Most Beds Remain Empty

February 3, 2008

By Mary Wade Burnside

Times West Virginian

FAIRMONT — After physical plant problems delayed the opening of the West Virginia Veterans Nursing Facility in Clarksburg for several months, now procedural problems will keep the home from accepting more patients until corrective measures have been taken.

The $26 million-budget, 90,000-square-foot nursing home began accepting patients on Veterans Day weekend and had taken in eight before the state Office of Health Facility Licensure and Certification (OHFLAC) conducted a five-day, four-member team inspection in mid-December.

OHFLAC, part of the state Department of Health and Human Resources, found 54 “deficiencies,” each of which requires a response and corrective measure from the nursing home.

“I would consider this atypical,” said Deanna Kramer, program manager for OHFLAC’s nursing home and nurse aid programs, who received the corrective measures on Jan. 24 and contacted the nursing home on Jan. 29 to request additional corrections.

Kramer responded to additional queries via e-mail. “The facility will be required to submit a corrected POC (plan of correction) within 10 working days, with Day 1 being 1/30/08,” she wrote.

Some deficiencies listed in the 120-page report include food service and patient-care problems, poor interaction with some residents, sub-par infection control procedures and a failure to screen employees for criminal activity or tuberculosis.

“None of them were gross enough to shut us down,” said Joe Thornton, deputy secretary of the state Department of Military Affairs and Public Safety. “OHFLAC knows there is good quality care here.”

In addition to citing problems that include poor interaction between staff and at least one particular patient, an employee also left the same patient unnecessarily exposed from the waist down following incontinence care while a nurse found a dressing for a sore, the report stated.

That same resident had been moved in his wheelchair without staff interacting with him, while staff did interact with five other residents present for a group activity. The activity director noted that the resident had impaired cognitive abilities and did not initiate conversation, although he would talk when engaged by others.

In another deficiency, that same patient had a sore to the coccyx (tail bone) but did not receive any pressure-relieving device until one of the inspection team members intervened, the report stated.

“The actual or potential impact of a deficient practice on the health and safety of a resident is more significant than the number of deficiencies cited,” Kramer said. “None of the deficient practices, cited as a result of this initial licensure inspection, constituted actual harm to a resident or placed a resident in immediate jeopardy.”

Food services are being provided by the adjacent Louis A. Johnson VA Medical Center, a federal facility that generally does not fall under the aegis of OHFLAC, although, “OHFLAC inspected the VA Medical Center’s kitchen, because this was where the nursing home’s food was being stored,

prepared, etc.," Kramer said.

Problems with food service included staff members giving a resident a regular-consistency meal instead of the pureed meal that he needed. When he received a pureed meal 15 minutes later, it was not the same food items that the other residents had received, which also went against OHFLAC regulations.

"As a quality of life issue, persons who required mechanically altered foods should not be treated differently than persons who do not require mechanically altered foods," Kramer said.

Nursing home officials submitted a corrected plan on Jan. 24, and Kramer received the plan on Jan. 25, she said.

"It was reviewed on 01/29/08, at which time a representative from this office contacted the facility's administrator to request that changes be made to the plan of correction," Kramer said.

The plan of correction submitted by the nursing home officials and the requested changes cannot be made public until the plan has been accepted, Kramer said.

"Once accepted by this office, it becomes a publicly, disclosable document under FOIA," or the Freedom of Information Act, she said.

Thornton said his understanding of the problems with the corrected plan primarily stemmed from "formatting" issues, because if a corrective measure applied to multiple deficiencies, nursing home officials wrote something to the effect of "see previous answer" as the solution.

"OHFLAC wants it spelled out, even if it's the same," Thornton said. "They don't want us to say, 'See our plan of correction.'"

Also, Thornton noted, the 120-page length of the report can be somewhat deceiving, because for each deficiency, the statute relating to that problem also is stated. The report takes up the left-hand side of each of the 120 pages, with room for corrective actions to be written in the right-hand side.

Once OHFLAC accepts the corrected plan, the nursing home can admit four more patients but then needs to pass an inspection by the U.S. Department of Veterans Affairs.

After that, the nursing home can begin to fill the facility to its 120-patient capacity, which will be done 20 patients at a time, Thornton said. However, some of those beds will be dedicated to a wing for residents with Alzheimer's, which Thornton said would require an additional certification.

Thornton had been using mid-year as a guideline for when officials hope to have the facility filled to capacity, but after the initial inspection problems, does not know if that will be the case.

"I'm not sure where we are now in terms of addressing these things and if the OHFLAC report has delayed any of that," he said. "I've been hesitant to put a date on it. When I do that, I start feeling like I have egg on my face."

Groundbreaking on the nursing home took place in October 2003, said Larry Linch, director of the state Division of Veterans Affairs. A completion date had not been set yet, he said, because a general contractor had not been hired yet. However, he believes eventually the targeted date was July 2006, which came and went without an open facility.

Later that year, on Veterans Day, Sen. Jay Rockefeller, Congressman Alan B. Mollohan and Gov. Joe Manchin all attended a dedication ceremony in the facility with hundreds of veterans and the commander of the USS West Virginia in attendance.

However, because of physical plant inspection issues, the nursing home did not open for another year, on Veterans Day weekend 2007.

Residents — all elderly and mostly who fought in World War II and Korea, Linch said — were checked in two at a time until the nursing home had attained an occupancy of eight.

Beginning a month later, a four-member OHFLAC team — consisting of a licensed dietitian, a registered nurse, a second RN who also is a licensed nursing home administrator, and a life-safety code inspector who also is a registered sanitarian, spent five days at the facility, observing and interacting with the residents.

In the interim, the facility's original executive director, Thomas H. McGraw, left in September 2007 under circumstances Linch said he could not disclose because of personnel confidentiality. However, he did state that, "That's why we got a new director there. Things weren't being done as they should have been done."

A new licensed nursing home administrator, Sonia Bailey-Gibson, was hired as interim executive director in October, Thornton said. No one has been dismissed because of the OHFLAC inspection report.

"We expected issues," Thornton said. "We wanted them to be identified so we can make corrections and get the facility to the place where it needs to be."