The Office of Lieutenant Governor

Missouri Veterans Home, St Louis Investigation

Oct 19th 2017

Investigative Summary

The Office of Lieutenant Governor was approached by a medical professional February 21st 2017, about issues at the Missouri Veterans Home, St Louis. In the discussion the main issue revealed was overuse of as needed anti-psychotics. The office began an investigation that led to veterans, family members*, and staff** coming forward with additional information.

The issues revealed by the investigation are:

- Medication Problems – As needed use of Anti-Psychotics and medications prescribed without informing primary care and neurologist
- Complaint procedures give the perception of being less than honest
- Complete lack of transparency for veterans and their families
- Administration is unable to hire and retain quality personnel
- Complete loss of faith between veterans, Families, and Staff with the leadership of the Missouri Veterans Home, St Louis and the Missouri Veterans Commission central office leadership

Although creating additional administrative positions does nothing to alleviate CNAs being required to work an average of three double shifts monthly, referred to as manadtion, it is not a violation of State or Federal regulations.

In addition there were several complaints about questionable practices, i.e., hydration records, where they show intake of 1200cc, the veteran in an adult diaper also showed an output of 500cc. But could not explain how they measured the output. The lack of showers, some report going a week with being properly groomed or having clean clothing put on.

Without access to internal reports or internal qualitative data, there cannot be a better assessment of additional problem areas, such as falls, urinary tract infections, or pressure ulcers. This can be addressed by official investigation through an outside agency.

It should also be noted that there are six additional Veterans Homes in the state of Missouri that have not reported the type of issues covered in this investigation.

* Any information from family members are made with a valid Medical Powers of Attorney for the veterans discussed.

** No member of the staff violated HIPPA either in meetings or their statements. In addition the statements made were in support of an investigation by the Lieutenant Governor's Office, pursuant to RSMo 660.620.

Purpose

The Office of Lieutenant Governor was approached by Rick Stream, Dori Poholsky, and Dr. Naveed Razzaque, about issues within the Missouri Veterans Home, St Louis. They not only noticed but were approached by veterans, family members, and staff about ongoing problems concerning safety, lack of transparency, and systemic management failings within the veterans' home.

Background

The Office of Lieutenant Governor serves as the advocate for both Veterans and Senior Citizens, in this capacity, the Lieutenant Governor's Office opened an investigation. The investigation proceeded by conducting several meetings with family members, staff, volunteers in person and by email and by onsite visits.

Methodology

All issues have been verified by either a very qualified, competent medical opinion or dual sourced i.e., family member and staff member. Staff from the Lieutenant Governor's Office also conducted an unofficial visit to the Veterans Home speaking with veterans, a family member, and staff. Other issues brought to our attention are not covered because they could not be verified by the above standard.

Although there are many issues systemic in the skilled nursing industry, the investigation focused on issues that could be verified, had been reported to the current leadership of the Missouri Veterans Commission, and with leadership intervention could and should have been fixed prior to the investigation.

Comments

Question regarding this investigation can be referred to Bill Bellomy or Ward Franz, Office of Lieutenant Governor, at 573.751.4727.

William Bellomy
Director of Veterans Affairs
Office of Lieutenant Governor

Issue 1

Medication Problems – As needed use of Anti-Psychotics and medications prescribed without informing primary care and neurologist.

When Naveed Razzaque, M.D. initially met with Lieutenant Governor Parson and Bill Bellomy the excessive use of anti-psychotic medications on an as needed or PRN basis was discussed. He brought to our attention that within the Missouri Veterans Home, St Louis the use of such medications, on a PRN basis is over the average of area private skilled nursing facilities. The use of these medications has been on a steady reduction nationwide as medical professionals recognized the risked of increased falls, neurological issues, and interactions with other medications.

In addition it has been recognized the as needed use of these medications can constitute chemical restraints, not authorized in non-restraint facilities. The Missouri Veterans Homes are all non-restraint facilities, as such the use would constitute a violation. As will be shown below, the most dangerous aspect is a lack of coordination between the facility Medical Director, when prescribing the anti-psychotics, and the neurologist and primary care doctors treating the veterans on a regular basis.

Veteran Ron Adler, suffering from Parkinson's disease and early stage dementia, his care plan on file at the Veterans Homes clearly stated that he should not be prescribed any additional medication without consulting his treating neurologist. After noticing a change in his demeanor, Mrs. Adler demanded a copy of his medication list and found anti-psychotics had been added, without informing her as his guardian or consulting is neurologist. This adds to the perception of families that some members of the staff and administration are less than transparent.

Once again, while this investigation was ongoing, the Veteran Home Administrator requested a meeting with Ron Adler's wife. The Administrator and Director of Nursing recommended a Veteran's Home psychiatrist evaluate Ron with the possibility of adding anti-psychotic medications to his medical regimen. Although she declined the evaluation she also stated he has had outbursts, due to the nature of his disease, which is exacerbated by a UTI, actions until she was rumored to have spoken to the Lieutenant Governor's Office as part of this investigation.

Recommendation

Considering the vast use of anti-psychotics, as compared to three private facilities, there should be an immediate review of use by an MD, not affiliated with the Missouri Veterans Commission.

Issue 2

Complaint Investigating Procedures

The current procedures to investigate a complaint, even if it is reported to the Department of Health and Senior Services, is referred back to the Missouri Veterans Commission for investigation, the results are sent back to the referring authority. They are the only skilled nursing facilities in the state of Missouri with a statutory ability to investigate themselves.

The complaints are investigated by the leadership of the Veterans Homes and the Commission Administration, not an independent body. As a result of this very few, if any, complaints have resulted in any finding of fault against the veteran's homes.

The perception of both veterans and their families is that the Missouri Veterans Commission administration is operating with the same willingness to be less than transparent and cover for employees by not allowing an independent organization or revealing the results of any investigations. See Issue 3 for more detailed information on families requesting copies of reports on investigations conducted internally by members of the Missouri Veterans Commission Administration.

A former administrator, respected enough by Bryan Hunt and Kim Packard to be asked to serve as an interim administrator, stated the Department of Veterans Affairs uses contract inspectors for the annual survey. The inspectors conduct a very cursory inspection during the surveys. According to him, a more in-depth inspection would discover the issues with medication, staffing, and administrative procedures. The same contract inspectors recommended that Cheri DeJournett remove her father from the home and hire in-home care because the basic needs, medical, safety, and hygiene were asking too much of the Veterans Home. The comment was verified by both her and a staff member. She also filed a complaint when her father was placed in a shower and received blisters from the heat of the water, the chair was removed but as far she was able to ascertain the CNA was simply moved to a different wing of the facility.

Recommendation

The current process seems almost designed, when the lack of feedback is given to families with medical Power of Attorney, to hide problems. The perception needs to be removed immediately by a complete review of procedures and until statute changes can be made create a Memorandum of Agreement/Understanding between the Missouri Veterans Commission and the Department of Health and Senior Services for complaint resolution/investigation by Health Service Regulation (HSR).

Issue 3

Complete lack of transparency for Veterans or families

The ability of family members to obtain reports on the investigations conducted has been fraught with road blocks emplaced by the leadership of the Missouri Veterans Commission administration. As we will show below, even when the investigation is because of the death of a veteran. Additionally, as stated previously, any request for the results of an investigation has been by a family member with a valid and current medical power of attorney, even when the wife of a veteran stated, in accordance with 45 CFR 164.514, exactly what information needed to be redacted to ensure the report did not violate HIPAA.

Jim Luebbert and Kimberly Hooper, whose father, a veteran, entered the home, July 3rd, 2017 with dementia and ALS. He was taken to the emergency room and died Aug 7th, 2017. During his stay at the Veterans Home there were issues such as the CNAs not being informed of the veterans ALS and proper care procedures, lack of hygienic care and clean clothes, medications not being given on time (up to a 5 ½ hour difference), and CNAs not being made aware that the veteran had a cath. When Jim requested a complete copy of his father's medical records, he received and incomplete copy. He filed a complaint with the Elderly Neglect and Abuse Hotline and was contacted by Patty Faenger, the Assistance Director of the Missouri Veterans Homes program, who had received the complaint and was investigating. After expressing concerns that the Missouri Veterans Commission administration investigate themselves he requested an impartial investigation and was told it was not possible. He requested a copy of the report in writing, as of this investigation, he has not received a copy of the report, due to an ongoing investigation. Although the Missouri Veterans Commission stated in the October 30th Quarterly Meeting, the investigation was complete.

Glenda Adler requested a copy of an investigative report after the initial complaints were filed in July, understanding that any identifying HIPPA information except her husbands would be redacted, the replies from Jill Talken, executive secretary, and Kevin Hall, the General Counsel, are as follows:

Aug 30th Jill Talken replied, by email to Mrs. Adler – cites section 610.210 (14) RSMo, This AG Opinion states "nor "trade secrets" that can be closed under § 610.021(14), RSMo"

Sep 11th Jill Talken replied, by email to Mrs. Adler – cites 45 CFR 164.514, Mrs. Adler responds with list of what had to be redacted to send her the report

Oct 5th Kevin Hall replied, by email to Mrs. Adler – again cites 45 CFR 164.514, although the CFR has two separate redaction methods listed.

Recommendation

Immediately develop procedures to ensure copies of reports, as they relate to the death or complaint, can be redacted in accordance with 45 CFR 164.514 and Section 610.021 (14) RSMo, and released to a family member with a valid Medical Power of Attorney.

Issue 4

Administration is unable to hire and retain quality personnel

As a state agency a pay raise is rarely an option, but the commission accomplished this for veteran's service officers. The six current staff and one former administrator that gave statement or participated in interviews were comprised of two CNAs, two RNs, and two department directors. All are aware of other facilities that have better pay but feel they owe the veterans they service a high quality of care. One of the subjects actually works in another Missouri Veterans Home and has the ability to compare the differences in leadership.

Currently the CNAs average three mandation shifts a month because of a shortage of personnel and call outs. If a member of the nursing staff refuses two mandation shifts they are terminated. There was a case reported in which a CNAs son was taken to the emergency room, she was told by the charge nurse she could leave to care for her son but upon return for her next shift she was informed that she had been written up for refusing mandation and would be placed on administrative leave for a day.

Hiring has become an assembly line conducting mass interview, a staff witness reported 23 in one group interview. The interim solution seems to be bringing in a temp agency personnel on the weekends. The temp agency CNAs are paid over twice as much and MVC CNAs, state employee. This has led to situation where families have not seen an improvement in quality of care, state employees resent the temporary workers make twice as much and additional staff have left because of this.

Staff as a whole responded that Rolando Carter style is to threaten and degrade staff in front of staff and veterans. This has led to experienced staff leaving. The situation has become such that currently staff members see anyone with a CNA, CMT, RN, or LPN is hired prior to completing due diligence on the part of Veterans Home.

The perception for families is that good staff often leave based on leadership issues. There are staff members who have worked there three or more years which stay, because they believe veterans deserve great quality of care.

Issues 5

Complete loss of trust between Veterans, Families, and Staff with the leadership of the Missouri Veterans Home, St Louis and the Missouri Veterans Commission administration

Every issue discovered through this investigation has been brought to the attention of Rolando Carter, Missouri Veterans Home St Louis, Patty Faenger, Kim Packard, Bryan Hunt and Larry Kay of the Missouri Veterans Commission administrative leadership, numerous times and the perception of the veterans and their families is that nothing has changed. If anything the statement, by Rolando Carter, posted in the Missouri Veterans Home, St Louis, after this investigation began, leadership in the Veterans Home would rather not allow true transparency and being accountable as public servants should.

In a comment made by Rolando Carter stating that in case of a fire, roll the veterans into their rooms and wish them luck, during a meeting at the Veterans Home, verified by multiple sources.

The leadership of the Missouri Veterans Commission administration has been made aware of the issues, by their own admission, but gives the perception to veterans and their family members of choosing to make excuses or refusing to allow an outside review of complaint reports. The leadership listed either has a current or has held a Nursing Home Administrator License, as such should understand, create policy, and ensure the highest quality of care across the Missouri Veteran's Homes.

In a meeting with Larry Kay and Jill Talken, February 23rd 2017, the following statements were made, "there are no issues with enough funding" and "the CNA turnover rate has been addressed and is no longer an issue". The perception from the above remark is he misled or has failed in the oversight of the Missouri Veterans Homes. Either means that the leadership of the Missouri Veterans Commission central office leadership should be either held accountable.

The veterans, families, and staff are in consciences that unless there are changes made there continues to be a lack of confidence in the Missouri Veterans Commission administration. As a state agency the leadership is accountable to the people of the state they serve, in this case it appears leadership has failed in its fundamental duties.

Recommendations

There needs to be a change in the leadership of both the Missouri Veterans Home, St Louis and the Missouri Veterans Commission. The complaints and issues captured in this report have been brought to the attention of Rolando Carter, Patty Faegen, Kim Packard, Bryan Hunt,

Larry Kay numerous times by Veterans, Family members, and staff with nothing being done to correct them. If anything, there seems to be a closing of ranks, threatened employees and making veiled threats to have veterans removed from the Veterans Home or further medicated.

Anything less than a new group of leaders will only display more of the same, as opposed to sustained change and improvement. This will lead to the impression that Missouri, like the Department of Veterans Affairs, is more interested in hiding issues than fixing them.

Family Members

Name	Relationship	Veteran Name
Glenda Alder –	Wife –	Ron Adler
Cheri DeJournett –	Daughter –	Robert DeJournett
Mimi McCausland Brunjes –	Wife –	William Brunjes
Barbra Burnett –	Wife –	John Burnett
Mary Warner –	Mother –	William Warner
Nancy Evans –	Daughter –	Harold Barlage
Dorathy McNair –	Wife –	Mr. McNair
Mary Neely –	Wife	
Doug Brown –	Father	
Jo Ann Wright –	Wife	
Jim Luebbert –	Son –	William Luebbert(Deceased)
Kimberly Hooper –	Daughter –	William Luebbert(Deceased)

Staff (Current)

Name	Position
Rucell Douglas	CNA
Carla Robinson	CNA
Michelle Toler	CNA
Debrah Bivens	CNA
Emie Callen	RN
Megan Martinez	Recreational Therapist

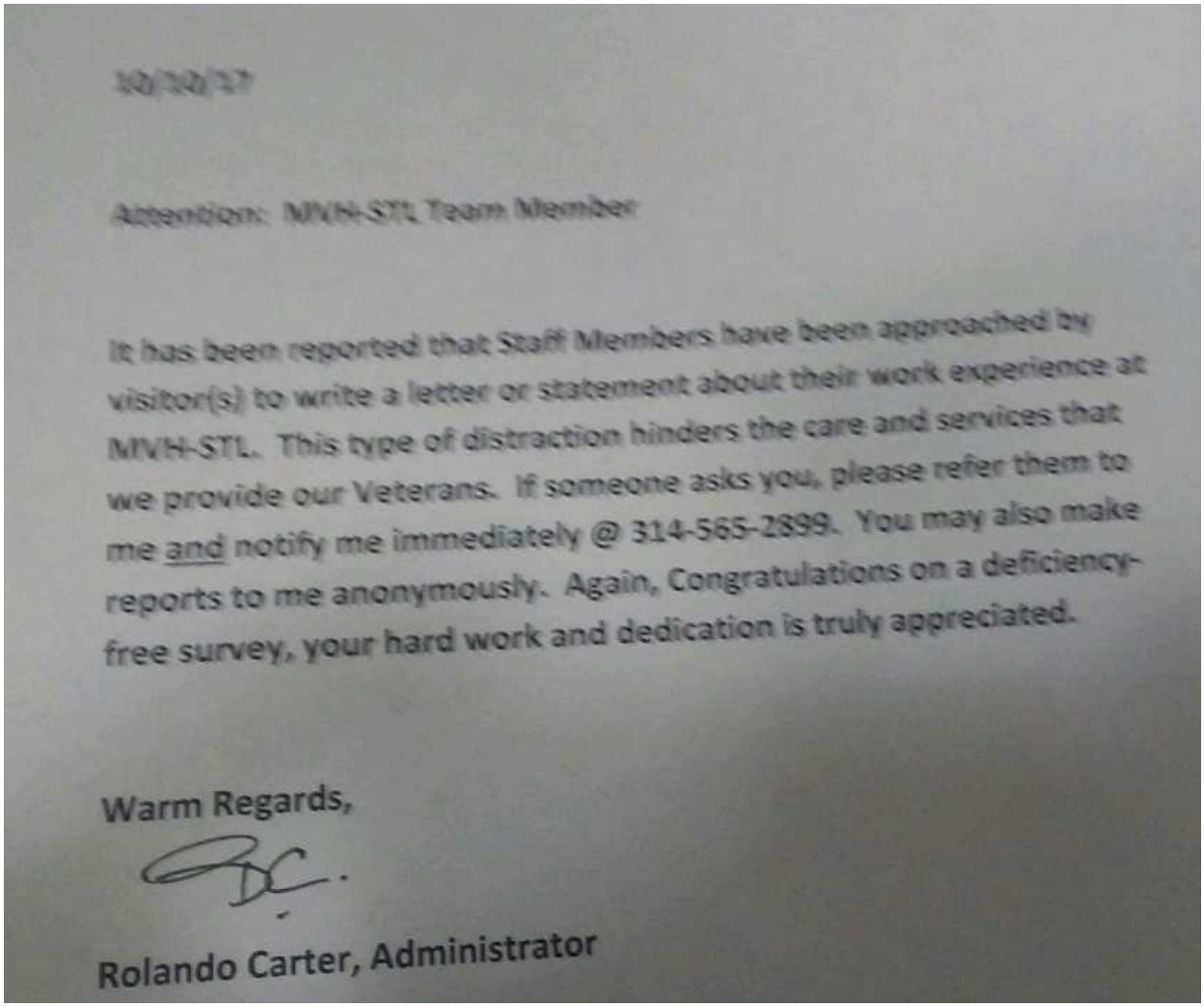
Staff (Former)

Name	Position
Naveed Razzaque	Med Director
Shelly Andrews	RN
Jim McCoy	Maint
Stan Smith	Administrator Warrensburg Veterans' Home (original) Administrator St Louis Veterans' Home (Kim Packard and Bryan Hunt request he take over temporarily)

Volunteers

Name	Background
Rick Stream	Volunteer, Former Member of the House
Lon & Cher Lowery	Volunteer, St Louis Veterans Home
Dori Poholsky	Volunteer, Veterans Home & Jefferson Barracks

Statement written and posted in the Veterans Home, St Louis by Rolando Carter



10/10/17

Attention: MVH-STL Team Member

It has been reported that Staff Members have been approached by visitor(s) to write a letter or statement about their work experience at MVH-STL. This type of distraction hinders the care and services that we provide our Veterans. If someone asks you, please refer them to me and notify me immediately @ 314-565-2899. You may also make reports to me anonymously. Again, Congratulations on a deficiency-free survey, your hard work and dedication is truly appreciated.

Warm Regards,

Rolando Carter, Administrator