and the type of incident.

**Summary of Management's Response:** LDVA partially agrees with this recommendation. According to LDVA, it provides top quality care to its residents, and while this finding does not negatively impact the quality of care provided to residents at LDVA facilities, LDVA recognizes that improvements in adherence to policy can always be reinforced. LDVA revised its "Incident/Accident Investigation" stating that the Director of Nursing (DON) will review the incident reports and the revisions made to care plans. See Appendix A, page 4, for LDVA's complete response.

**LLA Additional Comments:** To address this recommendation, LDVA revised its policies by removing the requirement for care plan updates. LDVA's "Incident/Accident Investigation" policy previously stated that the Director of Nursing (DON) update a resident's care plan when an incident occurs. The updated policy now states that the DON will review the incident reports and the revisions to care plans made. It does not address when a care plan should be updated.

## Veteran homes did not monitor whether contract providers provided quality services.

During fiscal years 2012 through 2014,[5] Veteran homes entered into 87 contracts with 26 providers totaling $7.7 million related to the delivery of health services. These contracts impact the quality of care for Veteran home residents because the contractors provide medical, pharmaceutical, radiology, and physical therapy services directly to these residents. Appendices E-1 and E-5 contain a summary of all contracts, by Veteran home. Louisiana Revised Statute (R.S.) 39:1500(B) requires that an evaluation of contract performance be conducted after the completion of a contract. However, none of the 26 contract providers we reviewed were evaluated for contract performance after their contracts expired. While Veteran homes did complete a performance evaluation on each contract provider, this evaluation failed to report on whether all contract requirements were met, as required by R.S. 39:1498.1.

We also found that all of the medical, physical therapy, pharmaceutical, and radiology contracts stated that each provider should consult with each Veteran home and provide them with a variety of documents as evidence of services provided, such as progress notes, evaluations, and statistical data. However, Veteran homes did not request any performance-related reports from contract providers in order to monitor the contract requirements. Obtaining these reports would help LDVA ensure that contract providers are providing quality services in accordance with their contracts.

**Recommendation 6:** LDVA should evaluate contract performance after the completion of a contract, as required by state law.

[5] Contracts are renewed annually.

**Recommendation 7:** LDVA should consider periodically requesting reports and other documentation of services required by the contract in order to better monitor contract providers

**Summary of Management's Response:** LDVA partially agrees with these recommendations. According to LDVA, it identified that improvements should be made in how Veteran homes document the way they monitor contract services in December 2013. Full implementation of these improvements took place throughout fiscal year 2014 and as a result, LDVA stated that they now have a process in place for monitoring contracts on a quarterly basis.

**LLA Additional Comments:** Although LDVA stated that improvements were made throughout fiscal year 2014, as of December 2014, LDVA was not able to provide documentation of contract monitoring for fiscal year 2014.

# APPENDIX A: MANAGEMENT'S RESPONSE

State of Louisiana

**BOBBY JINDAL**
GOVERNOR

**DAVID LACERTE**
SECRETARY

**Louisiana Department of Veterans Affairs**

July 20, 2015

Mr. Daryl G. Purpera, CPA, CFE
Louisiana Legislative Auditor
1600 North 3rd Street
Baton Rouge, LA 70804

RE: Audit Report Number: 40140013

Dear Mr. Purpera:

In response to the LLA Performance Audit entitled *Oversight of the Quality of Care in Louisiana's War Veterans Homes*, please accept the below information as well as the attached response.

Louisiana Department of Veterans Affairs (LDVA) operates five Veterans homes across the state which offer long-term care, rehabilitative therapies, skilled nursing, Alzheimer's care and more to Louisiana Veterans, their spouses and Gold Star parents.

LDVA Veterans Homes provide top-quality care to residents as evidenced by consistent outperformance of our peers in the long-term care industry. Surveys are conducted by Federal VA and CMS throughout the year and monitor such items as quality of resident care, medication management, staffing levels, facility cleanliness, and more.

While LDVA welcomes opportunities to improve its services, many of the findings listed in the LLA Performance Audit report have either already been addressed or will be addressed by the new LDVA Quality Assurance and Performance Improvement (QAPI) program, which was not implemented until after the timeframe reviewed by LLA staff.

Finally, LDVA would like to stress that none of the findings listed in the LLA Performance Audit report resulted in negative impact to the quality of care provided to residents.

Sincerely,

David A. LaCerte, Secretary
Louisiana Department of Veterans Affairs


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**Finding #1: Veteran homes did not always examine high risk areas on quality assurance reviews as required by policy.**

**LLA Recommendation 1:** LDVA should develop more specific guidance on high risk areas for quality assurance reviews.

**LLA Recommendation 2:** LDVA should track the results of quality assurance reviews in order to more effectively oversee the quality assurance process and identify areas that need improvement.

**LDVA Response:** The following is a response to both the finding and the recommendations and should be addressed together.

LDVA Partially Agrees.

LDVA Veterans homes implemented a new quality assurance process in October, 2014. LDVA believes this new program successfully addresses the concerns raised by LLA in its Performance Audit as detailed below. However, as the QAPI is still being fully implemented, LDVA will take LLA recommendations under advisement and will consider expanding QAPI as deemed necessary.

The Quality Assurance and Performance Improvement (QAPI) program developed processes to better assess areas of risk and to improve quality and safety of clinical care and outcomes across the LDVA Veterans Homes system. In it, each facility addresses specific areas such as falls, use of restraints, skin, nutrition, sentinel events and any deficient practices that may have been cited in the two yearly surveys conducted by CMS and Federal VA. These specific areas are considered "high risk" per the long-term care industry and require ongoing assessment and monitoring. Facilities communicate these areas of concern during daily meetings, shift reporting, high risk and care plan conferences across multiple lines of staffing and, when appropriate, with resident members and/or their family members.

With the implementation of this new QAPI program, LDVA has improved its documentation and monitoring processes to better identify each facility's focus topics for quality assurance in the following ways:

- Specific resident "high risk" care areas monitored: examples; repeat falls, restraint reduction, skin and nutrition, sentinel events, review of deficiencies cited during the survey process.
- Facilities provide LDVA headquarters with monthly QAPI report summaries which identify topics being reviewed across all departments as well as data analysis and outcomes of the study. Plans of correction are implemented.

- Additionally, LDVA headquarters has implemented a survey monitoring tool to address deficiencies cited in each facility during CMS and Federal VA surveys. This tool is used to identify practices where improvements can be made specific to each home in order to develop a plan of correction in an effort to eliminate an occurrence at other facilities.

**Finding #2: Veteran homes did not always address deficiencies identified during internal quality assurance reviews.**

**LLA Recommendation 3:** LDVA should ensure all non-compliant quality assurance reviews have an action plan to correct the problems identified, as required by policy

**LDVA Response:** The following is a response to both the finding and the recommendation and should be addressed together.

LDVA Partially Agrees.

LDVA Veterans homes implemented a new quality assurance process in October, 2014. LDVA believes this new program successfully addresses the concerns raised by LLA in its Performance Audit as detailed below. However, as the QAPI is still being fully implemented, LDVA will take LLA recommendations under advisement and will consider expanding QAPI as deemed necessary.

Each facility's process of identifying problem areas, documenting and monitoring corrective action plans have and continue to improve with implementation of the new QAPI program. Once a deficiency is identified, an approach is implemented and monitored on a continuous basis. Facilities provide LDVA with a monthly QAPI report summary identifying topics being reviewed across all departments, data analysis, outcomes of the study and plans of correction as implemented.

- Additionally, LDVA is now utilizing a survey monitoring tool created to track any deficient practices that may have been identified in CMS or Federal VA surveys, communicates this information to all facilities and assists in developing a plan of correction in an effort to eliminate an occurrence at other facilities.

**Finding #3: Veteran homes did not always resolve grievances timely.**

**LLA Recommendation 4:** LDVA should track grievances electronically in order to compare grievances among homes and determine whether grievances were addressed timely.

**LDVA Response:** The following is a response to both the finding and the recommendation and should be addressed together.

LDVA Partially Agrees.

LDVA strives to resolve grievances quickly and to the full satisfaction of residents. The below provides an explanation of current practices as well as steps already taken to improve as identified by LLA in its Performance Audit report:

LDVA facilities assist residents in filing grievances should they have the need to make a concern(s) known. In addition, each facility maintains and supports a Resident Council consisting of members chosen by residents who represent the resident body and meet regularly to discuss issues that affect them.

To improve in areas of timely documentation of grievances with resolution, the following has been implemented;

- The grievance policy has been revised to provide more time for a resolution, now allowing up to ten days to thoroughly investigate the grievance, follow-up with the resident and arrive at a successful resolution.
- Facilities now provide LDVA headquarters with a copy of the monthly grievance log for review and monitoring to insure timely, thorough investigation and resolution as well as additional oversight of the process.

**Finding #4: Veteran homes did not consistently update care plans when incidents occurred as required by policy.**

**Recommendation 5:** LDVA should consider developing risk based criteria for when care plans should be updated and revise its current policy accordingly. Risk based criteria could consider factors such as the frequency of incidents for each resident and the type of incident.

**LDVA Response:** The following is a response to both the finding and the recommendation and should be addressed together.

LDVA Partially Agrees.

LDVA provides top quality care to its residents. While Finding #4 as cited by LLA in its Performance Audit report does not negatively impact the quality of care provided to residents at LDVA facilities, LDVA recognizes that improvements in adherence to policy can always be reinforced.

Each resident has a comprehensive care plan that is current, individualized, and consistent with the medical regimen. Care plans are constantly reviewed and updated at a minimum every quarter, every year, and any time there is a *<u>significant change</u> in the

resident's condition. If a resident's needs change between the scheduled care plan conferences, the care plan is re-addressed and revised as needed. * (*Significant change- a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan)*

LDVA revised policies as follows:

- Incident/Accident Investigation policy- "The Director Of Nursing (DON) or designee will be responsible for review of incident report; missing information or blanks on the incident report, review of nurse's notes for the description of incident, proper notification of the family and physician, and reviewing the care plan for revisions made or updates if indicated."

- Falls Policy- "Approaches will be reviewed in the plan of care and revisions completed if indicated to address needs."

**Finding #5: Veteran homes did not monitor whether contract providers provided quality services.**

**Recommendation 6:** LDVA should evaluate contract performance after the completion of a contract, as required by state law.

**Recommendation 7:** LDVA should consider periodically requesting reports and other documentation of services required by the contract in order to better monitor contract providers.

**LDVA Response:** The following is a response to both the finding and the recommendations and should be addressed together.

LDVA Partially Agrees.

In December 2013, LDVA identified that improvements should be made in how veterans homes document the way they monitor contract services. Full implementation of these improvements took place throughout Fiscal Year 2014 and as a result, LDVA now has a process in place for monitoring contracts on a quarterly basis.

While informal communications with contract personnel work well and contract services being provided are observed regularly, LDVA will strive to improve the documentation of these successful practices.

# APPENDIX B:  SCOPE AND METHODOLOGY

We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended.  The purpose of this audit was to evaluate the Louisiana Department of Veterans Affairs' (LDVA) oversight of the quality of care for residents in Louisiana's five War Veterans Homes (Veteran homes).  Our audit covered calendar years 2012 through 2014 for internal and external reviews, as well as incidents, grievances, and QA reviews; and fiscal years 2012 through 2014 for contracts.  Our audit objective was:

**To evaluate LDVA's oversight of quality of care in Louisiana's War Veterans Homes.**

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standards* issued by the Comptroller General of the United States.  Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.  We believe the evidence obtained provides a reasonable basis for our findings and conclusions, based on our audit objective.  To answer our objective, we reviewed internal controls relevant to the audit objective and performed the following audit steps:

- Researched and reviewed relevant federal statutes, Louisiana Revised Statutes, and agency policies and regulations to determine quality of care criteria.  We used these criteria while examining LDVA's internal quality assurance reviews, grievance process, incident process, and monitoring of its contracts impacting quality of care.

- Interviewed LDVA staff and visited three of the five Veteran homes.

- Obtained and reviewed required annual Louisiana Department of Health and Hospitals and the United States Department of Veterans Affairs surveys and corrective action plans for calendar years 2012 through 2014 to determine each Veteran home's compliance with quality of care standards.

- Obtained and reviewed all internal quality assurance reviews of Veteran homes for calendar years 2012 through 2014 to determine compliance with quality of care standards.  We reviewed documentation for 2,366 reviews.  We removed 371 of the reviews from our analysis because they were incomplete, giving us a total of 1,995 for our analysis.  Created a data collection instrument using quality assurance reviews to perform our analysis.

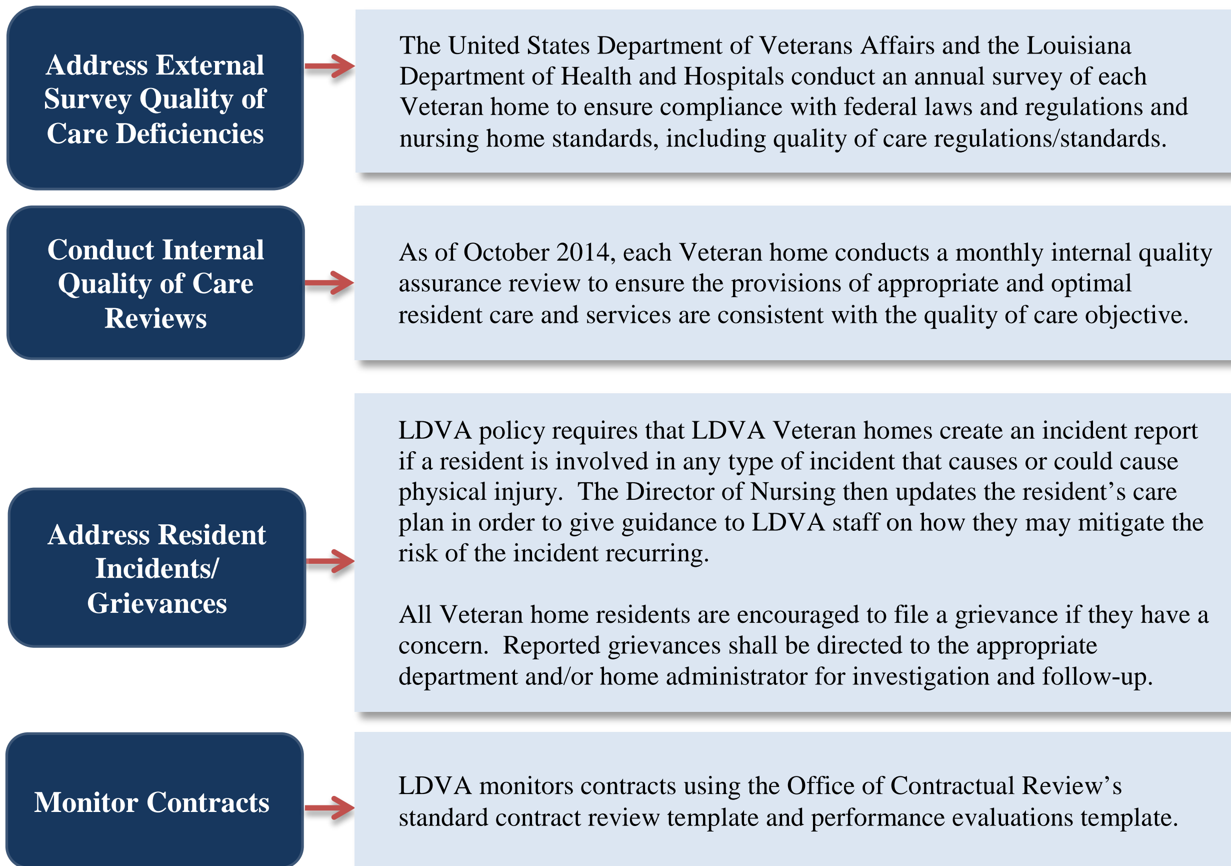
- Obtained and reviewed all grievances submitted within the Veteran homes for calendar years 2012 through 2014 to determine if grievances were addressed in a timely manner to ensure the quality of care of residents in the Veteran homes.

Created a data collection instrument using the grievance forms to perform our analysis. We also created categories for each type of grievance.

- Obtained and reviewed all Veteran home residents' incidents for calendar year 2014. For calendar year 2014, there were 3,874 total incidents across all five Veteran homes. We obtained copies of incident reports and care plans for the top 20 residents with the most incidents in each Veteran home (for a total of 100) to determine if incidents were being addressed to ensure quality of care. Our review of 100 residents accounted for 1,456 (37%) of the 3,874 incidents during calendar year 2014, with an overall total of 2,046 incidents over a three-year period (calendar years 2012 through 2014).

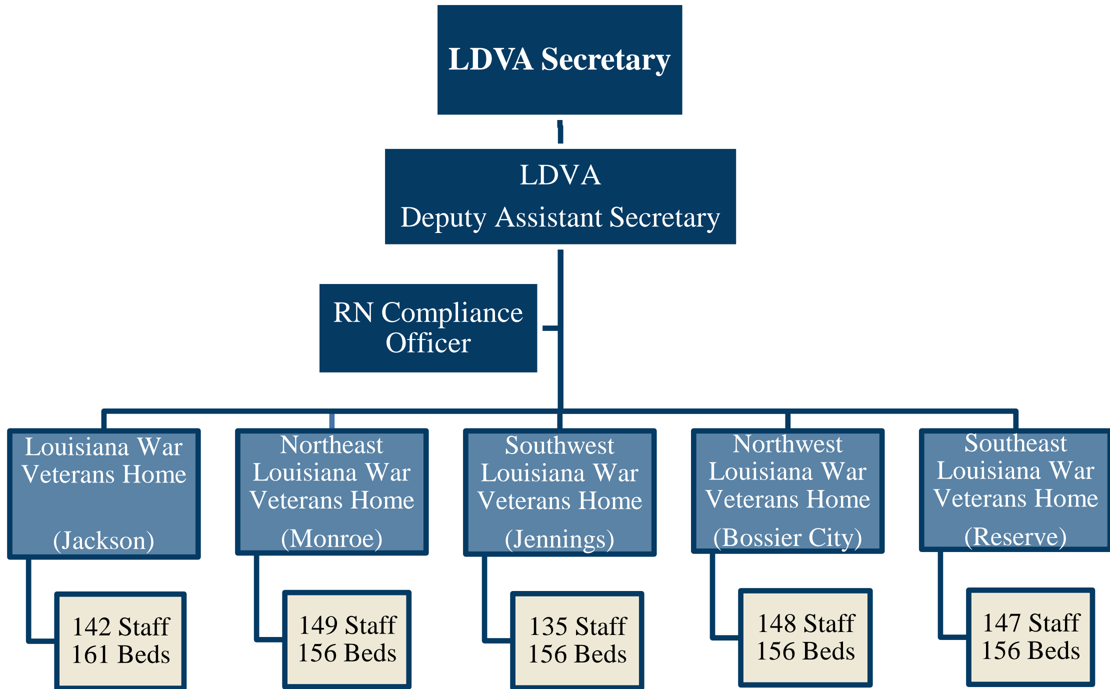
- Obtained and reviewed all Veteran home contracts impacting quality of care and monitoring tools for fiscal years 2012 through 2014 to determine whether LDVA was monitoring each contract for performance. Created a data collection instrument using the information in each contract to perform our analysis.

# APPENDIX C: LDVA PROCESSES TO ENSURE QUALITY OF CARE IN LOUISIANA WAR VETERANS HOMES




**Source:** Prepared by legislative auditor's staff using LDVA's internal policies and federal and state laws.

# APPENDIX D:
# WAR VETERANS HOME ORGANIZATIONAL STRUCTURE
# FISCAL YEAR 2015



# APPENDIX E:  VETERAN HOME FACT SHEETS

# Appendix E-1

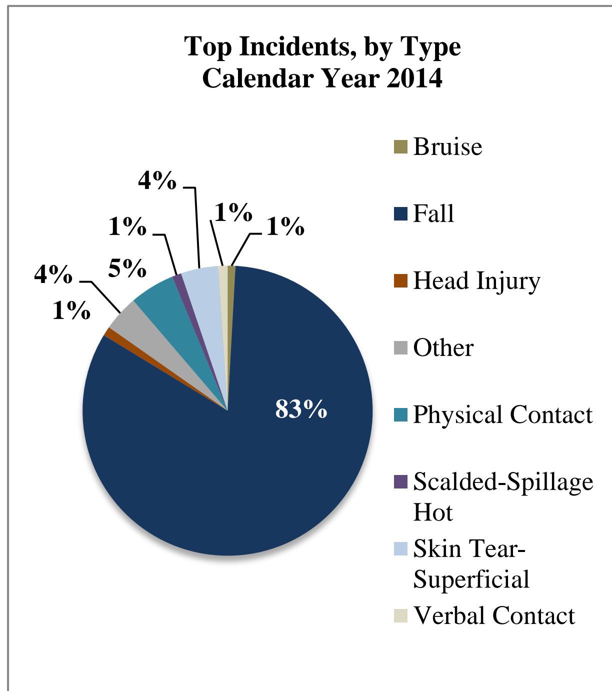
## Northwest Louisiana War Veterans Home (Bossier)

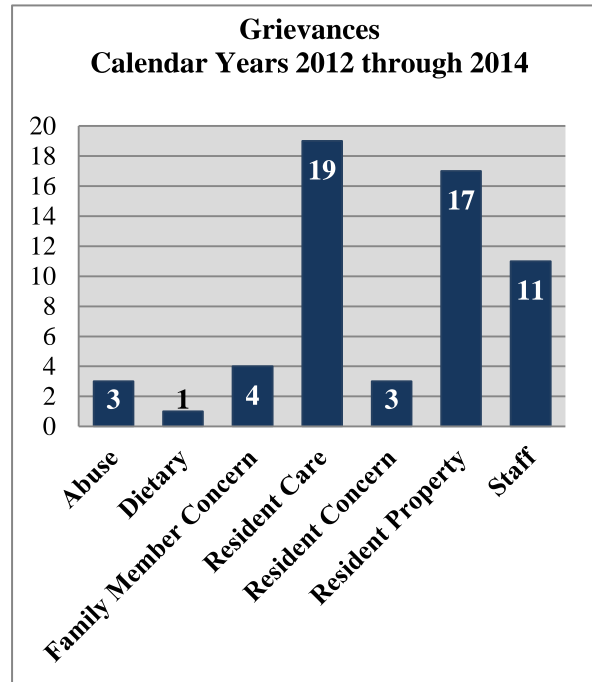
Bossier City, Bossier Parish
Total Home Capacity: 156
Total Home Residents: 146

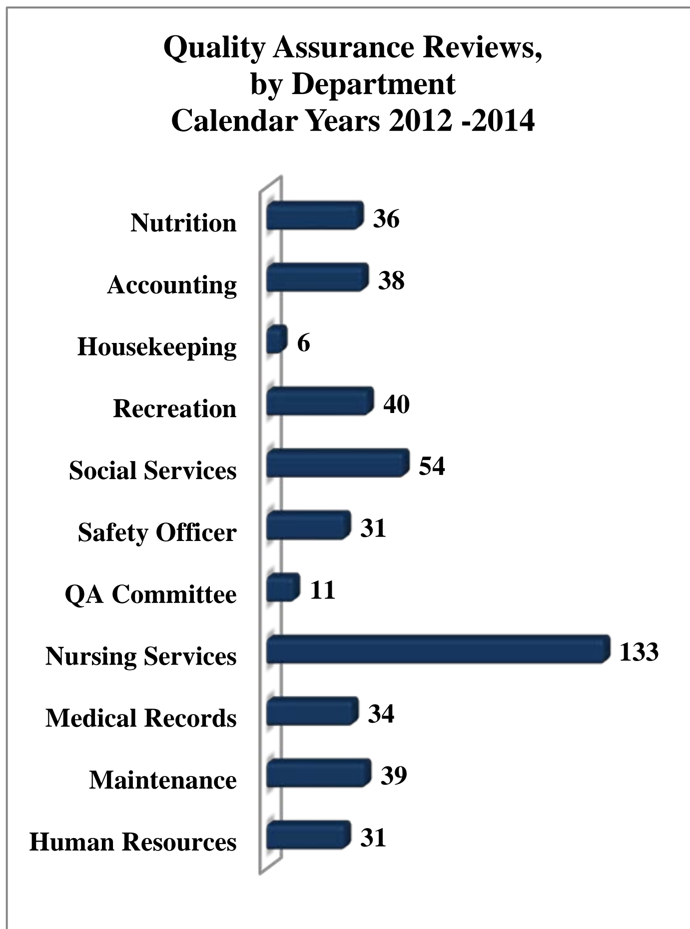
| Total Staff | Total Residents | Staff Per Resident | Voluntary Turnover | Involuntary Turnover | Total Turnover |
|---|---|---|---|---|---|
| 148 | 146 | 1.0 | 18.62% | 15.86% | 34.48% |

| Calendar Years 2012-2014<br>Six Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.90 Resident Behavior/ Facility Practices | Facility failed to ensure all residents were free from physical restraints for 12 residents and that three were free from chemical restraints. | Chemical restraints were administered to residents with no indication of staff intervention in an attempt to de-escalate the behaviors prior to the chemical restraint being administered. |
| 51.110 Resident Assessment | Facility failed to provide services in accordance with each resident's plan of care for seven of 24 sampled residents. | Residents' care plan included a mitt instead of wrist restraint, but reduction was not enacted upon quarterly review even though resident was a good candidate. No evidence staff had attempted to reduce restraints per the resident's written plan of care. |
| 51.110 Resident Assessment | Facility failed to ensure the care plans were reviewed and/or revised for six of 24 sampled residents identified as high-risk for falls and adequate supervision and assistive devices to prevent accidents. | Resident admitted to facility and later identified as a high-risk for falls. Resident fell seven times with no revision or review of care plan to induce interventions to prevent reoccurrence. Separate resident later fell and sustained hip fracture, with no revision to care plan or preventative measures implemented as a result of two falls four to six days prior. |
| 51.120 Quality of Care | Facility failed to ensure that six of the 24 sample residents received adequate supervision and assistive devices to prevent re-occurring falls. | Resident assessed and identified as high-risk and placed on Falling Leaf Program. Care plan was not revised and/or reviewed after two falls obtained while attempting to self-transfer from wheelchair. |
| 51.120 Quality of Care | Facility failed to ensure medication was administered in safe manner according physician's order. | Resident's medication was discontinued on 4/10/14 per physician's order. Medication was not pulled from resident's medication basket according to facility protocol after discontinuation until review on 4/23/14. |
| **DHH Deficiencies** | | |
| F271-F287: Resident Assessment | Failure to ensure accurate vision assessments for residents. Assessment records did not indicate corrective eyewear for residents even though care plan indicates impaired vision. | Six residents with impaired vision did not have corrective lenses. |

| Total Incidents (CY 2014) | Total Grievances (CY 2012-2014) | Total QA Reviews Performed |
|---|---|---|
| 591 | 58 | 454 |




| Contracted Services<br>Fiscal Years 2012 through 2014 | | |
|---|---|---|
| **Vendor** | **Type of Service** | **Contract Amount** |
| Bee Healthcare, Inc. | Pharmacy Service | $28,800 |
| John M Chandler | Medical Director | 72,000 |
| Mobile X-Ray Shreveport and Bossier | X-Ray and Cardiology Services | 135,558 |
| Nutrition Education Resources | Medical Nutritional Services | 112,320 |
| Synergy Care, Inc. | Physical Therapy, Occupational Therapy, Speech Therapy | 1,604,412 |
| William M Hall | Dentist | 3,000 |
| **Total** | | **$1,956,090** |

**Source:** Prepared by legislative auditor's staff using information obtained from LDVA, DHH, and USDVA.

# Appendix E-2

## Louisiana War Veterans Home (Jackson)

Jackson, East Feliciana Parish
Total Home Capacity: 161
Total Home Residents: 138

| Total Staff | Total Residents | Staff Per Resident | Voluntary Turnover | Involuntary Turnover | Total Turnover |
|---|---|---|---|---|---|
| 142 | 138 | 0.4 | 24.63% | 10.44% | 35.07% |

| Calendar Years 2012-2014<br>22 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.110 Resident Assessment | Facility failed to ensure care plans were developed to address resident care for three of 25 sampled residents. | Although staff had knowledge of residents' continued issues with drinking and driving while intoxicated, no care plan interventions were put into place to ensure residents' needs are met. On 6/14/12, intoxication led to emergency medical treatment for shoulder pain; and alcohol intoxication for three residents placed the community at-large at risk. |
| 51.120 Quality of Care | Facility failed to ensure measures were in place to prevent accident hazards for three of 25 sampled residents. | No measures were put in place to address three residents' drinking off grounds and driving while intoxicated. Upon returning, one resident fell in parking lot on 6/14/12 and later complained of shoulder pain. Care plan was updated to address fall of resident but did not address the cause of the fall identified as alcohol intoxication. |
| 51.90 Resident Behavior/Facility Practices | Facility failed to ensure an allegation of abuse was investigated for one of 24 sampled residents. | Resident informed nurse that he/she had been molested. The nurse did not report the allegation, but instead told the resident that all residents of the facility are monitored. No investigation of the allegation was conducted. |
| 51.100 Quality of Life | Facility failed to promote care to residents in a manner that maintained each resident's dignity for two of 24 sampled residents. | Resident with incontinence issues was assessed and identified with possibility of retraining or a toileting program. However, no retraining or toileting program was attempted. |
| 51.100 Quality of Life | Facility failed to ensure a resident received reasonable accommodation and preference regarding choice of mobility device for one of 24 sampled residents. | On 9/8/13, a veteran was found on floor with a skin tear and motorized wheelchair in the vicinity. Staff intervened by replacing the motorized wheelchair with a manual chair, against the resident's wishes and the facility policy of restricting the use of motorized chairs as a team decision. Resident had not been reassessed for the use of the motorized wheelchair as of 10/17/13. |

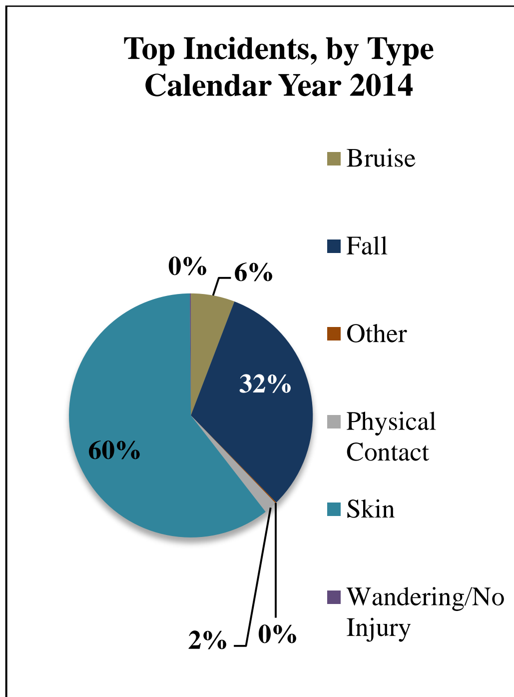
| Calendar Years 2012-2014<br>22 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.110 Resident Assessment | Facility failed to ensure care plans were updated for one of 24 sampled residents. | Resident fell and hit his head and was taken to ER where it was discovered he was intoxicated more than three times the legal limit. His care plan did not indicate he was taking narcotics, and therefore, should be monitored at all times. Also, the patient was not educated on the risks of drinking while taking the drugs. |
| 51.110 Resident Assessment | Facility failed to provide services to meet professional standards for two of 24 sampled residents. | Resident on modified diet had care plan interventions for aspiration precautions. Speech therapist recommended a pharngogram to assess swallowing but directive was not followed nor was physician informed of recommendation. |
| 51.120 Quality of Care | Facility failed to promote care to residents in a manner to assist with maintenance of bladder function for two of 24 sampled residents | Resident was incontinent of bowel and bladder and toilet-training program may have helped. He was not offered the program. Resident voided frequently and staff did not address the incontinence in a timely manner. He, too, qualified for the toileting program but was not given the option. |
| 51.120 Quality of Care | Failed to ensure a resident was cleaned appropriately after an incontinence episode. | The resident required extensive assistance of two persons for transfers and staff indicated toileting did not occur during the observation period. Staff did not properly clean front or groin areas. |
| 51.120 Quality of Care | Facility failed to ensure residents' environments remained free of accident hazards and each resident received the appropriate supervision to prevent accidents for one of the 24 sampled residents. | Resident fell and hit his head and was taken to ER where it was discovered he was intoxicated more than three times the legal limit. His care plan did not indicate he was taking narcotics, and therefore, should be monitored at all times. Also, the patient was not educated on the risks of drinking while taking the drugs. |
| 51.190 Infection Control | Facility failed to establish infection control program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection. | Two of three observations of wound treatments revealed failure to prevent contamination of supplies by the nurse providing the treatment as well as failure to appropriately clean the perianal area and foley catheter tubing. |
| 51.90 Resident Behavior/Facility Practices | Facility failed to appropriately assess for the use of a pommel cushion as a positioning device versus a restraint for one resident in a sample of 24. | High fall risk resident was observed with pommel cushion for positioning with no physician order for such device. |
| 51.100 Quality of Life | Facility failed to provide a dignified experience by ensuring residents meals were served at the same time and those requiring feeding assistance were not sitting waiting to be assisted while other residents ate. | Twenty minutes into meal service, some residents were still waiting to be served while others had finished. Those requiring assistance were still waiting to be fed up to an hour into meal service. Meals were not reheated to accommodate wait times. |

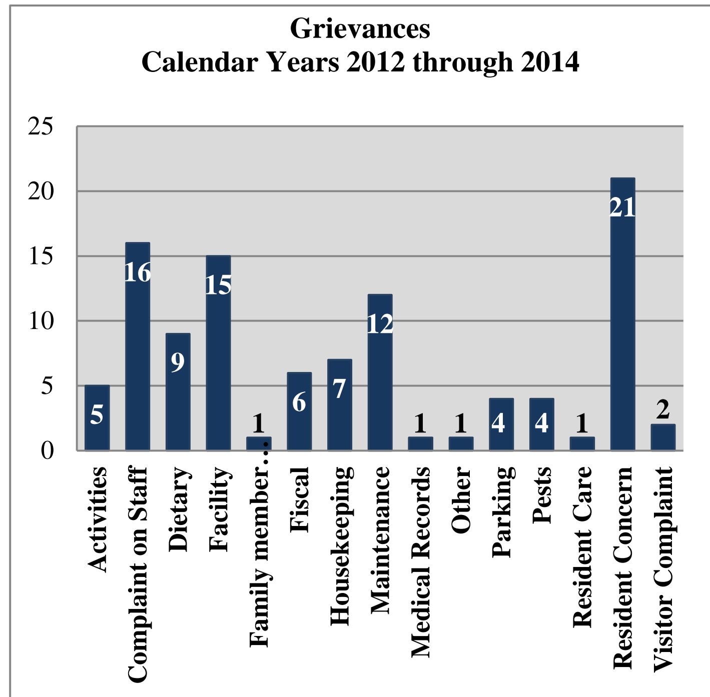
| Calendar Years 2012-2014<br>22 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.120 Quality of Care | Facility failed to provide verbal cueing and consistently assist with eating for three of 26 sampled. | Resident with cognitive impairment left table and dining room. Upon return to the dining room, resident could not find place setting and was not assisted by staff. Resident did not finish his/her food. Another cognitively impaired resident was observed not eating. When asked if he/she liked the food, the resident responded "No." Staff did not offer additional substitutes or eating assistance, and resident did not eat his entrée/or vegetables. |
| 51.120 Quality of Care | Facility failed to administer medications as ordered for two of 45 residents during a medication pass. | Resident received one capsule of Lactobacillus on 10/15/14 instead of the physician-ordered prescription for Lactinex packet 3X daily, as written on 3/12/14. Per Director and Assistant Director of Nursing, medication dosages are not the same and resident should have received the Lactinex packet as prescribed. Staff was unable to state how long resident received the wrong medication. |
| **DHH Deficiencies** | | |
| F201-208: Admission, Transfer, and Discharge Rights | Failure to notify responsible party of resident transfer/discharges. Failure to notify at least 30 days prior to transaction date, provide appeal statement to resident, and provide contact information to state long-term care ombudsman. | Resident sent to emergency room for psychiatric evaluation on 7/8/13, as a result of suicide attempt. Resident was discharged from nursing home on 7/22/13 without notice of discharge or notification of appeals rights. |
| F201-208: Admission, Transfer, and Discharge Rights | No documentation of bed hold policy given to Resident #3 or responsible party. | Administrator did not give resident's responsible party a copy of the facility's bed hold policy when resident was sent to local hospital for psychiatric evaluation due to attempts to harm himself. |

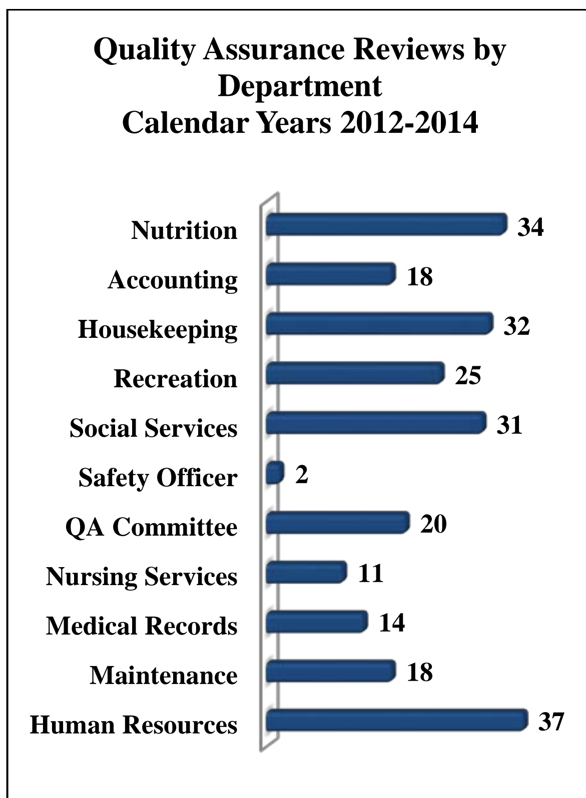
| Calendar Years 2012-2014<br>22 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| F271-F287: Resident Assessment | **483.20(d)(3)**: The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care.<br>**483.10(k)(2):** A comprehensive care plan must be 1) Developed within seven days after completion of the comprehensive assessment;<br>2) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and 3) Periodically reviewed and revised by a team of qualified persons after each assessment. Failure to reassess effectiveness of the interventions presented and review/revise care plan for presence of UTIs. | Residents with reoccurring urinary tract infections (UTIs) were not given effective interventions to reduce the amount of infections. One sampled resident tested nine times for UTIs positive for E. Coli between October 2012 and July 2013. This resident did not have a care plan for reoccurring UTIs or preventions aimed at decreasing the occurrences of UTIs with E. Coli. |
| F309-F334: Quality of Care | Failure to provide necessary care and services to attain or maintain the highest physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | Resident's care plan did not have care plan for reoccurring UTIs. Staff acknowledged there had been an increased number of UTIs from April to July 2013, but facility did not perform in-services to address specific number of UTIs on A and B hall. |
| F441: Infection Control | Failure to establish and maintain an Infection Control Program designed to prevent the development and transmission of disease and infection. Lack of hand washing and procedure training on techniques to prevent spread of infection. Lack of adequate tracking of UTI infections. | Ineffective infection tracking to identify resident with reoccurring UTIs. Resident was later admitted to hospital with diagnosis in part to UTI and acute kidney injury. |
| F490-F522: Administration | Failure to ensure nursing staff was competent in skills and techniques necessary to care for residents who required incontinent care. | Cross contamination by soiled diaper onto changing station, clean diaper, and resident; a result of staff not ensuring clean supplies are protected from soiled diapers and gloves. |

| Calendar Years 2012-2014<br>22 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| F490-F522: Administration | Failure to identify quality deficiencies and develop and implement plans of action to correct these quality deficiencies. Failure to identify concerns with the quality of the facility systems involving interventions aimed at decreasing the number of UTI residents. | Administration did not ensure adequate tracking of infections and suitable in-services were conducted to reduce the amount of reoccurring infections. |

| Total Incidents (CY 2014) | Total Grievances (CY 2012-2014) | Total QA Reviews Performed |
|---|---|---|
| 757 | 105 | 242 |




| Contracted Services Fiscal Years 2012 through 2014 | | |
|---|---|---|
| **Vendor** | **Type of Service** | **Contract Amount** |
| American Mobile Medical Contract | X-Ray/Radiology | $27,000.00 |
| Bee Healthcare, Inc. | Pharmacy Service | 36,900.00 |
| Dr. Kakarala (Piker Clinic) | Medical Director | 54,000.00 |
| Nicholas Campo | Medical Director | 108,000.00 |
| Nutrition Education Resources | Medical Nutritional Services | 93,600.00 |
| Synergy Care, Inc. | Physical Therapy, Occupational Therapy, Speech Therapy | 1,345,676.30 |
| **Total** | | **$1,665,176.30** |

**Source:** Prepared by legislative auditor's staff using information obtained from LDVA, DHH, and USDVA.

# Appendix E-3

## Southwest Louisiana War Veterans Home (Jennings)

Jennings, Jefferson Davis Parish
Total Home Capacity: 156
Total Home Residents: 144

| Total Staff | Total Residents | Staff Per Resident | Voluntary Turnover | Involuntary Turnover | Total Turnover |
|---|---|---|---|---|---|
| 135 | 144 | 1.0 | 21.74% | 18.12% | 39.86% |

| Calendar Years 2012-2014<br>29 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.90 Resident Behavior/Facility Practices | Facility failed to protect one of 24 residents sampled from abuse. | Resident was physically abused by another resident. No protective measures were put in place and one week later the resident was abused again by the same person. |
| 51.110 Resident Assessment | Facility did not develop and/or revise care plans for three of 24 sampled residents. | Care plans were not updated to reflect the two residents' behavior after a physical altercation. One other resident experienced frequent falls and the care plan was not updated. |
| 51.120 Quality of Care | Facility failed to ensure that four of 24 residents were provided with appropriate supervision to prevent accidents. | Failure to implement protective measures for a resident being abused by another, resulting in subsequent abuse. Resident with numerous falls and attempted elopement from facility had no preventative measures in place. |
| 51.100 Quality of Life | Facility failed to provide an adequate number of qualified social workers resulting in the residents not having access to medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being for all residents. | Social Work Director (SWD) is the facility's only qualified social worker and licensed as a clinical social worker. SWD stated there are a number of residents on anti-depressants and anti-psychotic medication that would benefit from counseling and supportive services. |
| 51.110 Resident Assessment | Facility failed to review and revise the individualized plan of care for one of 25 sampled veterans. | Resident was supposed to receive medicine for urinary tract infections to start on 4/5/13; however, care plan noted an allergy to medication, and therapy was never started. Record review revealed resident did not have a true allergy to the medication but would need to be monitored. |
| 51.210 Administration | Facility failed to assure labs ordered were completed and reported to the physician. | Ordered labs not reported to physician. |
| 51.210 Administration | Facility failed to assure confidentiality of resident's medical records. | Communication regarding patients was conducted via personal smartphones for Veteran home nursing and medical director. |

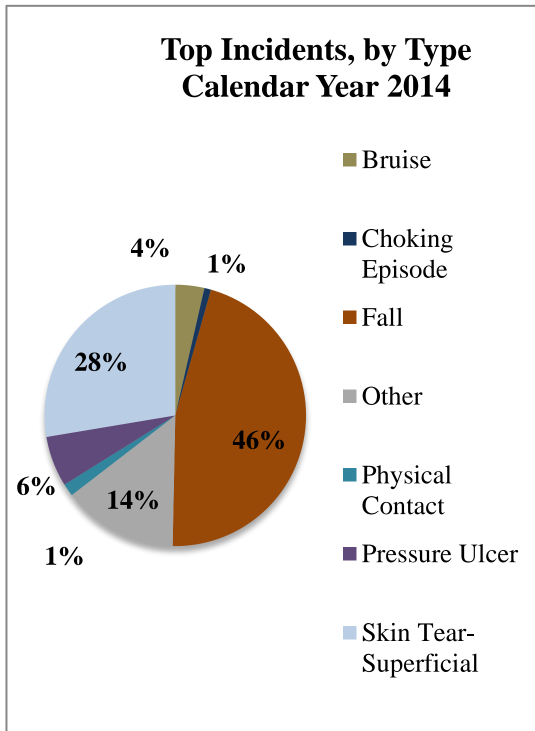
| Calendar Years 2012-2014<br>29 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.70 Resident Rights | Facility failed to ensure that personal and confidential medical information would not be communicated between staff by the use of a Samsung smartphone for one of 24 sampled residents. | Confidential patient information in the form of medical x-rays and patient identifying information (PII) transmitted via personal cellphones between physician and nursing staff. |
| 51.110 Resident Assessment | Facility failed to ensure assessments met professional standard of quality and were provided in accordance with each resident's written plans of care for five of 24 sampled residents. | Nurse overrode black box warning indicating severe adverse drug interaction when administering resident's medication. For three consecutive months, resident did not receive colonoscopy per physician's orders. |
| 51.110 Resident Assessment | Facility failed to ensure one of 24 sampled residents received the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. | Pressure sores were not treated according to physician's orders for five days. Cross contamination during dressing change. |
| 51.120 Quality of Care | Facility failed to ensure unnecessary medications were administered to 24 sampled residents. | Immediate harm cited for nurse overriding electronic system drug interaction warning for resident on anticoagulant medication. |
| 51.190 Infection Control | Facility failed to ensure nursing staff followed appropriate infection control precautions for one of 24 sampled residents. | Nursing staff failed to wash hands during wound care dressing change and contaminated clean field. |
| **DHH Deficiencies** | | |
| F221-F226: Resident Behavior and Facility Practices | Failure to implement written abuse investigation policy and procedure. Lack of investigative documentation of alleged abuse. | Resident had filed a Grievance form stating he asked the CNA to stop her remarks, etc. (6/11/12) and no completed documentation by supervisor on 8/22/12. |
| F240-F258: Quality of Life | Failure to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. | Dust and cracks in the armrests of wheelchair. |
| F240-F258: Quality of Life | Failure to provide comfortable and safe temperature levels and to maintain a temperature range of 71-81 degrees. | Interviews with residents and their family members, as well as use of a thermometer gun, determined the air temperature in various spots in the home to be cooler than criteria. |
| F271-F287: Resident Assessment | Failure to ensure that RAI assessment was completed of the resident's worsening condition. | During the night, resident's condition deteriorated; due to lack of assessment documentation was taken to the hospital; diagnosed with Congestive Heart Failure. |

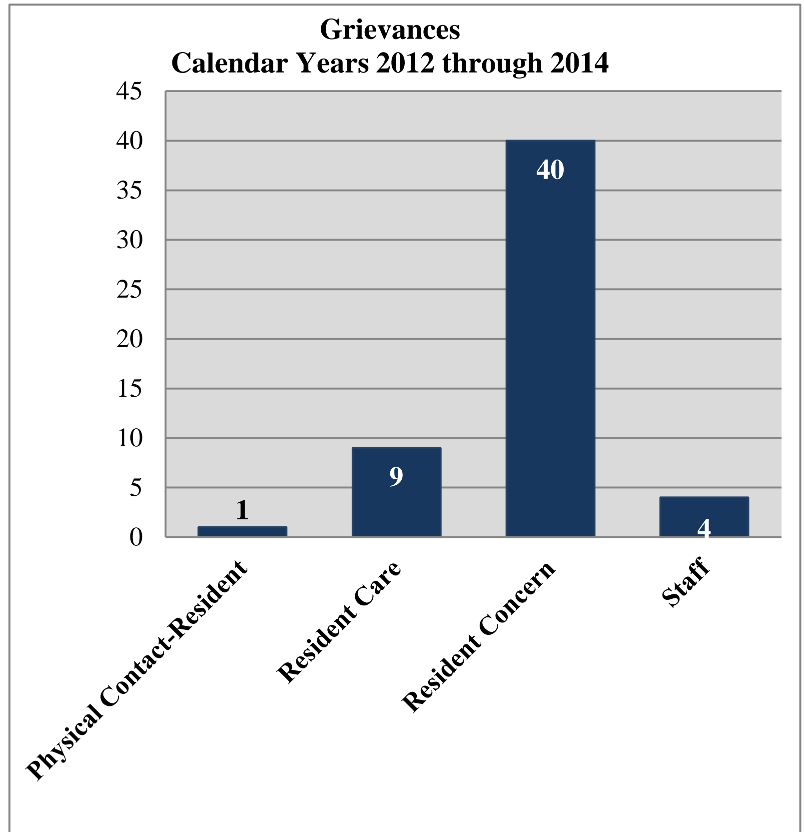
| Calendar Years 2012-2014<br>29 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| F271-F287: Resident Assessment | **483.20(d)**: A facility must maintain and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.<br>**483.20(k)(1)**: The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. | Failure to use the results of comprehensive assessment to develop and record interventions for the resident's limited vision. |
| F271-F287: Resident Assessment | **483.20(d)(3)**: The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care.<br>**483.10(k)(2)**: A comprehensive care plan must be 1) Developed within seven days after completion of the comprehensive assessment; 2) Prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family, or the resident's legal representative; and 3) Periodically reviewed and revised by a team of qualified persons after each assessment. | Failure to review and revise a resident's care plan after a change in their care and treatment. Resident completed therapy and transferred to restorative nursing at which time the care plan should have been updated. |
| F309-F334: Quality of Care | Failure to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical well-being. | Assessment of resident's worsening condition during the nightshift not done. As a result of the resident's deteriorating condition, the resident was transferred to the hospital and diagnosed with Congestive Heart Failure. |

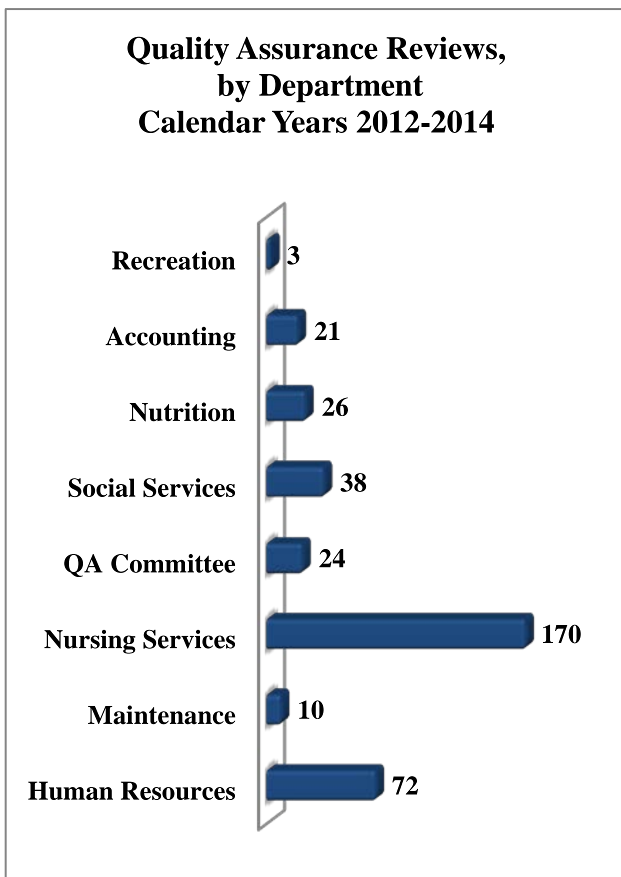
| Calendar Years 2012-2014<br>29 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| F309-F334: Quality of Care | **(1)** Failed to document diagnosis for the use of the anti-psychotic medication Risperdal; a resident was admitted with multiple diagnoses which included the mental health diagnoses of AMS and Depression. A review of the Physician orders from admission to the survey date indicated the resident was prescribed and was receiving Risperdal. **(2)** Failed to monitor the use of the antipsychotic medication according to facility's policy. | Resident was admitted with multiple diagnoses which included mental health diagnoses of AMS and depression. Resident was currently on anti-psychotic medication, but a review of the Social Services admission notes indicated the resident had no documented history of mental health issues. |
| F353-F356: Nursing Services | Failure to post certain information on a daily basis as required by law.<br>Facility name, current date, total number and actual hours worked by categories of licensed and unlicensed nursing staff directly responsible for resident care per shift (RNs, LPNs, LVNs, CNAs and Resident Census). | Resident census and actual and projected hours of nursing staff were not posted in a readily accessible area. |
| F425-431: Pharmacy Services | Failure of consultant pharmacist to identify a lack of diagnosis for the use of the antipsychotic Risperdal. | The 8/20/12 documentation read noted resident is on Risperdal therapy and to give a diagnosis, which was signed by the pharmacist. The resident had been on the Risperdal since 6/29/12 without documentation of the diagnosis on the resident's medical record. |
| F490-F522: Administration | Failure to train staff in emergency procedures upon hire; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. | Custodian not trained upon hire. |
| F240-F258: Quality of Life | Failure to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. | Staff observed entering resident's rooms and common bathroom areas without knocking on the door and not giving residents privacy in the showers. |
| F309-F334: Quality of Care | Failure to ensure that a resident who entered the facility without pressure ulcers did not develop any and did not ensure that a resident without a pressure ulcer does not develop a pressure ulcer unless unavoidable. | Resident entered the facility at a low-risk for pressure sores but developed multiple sores within six months in residency. |

| Calendar Years 2012-2014<br>29 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| F309-F334: Quality of Care | Failure to ensure that each resident receives adequate supervision and assistance to prevent accidents. | A resident's wheelchair flipped backwards while being transferred up on a van ramp by one CNA at the dialysis center. The resident was noted as being at high risk for falls and coded as being totally dependent for transfer and requiring two-plus person assist for transfers. |
| F441: Infection Control | Failure to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. | Nasal equipment left uncovered while resident was off-site for four days. Not following facility policy for the proper storage of resident use equipment when not in use. |
| F150-F177: Resident Rights | Failure to notify the resident's physician of a significant change in the resident's mental status. | The Veteran home did not notify the resident's physician of a new occurrence of delusional and agitated behaviors and a side effect of confusion for unnecessary medications. |
| F271-F287: Resident Assessment | Failure to ensure the services provided or arranged by the facility were provided by qualified persons in accordance with each resident's written plan of care. | The staff did not document additional information in the nursing progress notes regarding behaviors and side effects as identified on the MAR and did not notify the physician of changes in the behavior for unnecessary medications. |

| Total Incidents (CY 2014) | Total Grievances (CY 2012-2014) | Total QA Reviews Performed |
|---|---|---|
| 1126 | 54 | 364 |




| Contracted Services Fiscal Years 2012 through 2014 | | |
|---|---|---|
| **Vendor** | **Type of Service** | **Total** |
| Amanda M. LaComb | Medical Director | $126,000.00 |
| Jennings American Legion Hospital | Clinical Laboratory/ Radiology Services | 45,000.00 |
| Bee Healthcare, Inc. | Pharmacy Service | 33,930.00 |
| Sittig Mobile X-Ray | Digital X-ray and EKG visits | 45,000.00 |
| Synergy Care, Inc. | Physical Therapy, Occupational Therapy, Speech Therapy | 1,373,669.60 |
| **Total** | | **$1,623,599.60** |

**Source:** Prepared by legislative auditor's staff using information obtained from LDVA, DHH, and USDVA.

# Appendix E-4

## Northeast Louisiana War Veterans Home (Monroe)

Monroe, Ouachita Parish
Total Home Capacity: 156
Total Home Residents: 144

| Total Staff | Total Residents | Staff Per Resident | Voluntary Turnover | Involuntary Turnover | Total Turnover |
|---|---|---|---|---|---|
| 149 | 144 | 1.0 | 19.46% | 11.41% | 30.87% |

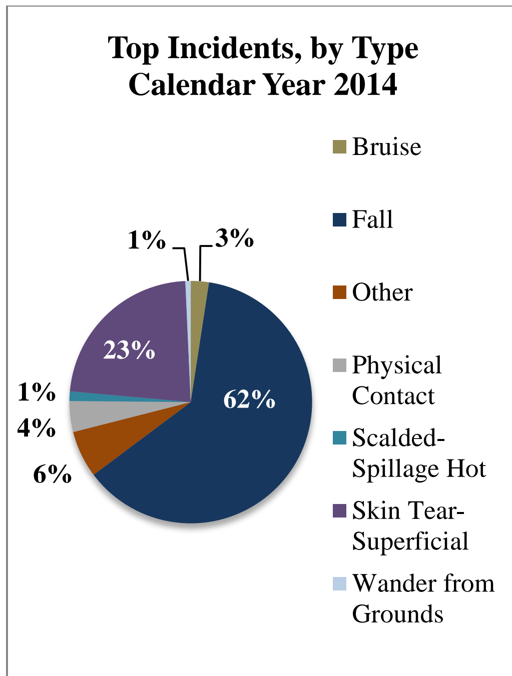
| Calendar Years 2012-2014<br>34 Total Deficiencies | | |
|---|---|---|
| USDVA Deficiencies | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.210 Administration | The facility did not have policies and procedures to prevent falls. | Facility did not have procedures to prevent falls. As resident's falls occurred, facility failed to revise care plans with individualized interventions to prevent reoccurring incidents. Interview with administrative staff indicated facility did not have a fall policy, fall committee, or program to review residents' falls. Potential for serious injury, harm, or impairment to resident. |
| 51.210 Administration | Quality assurance committee does not function to ensure assurance activities are met. | The facility has QA meetings that the physician does not regularly attend. The facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies regarding a high number of resident falls. |
| 51.90 Resident Behavior/Facility Practices | The facility failed to ensure the least restrictive device was used for six of 24 sampled residents. | Facility failed to assess the use of a waist restraint prior to the placement of the restraint and failed to attempt the elimination of the restraint, even though the resident fell from the wheelchair with the restraint in place. |
| 51.100 Quality of Life | The facility failed to provide appropriate care and services for the 39 patients/ residents residing in the specialized dementia care unit, which is a secured unit. | Residents representing three levels of care (ambulatory, Geri-chairs, and wheelchair mobility) were observed on the Specialized Dementia Care Unit with no activities being offered and the staff present were not engaged with residents via meaningful activities or conversations. |
| 51.100 Quality of Life | The facility failed to ensure there was an ongoing program of activities to meet the needs of residents who were identified with cognitive impairment. | Five of the 39 residents on the Specialized Dementia Care Unit were not offered, encouraged, or engaged in activities that would give meaning to their day. Inappropriate television viewing was displayed in the sitting room. |

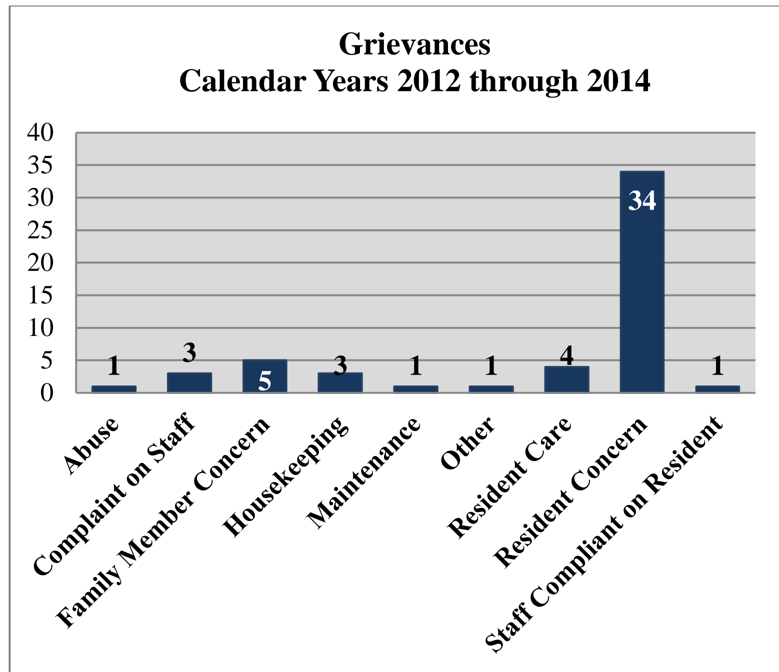
| Calendar Years 2012-2014<br>34 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.110 Resident Assessment | The facility failed to periodically review and revise the care plan for three of 24 sampled residents residing on Wings 1 and 2 and identified at a risk for falls. | Resident was admitted to secure wing by ambulatory. Resident fell six times in three months, with three falls resulting in hematomas including two subdural hematomas. Facility did not have policies in place to prevent falls or revise care plans with individualized interventions. |
| 51.110 Resident Assessment | The facility failed to provide care and services to meet the standards of professional quality and in accordance with the resident's written care plan for seven of 24 sampled residents. | Resident fell in dining room when a staff member who should have physically-assisted the resident shouted at him to get his walker. Resident sustained a subarachnoid hemorrhage and was hospitalized for 18 days. |
| 51.120 Quality of Care | The facility failed to provide adequate supervision for six residents of 24 sampled residents on Wing 1 and Wing 2 and identified at risk for falls. | Resident sustained 22 falls within 11-month period since admission to the facility. A review of the clinical record lacks any evidence of the facility investigating the cause of the resident's falls. |
| **DHH Deficiencies** | | |
| F240-F258: Quality of Life | Provide care for residents in a way that maintains or improves their dignity and respect in full recognition of their individuality. | Failure to promote care for residents by failing to feed three residents who required assistance; food placed in front of residents for 25 minutes before feeding assistance was provided. Pulling residents backwards in Geri-chairs. |
| F240-F258: Quality of Life | Reasonably accommodate the needs and preferences of each resident. | Failed to ensure reasonable accommodations of individual needs by not providing beds long enough for two sampled residents who were over six-feet tall. |
| F271-F287: Resident Assessment | Conduct initial and periodic assessments of each resident's functional capacity. | Lack of full body audits for high-risk pressure sore patients; avoidable sores missed. Resident had two falls involving his electric scooter and no appropriate preventative measures by staff. |
| F271-F287: Resident Assessment | Allow residents the right to participate in the planning or revision of care and treatment. | Preventative measures indicated in care plan (mat on floor, bed in low position, and side rails) not followed to limit accidental falls. |
| F271-F287: Resident Assessment | Ensure services provided by the nursing facility meet professional standards of quality. | Physician orders stated that the resident's bedside rails should be padded. The surveyor observed the resident in bed on three separate days with the side rails not padded. |
| F309-F334: Quality of Care | Provide necessary care and services to maintain or improve the highest well-being of each resident. | Lack of preventative measures for falls violated physician orders. |
| F309-F334: Quality of Care | Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores. | Failure to ensure residents with pressure sores received necessary treatment and services to promote healing and prevent new sores from occurring. |

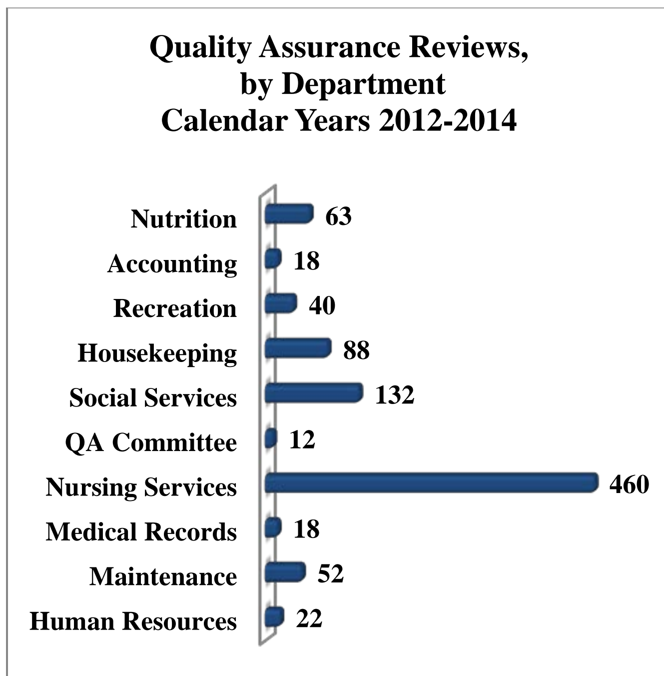
| Calendar Years 2012-2014<br>34 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| F309-F334: Quality of Care | Ensure that a nursing home area is free from accident hazards and provide adequate supervision to prevent avoidable accidents. | Resident with cognitive impairment was found on the floor beside bed four times within four months. No noted injuries. Review of investigative report revealed no safety devices were in use before or implemented as a result of the incidents. |
| F309-F334: Quality of Care | Ensure that each resident's 1) entire drug/medication regimen is free from unnecessary drugs; and 2) is managed and monitored to achieve highest level of well-being. | Resident received Benadryl and Trazodone by mouth every night for 2 months. Medication more likely to cause dizziness, excessive sedation, toxic confusional states, and hypotension in older adults. |
| F360-F373: Dietary Services | Store, cook, and serve food in a safe and clean way. | Roaches observed in the pantry and kitchen area. Food packaging not secured tightly enough to ensure pests were unable to enter the bags. |
| F425-431: Pharmacy Services | At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor. | Pharmacist failed to identify Benadryl as an unnecessary medication for sampled resident. |
| F454-469: Physical Environment | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. | Extensive roach and fly infestation in food prep, general kitchen, and dining area. |
| F271-F287: Resident Assessment | Provide care by qualified persons according to each resident's written plan of care. | Resident's care plan stated that he was to have a pressure reducing device on his bed/chair. Resident was observed by surveyor with no such device in place. |
| F309-F334: Quality of Care | Provide necessary care and services to maintain or improve the highest well-being of each resident. | A resident who was totally dependent on staff for all activities of daily living was not reassessed by staff after displaying abnormal vital signs. |
| F309-F334: Quality of Care | Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores. | No pressure relieving device in patient's bed/chair to prevent the development of pressure sores. |
| F309-F334: Quality of Care | Keep the rate of medication errors (wrong drug, wrong dose, and wrong time) to less than 5%. | Two medication errors in 31 attempts resulting in a 6.45% medication error rate for one of four residents in which a medication pass was observed. |
| F271-F287: Resident Assessment | Develop a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. | A resident had a contracture of the left hand and a hand roll was to be kept in that hand. The surveyor observed the hand roll one time, the other five times there was no hand roll. Hand roll was not addressed in care plan. |
| F271-F287: Resident Assessment | Allow residents the right to participate in the planning or revision of care and treatment. | Failure to revise the care plan. Did not implement any new interventions for a resident after a fall. |

| Calendar Years 2012-2014<br>34 Total Deficiencies | | |
|---|---|---|
| USDVA Deficiencies | | |
| **Regulatory Violation** | **Description** | **Example** |
| F309-F334: Quality of Care | Ensure that residents with limited range of motion receive appropriate treatment and services to increase range of motion or prevent further decrease in range of motion. | Resident did not have adequate treatment (hand roll) for left hand contracture. |
| F360-F373: Dietary Services | Store, cook, and serve food in a safe and clean way. | The Veteran home had expired foods available for resident consumption and stored powdered sugar in a dirty container. |
| F441: Infection Control | Have a program that investigates controls and keeps infection from spreading. | The staff did not implement a hand washing procedure prior to or during pericare; additionally, they failed to implement interventions for infection prevention once infection concerns were identified through tracking and trending. Flies near the dining hall during and inbetween meal services and had a fly swatter on the tables. |
| F454-469: Physical Environment | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. | Flies frequently observed in dining area on and around residents and food; fly swatter present on table where resident's food is located. |
| F490-F522: Administration | Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly and develop corrective plans of action. | QAA quarterly meeting sign-in sheets show that meetings were held on 10/24/13, 2/6/14, 5/8/14, and 7/23/14. According to the documentation, there was no designated physician attending the QAA quarterly meetings. Facility-designated physician does not attend quarterly meetings. |
| F221-F226: Resident Behavior and Facility Practices | Develop and implement policies for 1) screening and training employees; and 2) the prevention, identification, investigation, and reporting of any abuse, neglect, mistreatment and misappropriation of property. | Wife of resident noticed swollen ankle and sore to the touch; CT scan by emergency room revealed fractured ankle and tibia. No staff was interviewed by administration regarding mystery injury, and investigation did not start until three days later, neglecting 24-hour mandate. |
| F271-F287: Resident Assessment | Ensure services provided by the nursing facility meet professional standards of quality. | Failures to implement and document assessment of a pain scale in order to administer hydrocodone/acetaminophen and failed to document the efficacy of medicine. |
| F309-F334: Quality of Care | Provide necessary care and services to maintain or improve the highest well-being of each resident. | Failed to implement and document assessment of pain scale and failed to implement and document efficacy of medication. |

| Total Incidents (CY 2014) | Total Grievances (CY 2012-2014) | Total QA Reviews Performed |
|---|---|---|
| 718 | 53 | 905 |




| Contracted Services Fiscal Years 2012-2014 | | |
|---|---|---|
| Vendor | Type of Service | Sum of Contract Amount |
| Bee Healthcare, Inc. | Pharmacy Service | $33,930.00 |
| Wheeler | Medical Director | 126,000.00 |
| Synergy Care, Inc. | Physical Therapy, Occupational Therapy, Speech Therapy | 1,665,334.80 |
| Total | | $1,825,264.80 |

**Source:** Prepared by legislative auditor's staff using information obtained from LDVA, DHH, and USDVA.

# Appendix E-5
## Southeast Louisiana War Veterans Home (Reserve)

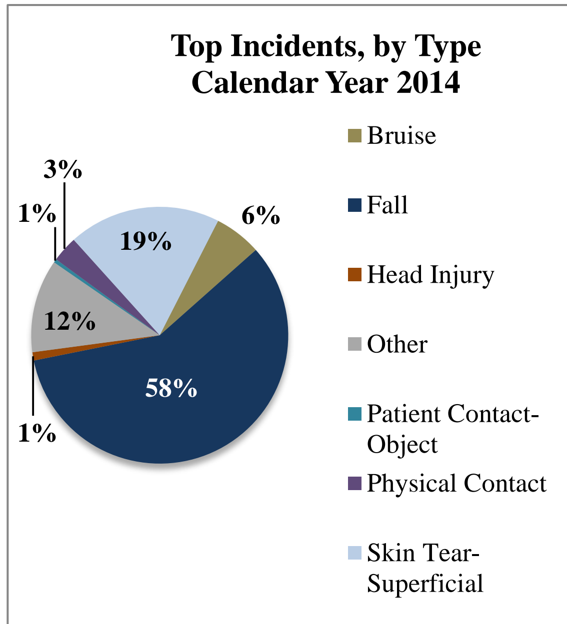
Reserve, St. John the Baptist Parish
Total Home Capacity: 156
Total Home Residents: 151

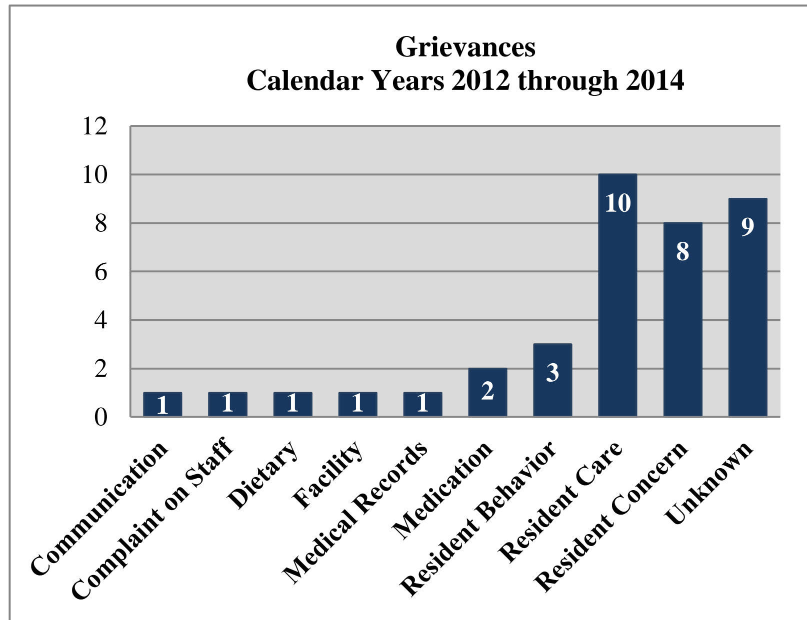
| Total Staff | Total Residents | Staff Per Resident | Voluntary Turnover | Involuntary Turnover | Total Turnover |
|---|---|---|---|---|---|
| 147 | 151 | 1.0 | 29.85% | 15.67% | 45.52% |

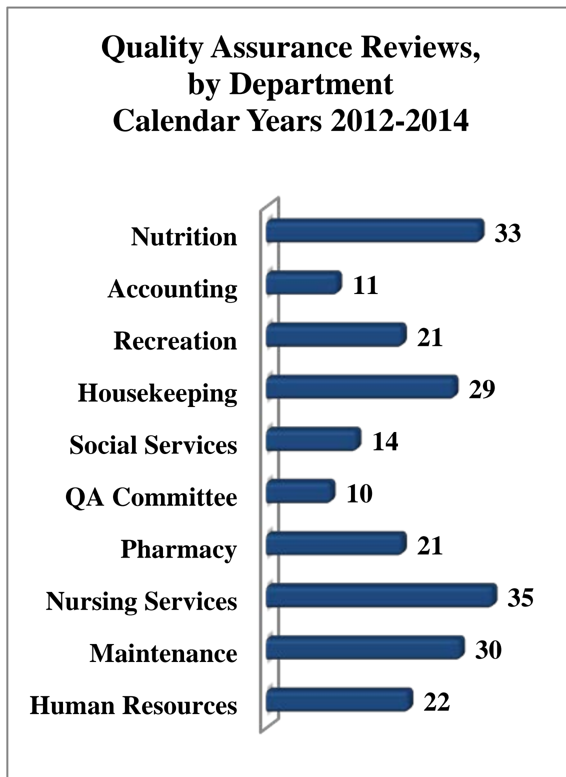
| Calendar Years 2012-2014<br>11 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.90 Resident Behavior/Facility Practices | Facility did not ensure that 10 of 24 residents were free from restraints which were not assessed as necessary to treat a medical symptom. Also, restraints were utilized without evidence that prior, less restrictive intervention had been implemented for nine of the 24 residents reviewed. | Residents were restrained when they should not have been. |
| 51.110 Resident Assessment | Facility failed to provide appropriate care to residents with restraints in conformance with the resident's care plan for restraints for seven residents. | Residents were not reevaluated according to the care plan to determine if continued use of restraints were necessary. |
| 51.120 Quality of Care | Facility failed to ensure staff were applying restraints properly per manufacturer's directions and failed to prevent falls and adequate supervision to prevent falls and subsequent injury for three out of 24 sampled residents. | Several residents were found on the ground due to falls. These falls were because of inadequate supervision or incomplete fall assessments. |
| 51.120 Quality of Care | Facility did not ensure physician orders were followed for one resident out of a sample of 24 which resulted in a medication error. | Resident continued to receive medication after doctor's orders to stop. |
| 51.180 Pharmacy Services | Pharmacist did not report on physician orders that were not applied as ordered for one resident out of a sample of 24 and resulted in a medication error | Pharmacist should have reported an error for missing doctor order when conducting the monthly drug regimen for the resident. |
| 51.110 Resident Assessment | Facility failed to follow the care plan for one of the 25 sampled residents. Resident was not supervised, and as a result the resident was found floating in a pond and pronounced dead. | Care plan stated the resident was not allowed to leave the facility without staff or family member because he had the possibility of wandering. |
| 51.120 Quality of Care | Facility failed to prove adequate supervision to prevent accidents for one of 25 sampled residents. | The facility failed to use all the proper forms which could have prevented potential elopement. |

| Calendar Years 2012-2014<br>11 Total Deficiencies | | |
|---|---|---|
| **USDVA Deficiencies** | | |
| **Regulatory Violation** | **Description** | **Example** |
| 51.90 Resident Behavior/Facility Practices | Facility failed to report in a timely manner and investigate an injury of unknown origin for one resident from a sample of 25 residents | Resident fell and CNA reported no bruises; however, spouse of resident did. The facility did not investigate how the bruise got there. |
| **DHH Deficiencies** | | |
| F271-F287: Resident Assessment | **483.20(d)(3)**: The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care.<br>**483.10(k)(2)**: A comprehensive care plan must be 1) Developed within seven days after completion of the comprehensive assessment; 2) Prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and 3) Periodically reviewed and revised by a team of qualified persons after each assessment. | A resident's care plan was not revised or updated after the resident had fallen. This failed practice had the potential to affect all residents in the facility that may experience a fall. |
| F360-F373: Dietary Services | Failures to ensure meals are prepared under sanitary conditions. | Staff member walked through the kitchen during preparation of the dinner meal with no head covering. |
| F360-F373: Dietary Services | Failure to dispose of garbage properly. | Cups, dirty gloves, paper trash, and cigarette butts around and under the garbage dumpster. |

| Total Incidents (CY 2014) | Total Grievances (CY 2012-2014) | Total QA Reviews Performed |
|---|---|---|
| 682 | 37 | 226 |




**Source:** Prepared by legislative auditor's staff using information obtained from LDVA, DHH, and USDVA.

| Contracted Services Fiscal Years 2012 through 2014 | | |
|---|---|---|
| **Vendor** | **Type of Service** | **Contract Amount** |
| Bee Healthcare, Inc. | Pharmacy Service | $43,200.00 |
| Byron Millet | Pharmacist Relief Services | 20,000.00 |
| Dr. Miles | Podiatric Services | 4,500.00 |
| Dr. Ory | Dentist | 3,000.00 |
| Gem Drugs | Pharmacy Back-up | 30,000.00 |
| Joan St. Pierre | Pharmacist Relief Services | 20,000.00 |
| Julie Kilbride | Pharmacist Relief Services | 10,000.00 |
| Nutrition Education Resources | Medical Nutritional Services | 112,320.00 |
| River Parishes | Physician Professional Services | 126,000.00 |
| St. James Hospital | Lab and X-Ray Services | 90,000.00 |
| Synergy Care, Inc. | Physical Therapy, Occupational Therapy, Speech Therapy | 1,446,998.40 |
| William Terry | Pharmacist Relief Services | 20,000.00 |
| Xpress Ray | Mobile X-Ray and Cardiology | 13,500.00 |
| **Total** | | **$1,939,518.40** |