United States Government Accountability Office

Report to Congressional Requesters

November 2021

COMMUNITY LIVING CENTERS

VA Needs to Strengthen Its Approach for Addressing Resident Complaints

Accessible Version

GAO@100
A Century of Non-Partisan Fact-Based Work

GAO-22-105142

GAO Highlights

Highlights of GAO-22-105142, a report to congressional requesters

November 2021

Community Living Centers

VA Needs to Strengthen Its Approach for Addressing Resident Complaints

Why GAO Did This Study

VA is responsible for overseeing the quality of care provided in its CLCs. However, several reports have raised concerns about substandard care at certain CLCs. Complaints are a valuable source of information about the quality of care in nursing homes because investigations of these complaints can identify and resolve issues promptly for this vulnerable population.

GAO was asked to review the quality of care at CLCs. In this report, GAO examined, among other objectives, VA's approach to addressing complaints about care at CLCs and VA's communications about how to file complaints.

For this report, GAO reviewed VA policies and interviewed VA officials. GAO also selected six VA CLCs to obtain variation on factors such as CLC performance on quality metrics and geographic location. For each, GAO interviewed CLC officials and officials from corresponding regional offices and reviewed complaints information and policies.

What GAO Recommends

GAO is making five recommendations for VA, including recommendations regarding its policies for how CLCs document and elevate complaints, as well as how VA monitors adherence to these policies and the information VA communicates about how to file a complaint. VA concurred with GAO's recommendations, and identified steps it will take to implement them. For example, VA stated that it will clarify its guidance on elevating complaints to leadership.

View GAO-22-105142. For more information, contact Sharon M. Silas at (202) 512-7114 or SilasS@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) provides care to nearly 9,000 veterans per day in 134 VA-operated nursing homes, called community living centers (CLC), which are associated with VA medical centers (VAMC). CLC residents and their representatives can voice their concerns about the quality of care in the CLC by filing a complaint to CLC staff or to patient advocates at VAMCs. GAO found that VA has insufficient policies, limited monitoring, and unclear guidance for addressing complaints about care in its CLCs, among other issues. Specifically:

- VA only requires staff to document complaints elevated to VAMC officials, which means that most complaints about CLC care are likely not documented. According to VA officials, most complaints are resolved at the CLC level and not elevated. As a result, VA cannot have assurance that complaints are resolved for the vulnerable CLC population.
- GAO's review of complaints documentation from four CLCs found that some staff did not properly implement VA's complaints policies. For example, GAO found that staff did not always address complaints in a timely manner, such as waiting 1 month to begin addressing a complaint about unsanitary conditions. This reflects VA's limited monitoring of adherence to its policies. With more robust monitoring, VA may be able to identify and address errors in addressing complaints about care at CLCs.
- VA has not clearly specified which serious complaints should be elevated to VA leadership through alerts called issue briefs, resulting in underreporting. Specifically, GAO found that most abuse-related complaints it reviewed did not result in an issue brief.

These issues in policies, monitoring, and guidance are inconsistent with VA's strategic objectives to provide high quality care and have accountability for its actions. Until these issues are addressed, VA cannot ensure that all complaints about CLC care are tracked and resolved as part of its oversight of quality improvement efforts for the vulnerable CLC population.

Further, GAO found that CLC residents and their representatives do not receive accurate and complete information about how to file complaints. For example, VA's Rights and Responsibilities documents for residents and their representatives direct them to complain to entities that do not receive complaints about CLC care. This misinformation is inconsistent with VA strategic objectives for veterans to be informed and for VA to be transparent and openly accountable for its actions. Without providing accurate and complete information about options for filing complaints about care at CLCs, VA cannot ensure that the concerns of residents and their representatives about CLC care are heard and resolved.

Contents

Figures

Abbreviations

COVID-19	Coronavirus Disease 2019
CLC	community living center
CMS	Centers for Medicare & Medicaid Services
GEC	Office of Geriatrics and Extended Care
OIG	Office of the Inspector General
OPA	Office of Patient Advocacy
PATS	Patient Advocate Tracking System
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

441 G St. N.W.
Washington, DC 20548

November 30, 2021

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Edward J. Markey
United States Senate

The Honorable Elizabeth Warren
United States Senate

The Department of Veterans Affairs (VA) provided care to nearly 9,000 veterans with disabilities or who are elderly per day in 134 VA-operated nursing homes, called community living centers (CLC), in fiscal year 2019.[1] Veterans can receive care in CLCs for short periods of time—such as for rehabilitation after a stroke—or move into CLCs to live and receive care for long periods of time.[2] If the care at a CLC does not meet their expectations, CLC residents, their representatives, and others can voice their concerns by filing a complaint. Complaints can range from feedback on resident preferences for their living environment, such as the food available at the CLC, to reports of abuse or other serious resident safety concerns.

[1]In fiscal year 2020, CLCs provided care to nearly 8,000 elderly and disabled veterans. We report numbers from 2019 because some CLCs' capacity was reduced during the Coronavirus Disease 2019 (COVID-19) pandemic. For example, some CLCs located in areas that had particularly high rates of COVID-19 infection took steps to convert their CLC beds to acute care or surge capacity beds, discharged CLC residents into the community or transferred CLC residents to other VA medical centers when possible, and halted normal admissions, according to VA officials. For more information on VA CLCs' response to the pandemic, see GAO, *COVID-19: VA Should Assess Its Oversight of Infection Prevention and Control in Community Living Centers*, GAO-21-559 (Washington, D.C.: July. 28, 2021).

[2]VA also pays for nursing home care for veterans in two other settings: public or privately-owned community nursing homes and state-owned and -operated veterans' homes. VA is required to provide nursing home care for veterans who require nursing home care because of a service-connected disability and veterans who require nursing home care and who also have a service-connected disability rated at 70 percent or greater. A service-connected disability is an injury or disease that was incurred or aggravated while on active duty. Additionally, VA may provide nursing home care to other veterans, on a discretionary basis, as capacity and resources permit. See 38 U.S.C. §§ 1710, 1710A.

Complaints are a valuable source of information about the quality of care in nursing homes because investigations of these complaints can identify and resolve issues quickly for this vulnerable population. We have previously reported on the importance of complaints, particularly for understanding and addressing resident abuse at community nursing homes.[3] Nursing home residents—including those in CLCs—are particularly vulnerable to abuse as many suffer from several chronic diseases that lead to limitations in physical and cognitive functioning, and because they are dependent on others.[4] It is important to identify and resolve issues promptly to prevent ongoing harm and help ensure residents living in nursing homes are receiving quality care.

Several reports prompted questions about the quality of care at individual CLCs.[5] In 2020 we began work reviewing CLC quality at your request. During the course of that review, we identified issues with VA's approach to addressing complaints in CLCs, among other issues, and split the work into multiple reports.[6] In this report we examine

1. VA's approach to addressing complaints about care at CLCs;
2. VA's use of complaints to inform its oversight of quality of care at CLCs; and

[3]GAO, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse,* GAO-19-433 (Washington, D.C.: June 13, 2019).

[4]C. Hawes, *Elder Abuse in Residential Long-Term Care Settings: What is Known and What Information is Needed?* National Research Council of the National Academies, Panel to Review Risk and Prevalence of Elder Abuse and Neglect (Washington, D.C.: 2003).

[5]For example, see Department of Veterans Affairs, Office of the Inspector General, *Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center New York*, Report No. 17-03347-293, (Sept.18, 2018); Department of Veterans Affairs, Office of the Inspector General, *Alleged Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center*, Report No. 17-03347-290, (Sept. 18, 2018); A. Estes and D. Slack, "Secret VA Nursing-home Ratings Hid Poor Quality Care from Public," *Boston Globe*, June 17, 2018 and H. Knowles, "'They Feasted on Him': Ants at VA Nursing Home Bit Veteran 100 Times before His Death, Daughter Says," *Washington Post,* Sept. 13, 2019.

[6]For our report examining quality of care at CLCs more broadly, see GAO, *VA Community Living Centers: Opportunities Exist to Strengthen Oversight of Quality of Care*, GAO-22-104027 (Washington, D.C.: Nov. 30, 2021). For our report examining issues with infection control in CLCs, see GAO, *VA Health Care: Community Living Centers Were Commonly Cited for Infection Control Deficiencies Prior to the COVID-19 Pandemic*, GAO-21-195R (Washington, D.C.: Jan. 6, 2021).

3. VA's communication to CLC residents and their representatives about filing complaints.

To examine VA's approach to addressing complaints about care at CLCs and how VA uses complaints to inform its oversight of CLCs, we interviewed VA officials responsible for overseeing CLCs and the complaints process, including those from the Office of Geriatrics and Extended Care (GEC) and the Office of Patient Advocacy (OPA); officials from the VA Office of the Inspector General (OIG); and officials from the VA contractor that conducts CLC inspections. From these offices, we reviewed relevant policies and documentation, including VA handbooks and issue briefs—which are alerts to VA leadership, such as about serious patient safety issues—from fiscal years 2018 and 2019 (the most recent comparable data available at the time of our review). We also reviewed data and conducted interviews with officials from six selected CLCs. We selected this nongeneralizable sample of CLCs to achieve geographic diversity and a range of prior quality ratings, among other factors.[7] From each selected CLC, we reviewed available data on complaints, including those documented in VA's Patient Advocate Tracking System (PATS); reports from annual quality inspections in fiscal years 2015 through 2019 (the most recent years with complete data available at the time of our review); and CLC policies and procedures for receiving and addressing complaints.[8] We also interviewed staff–such as the patient advocate from the associated VA medical center (VAMC) and CLC staff. To assess the reliability of issue brief and complaints data, we reviewed documentation and interviewed agency officials. We determined them to be sufficiently reliable for the purposes of our reporting objectives. We also evaluated the information we reviewed against VA's

[7]We selected the same six CLCs as those we selected for review as part of our related work on CLC quality—Menlo Park, California; Bedford, Massachusetts; Durham, North Carolina; Miles City, Montana; Milwaukee, Wisconsin; and Jackson, Mississippi. We selected this nongeneralizable sample of six CLCs for variation in ratings on VA's CLC Compare website, maximum bed capacity, the complexity level of the associated VA medical center, and regional location.

[8]VA implemented a revised PATS nationwide in 2020. The most recent national policy VAMCs are required to follow for their patient advocacy programs was published in February 2018 prior to the implementation of the revised system. As such, our description of the patient advocate requirements are from this national policy. In this report, we incorporate data on complaints from before the implementation of the revised PATS, but interviewed staff in 2020 and 2021 under the new system. We refer to the tracking system collectively as PATS. See Department of Veterans Affairs, Veterans Health Administration, *VHA Patient Advocacy*, VHA Directive 1003.04 (Washington, D.C.: Feb. 7, 2018).

strategic plan and federal internal control standards related to control activities and information and communication, as well as federal quality standards for nursing homes that VA applies to CLCs.[9]

To examine VA's communication to CLC residents and their representatives about filing complaints, we reviewed documents typically provided to CLC residents and their family members when they are admitted to CLCs. We also interviewed officials from VA's GEC and Veterans Experience Office and contacted veterans service organizations.[10] We also reviewed inspection reports from VA's contractor that cited CLCs with deficiencies related to complaints. We evaluated all information we reviewed against VA's strategic plan, as well as federal quality standards for nursing homes that VA applies to CLCs.

We conducted this performance audit from January 2020 to November 2021 in accordance with generally accepted government auditing standards. 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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CLCs provide services to eligible veterans whose health care needs are extensive enough to require care in an institutional setting. CLCs offer residents a range of services, including help with activities of daily living (e.g., bathing and getting dressed), medical care, end of life care for terminal illnesses, and, in some facilities, mental health care. Veterans

[9]See Department of Veterans Affairs, *Department of Veterans Affairs FY 2018 - 2024 Strategic Plan*, (Refreshed May 31, 2019) and GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. A VA 2016 memorandum specified that VA implement an unannounced inspection program modeled on Centers for Medicare & Medicaid Services (CMS) oversight, which includes regular inspections or surveys to monitor compliance with federal quality standards. See 42 U.S.C. §§ 1395i-3(f)(1),1396r(f)(1); 42 C.F.R. Part 483, Subpart B (2020).

[10]Specifically, we reached out to representatives from AMVETS, Disabled Veterans of America, and Paralyzed Veterans of America.

rely on VA to ensure that the services provided in its CLCs are high quality and maintain their quality of life.

Quality of Care Oversight at CLCs

CLCs are owned and operated by VA and are associated with—and often co-located within—VAMCs. CLCs may adopt the policies and procedures—such as patient safety and infection control—from their associated VAMC, work with VAMC staff—such as patient advocates who are responsible for documenting complaints and their resolution—and report to VAMC leadership.[11] VAMC leadership is responsible for determining which quality of care complaints are serious enough to be reported to regional and national VA offices.

At the regional and national level, different VA offices have varying degrees of involvement in CLC quality of care.

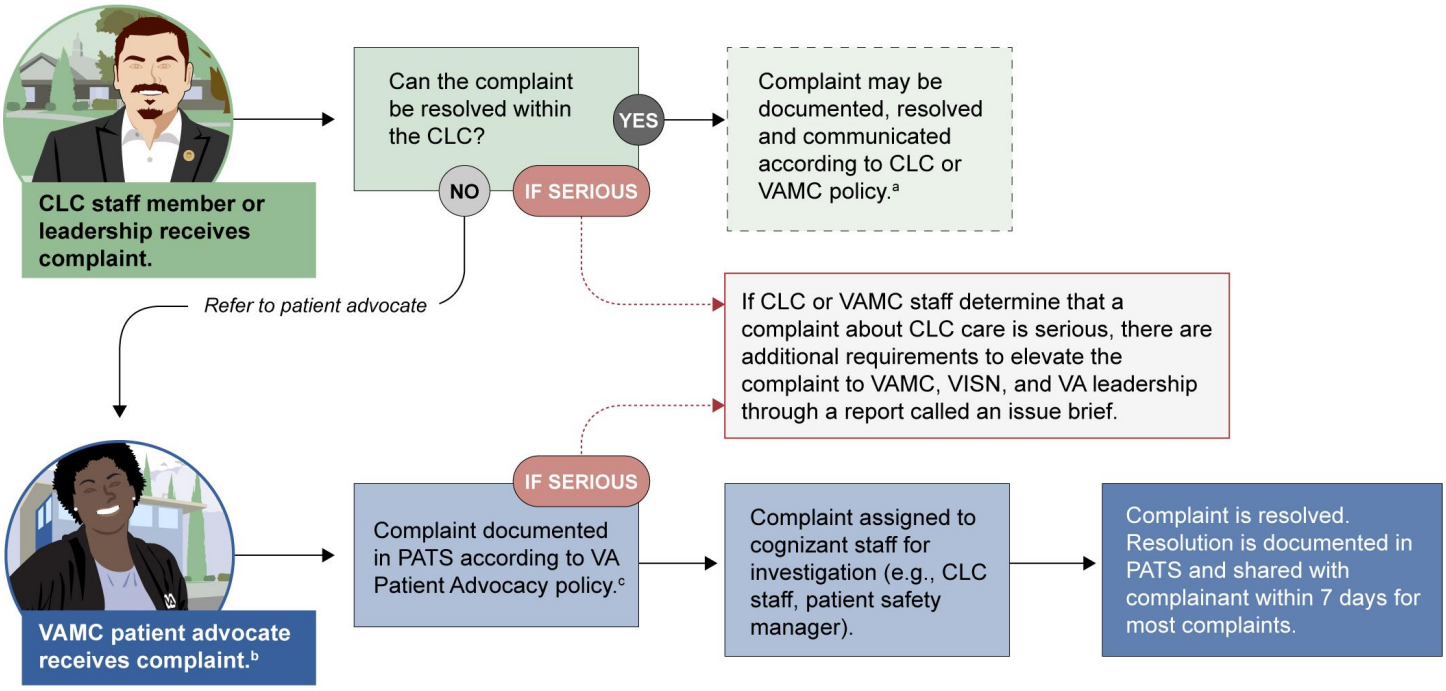
- At the regional level, the Veterans Integrated Service Networks (VISN) oversee quality of care at medical facilities in each of VA's 18 regions. VISNs provide administrative and clinical oversight of VAMCs and their departments, including CLCs, in their region. Each CLC is assigned to one of 18 VISNs and each VISN oversees up to 13 CLCs.
- At the national level, VA's GEC is responsible for the oversight of quality of care at CLCs. It sets guidance for the CLCs and uses a contractor to conduct inspections of CLCs for compliance with quality standards, including standards related to addressing complaints. We refer hereafter to the contractor staff who conduct these inspections as "inspectors." VA's OPA is responsible for overseeing the national process for patient advocates to receive and resolve complaints throughout the VA system, including at CLCs. OPA sets forth minimum expectations for VAMCs' administration of the program, including that veterans must have easy access to a patient advocate and must have their complaints addressed in a convenient and timely manner.

[11]Each of VA's approximately 170 VAMCs is required to establish a patient advocacy program to receive complaints and other feedback from veterans. The patient advocate is responsible for documenting the complaint and its resolution within PATS. Some CLC staff can serve as service-level advocates, which means they can document complaints in PATS and coordinate resolution in communication with the patient advocate at their associated VAMC.

Complaints about CLC Care

VA's complaints process is primarily governed by its national Patient Advocacy policy, including use of a centralized system called PATS to manage the process.[12] This policy applies to complaints about care across the VA system. In addition, CLCs can also create local policies for addressing complaints about care in CLCs. CLC residents and their representatives can initiate the filing of complaints about CLC care in several ways.[13] See figure 1 for VA's process for addressing complaints about CLC care.

Figure 1: Department of Veterans Affairs' (VA) Process for Addressing Complaints about Care at a Community Living Center (CLC), by Entity, according to VA Documents and Interviews with Officials



Source: GAO review of Department of Veterans Affairs information. | GAO-22-105142

[12]See VHA Directive 1003.04. Other policies, such as patient safety policies, can also direct staff on how to respond to specific types of complaints such as allegations of abuse.

[13]We use the term "representatives" to collectively refer to those individuals who raise complaints on the behalf of a CLC resident, including family members.

Text of Figure 1: Department of Veterans Affairs' (VA) Process for Addressing Complaints about Care at a Community Living Center (CLC), by Entity, according to VA Documents and Interviews with Officials

CLC staff member or leadership receives complaint.

1) Can the complaint be resolved within the CLC?

   a) If Yes: Complaint may be documented, resolved and communicated according to CLC or VAMC policy./a/

   b) If Serious: If CLC or VAMC staff determine that a complaint about CLC care is serious, there are additional requirements to elevate the complaint to VAMC, VISN, and VA leadership through a report called an issue brief.

   c) If No (Refer to patient advocate)

VAMC patient advocate receives complaint./b/

1) Complaint documented in PATS according to VA Patient Advocacy policy./c/

2) Complaint assigned to cognizant staff for investigation (e.g., CLC staff, patient safety manager).

3) Complaint is resolved. Resolution is documented in PATS and shared with complainant within 7 days for most complaints.

Notes: CLCs are nursing homes owned and operated by VA, are associated with VA medical centers (VAMC), and are overseen by Veterans Integrated Service Network (VISN) officials. CLC residents and their representatives can voice their concerns about the care in the CLC by filing a complaint. Complaints can range from issues such as the quality of food available at the CLC to reports of serious resident safety concerns, such as abuse or neglect.

[a]VAMCs and CLCs can create local policies for addressing complaints about care in CLCs.

[b]Each VAMC is responsible for making at least one patient advocate available to respond to feedback about the care provided in its facilities and for ensuring that feedback is recorded in the Patient Advocate Tracking System (PATS). At some CLCs, service-level advocates, such as nurses or administrative staff at CLCs, can receive and enter complaints information into PATS before involving a patient advocate.

[c]VA's complaints process is primarily governed by its national Patient Advocacy policy, including use of PATS to manage the process. See Department of Veterans Affairs, Veterans Health Administration, *VHA Patient Advocacy*, VHA Directive 1003.04 (Washington, D.C.: Feb. 7, 2018).

Source: GAO review of Department of Veterans Affairs information. | GAO-22-105142

CLC residents and their representatives can report complaints to CLC staff and VAMC patient advocates. These VA entities receive complaints about CLC care and transmit them into PATS in the following ways.

- **CLC staff**. Residents and their representatives can speak directly with CLC staff to file a complaint at any time. According to GEC officials, each CLC should establish its own process for documenting and tracking complaints, though CLCs may adopt policies from their associated VAMC.[14] If CLC staff cannot resolve a complaint, the staff member may contact a patient advocate, encourage the complainant to contact the patient advocate, or may enter the complaint directly into PATS if they have access to the system.
- **Patient advocates**. Residents and their representatives can file complaints by contacting a patient advocate at the CLC's associated VAMC, or at a CLC-specific patient advocate at some CLCs.[15] Patient advocates are required to follow procedures from VA's system-wide Patient Advocacy policy, as well as any local policies that operationalize this system-wide policy.[16]

  VA's Patient Advocacy policy requires patient advocates to use PATS for managing the complaints process. PATS was designed so patient advocates can document complaints, refer complaints about the wide variety of care delivered within VAMCs to other staff to address the concern, track the status of resolution, and identify high-level trends in complaints. Per VA policy, patient advocates are responsible for resolving complaints that cannot be resolved at the point of service, such as in a CLC. For example, a complaint about failure to coordinate care from another service in the VAMC should be documented in PATS. These complaints must be documented in PATS, including details about the incident, selecting a category or issue code from a list that best describes the complaint, steps taken to investigate the complaint, how the complaint was resolved, and whether the result was communicated to the complainant. For most complaints, these steps must be completed within 7 business days.

[14]See Department of Veterans Affairs, Veterans Health Administration, *Criteria and Standards for VA CLCs*, VHA Directive 1142.01 (Aug. 13, 2008). Under this policy, CLCs are also required to allow residents to participate in monthly meetings with other residents, known as resident councils, to provide feedback and voice concerns.

[15]Each VAMC is responsible for making at least one patient advocate available to respond to feedback about the care provided in its facilities and for ensuring that feedback is recorded in PATS. VAMCs may designate other staff to assist patient advocates in responding to feedback, such as lead patient advocates and service-level advocates. Service-level advocates, such as nurses or administrative staff at CLCs, are designated at some VAMCs to respond to veterans' feedback before involving a patient advocate and to enter complaints information into PATS.

[16]See VHA Directive 1003.04.

If CLC or VAMC staff determine that a complaint about CLC care is serious—such as those related to the harm of a resident through abuse or neglect—there are additional requirements for CLC or VAMC staff to elevate the complaint to VAMC, VISN, and VA leadership. This includes quickly notifying VISN and VA leadership that a serious issue occurred and submitting an issue brief within 2 business days that summarizes what occurred, how it was investigated, and steps taken to prevent it from happening again, among other things.[17] CLC or VAMC staff are instructed to take immediate actions to ensure residents' welfare, such as removing providers from a resident's care if a resident reports abuse or neglect.

CLC residents and their representatives can also file complaints with the White House VA hotline or VA OIG. According to VA officials, these complaints are often routed to and addressed by CLC or VAMC staff.

- CLC residents and their representatives can contact the White House VA Hotline and speak with a live agent at any time to file a complaint. Officials from VA's office responsible for the White House VA hotline told us that the hotline's primary purpose is to provide one number that veterans can call for a referral to the correct VA office to address their question or concern, such as patient advocates at the VAMC.[18] The patient advocate—not White House VA Hotline staff—would then resolve the complaint and communicate with the complainant using VA's complaints process. Although White House VA Hotline agents are not responsible for investigating or resolving complaints, they track complaints filed through the hotline to ensure that complaints are resolved and the results are communicated to the complainant.

[17]Per VA Directive 0321, VA leadership must be informed of serious incidents within 2 hours of staff becoming aware of the incident. VA defines multiple types of serious incidents, including suspicious deaths on VA property and incidents on VA property that result in serious illness or bodily injury, including sexual assault or aggravated assault. According to VA guidance, VISN and VA leadership must be informed of all other incidents that require an issue brief, such as serious events that occur at the CLCs, within 1 business day. See Department of Veterans Affairs, *Serious Incident Reports,* VA Directive 0321 (Washington, D.C.: June 6, 2012) and Department of Veterans Affairs, Veterans Health Administration, Deputy Undersecretary for Health Operations and Management (10N), *10N Guide to VHA Issue Briefs*, (June 20, 2017).

[18]The White House VA Hotline was established in 2017 and is run by VA's Veterans Experience Office. According to VA, the hotline is staffed by agents who have "extensive training on VA programs and services" and trends in calls will be used to "resolve Veteran concerns quickly."

- CLC residents and their representatives may also contact the VA OIG to file complaints. VA OIG staff may open an investigation—including conducting timely on-site investigations of serious complaints—or refer complaints to the CLC or VAMC for resolution. According to VA OIG officials, most complaints they receive are referred to CLC or VAMC staff, and VA OIG tracks resolution of these complaints. For complaints that VA OIG investigates, it releases public reports on the results and makes recommendations for improvement to the CLC or VAMC.

VA Models Oversight on CMS Oversight

VA generally models its oversight of CLCs on CMS oversight of community nursing homes.[19] CMS defines the federal standards for quality of care in approximately 15,600 community nursing homes that participate in the Medicare and Medicaid programs, as well as a protocol for assessing compliance with these standards.[20] To monitor compliance with these standards in CLCs, with some exceptions, the inspector uses the CMS protocol to inspect nursing homes about once a year to determine whether CLCs meet federal quality standards for nursing homes.[21] For example, inspectors may assess whether CLCs develop a process to document and address complaints, and notify residents about this process. (See app. I for an excerpt of CMS requirements for facilities' grievance polices. CMS refers to internal complaints as grievances.)

A key difference between VA and CMS oversight of complaints is that in CMS's oversight of community nursing homes, residents may file

[19]A VA 2016 memorandum specified that VA implement an unannounced inspection program modeled on CMS oversight, which includes regular inspections or surveys to monitor compliance with quality standards through direct observations, during which inspectors cite deficiencies if nursing homes do not comply with these standards. VA relies on a contractor to conduct unannounced inspections of CLCs about once a year.

[20]See 42 U.S.C. §§ 1395i-3(f)(1),1396r(f)(1); 42 C.F.R. Part 483, Subpart B (2020). CMS nursing home quality standards focus on the delivery of care, resident outcomes, and facility conditions. The survey standards are grouped into 21 categories, such as Resident Rights, Quality of Life, Resident Assessment, Quality of Care, Pharmacy Services, and Administration. We refer to these quality standards for nursing homes defined by CMS as federal quality standards.

[21]VA requires that CLCs develop and implement corrective action plans for each deficiency—or failure to meet a quality standard—that the inspectors identify. These corrective action plans must detail how the deficiency will be addressed, and VA and the VISN monitor CLCs' actions until each deficiency is addressed.

complaints directly with the independent agency responsible for nursing home quality inspections at any time throughout the year, and such complaints may be investigated by the agency.[22] In contrast, for VA oversight of CLCs, residents can only file complaints with inspectors on the 2 to 3 days they are inspecting the CLC on-site each year, and the inspectors do not conduct complaint investigations.

VA Has Insufficient Policies, Limited Monitoring, and Unclear Guidance for Addressing Complaints about CLC Care

In our review, we found VA has insufficient policies, limited monitoring, and unclear guidance for addressing complaints about CLC care. Specifically, VA policy insufficiencies, such as the lack of a national policy requiring CLCs to document complaints, has resulted in limited documentation of complaints about CLC care. Similarly, VA's monitoring of existing complaint policies has been limited, and our review showed errors in the implementation of the policies such as staff not always taking steps to ensure resident welfare. Further, the guidance VA has provided to CLCs about when they expect staff to file reports of serious issues is unclear and appears to result in underreporting of serious complaints to VA leadership.

Insufficient VA Policies Result in Limited Documentation of Complaints about CLC Care

We found insufficiencies in VA's policies—national, CLC-specific, and local policies—that result in limited documentation of complaints about CLC care.

- VA's national Patient Advocacy policy complaint documentation requirements do not typically apply to most complaints about CLC

[22]Specifically, entities called state survey agencies are required by federal law to investigate complaints submitted by residents, family members, friends, physicians, and nursing home staff. State survey agencies review the information provided through complaints and determine if an on-site investigation is required. During this unannounced investigation, the state surveyors assess available evidence to determine whether the allegation can be substantiated. These investigations offer the state survey agency the opportunity to identify and correct care problems in a more timely manner than through the standard inspections.

care, according to VA and CLC officials. Specifically, according to OPA officials, staff must follow procedures in this policy only for complaints entered into PATS, such as documenting these complaints and their resolution within 7 days.[23] However, VA GEC officials and staff from three CLCs told us that most complaints in CLCs are resolved at the CLC level rather than through PATS—for example, one CLC said 90 percent of complaints are resolved within the CLC—which means they would not be subject to the required documentation procedures. Staff at two CLCs could not identify or recall any complaints about CLC care being entered in PATS in recent years. Because of this gap in VA's Patient Advocacy policy, most complaints about CLC care are likely not documented in PATS, although it is not possible to know exactly how many complaints are received and resolved by CLC staff without any documentation.

- VA's national CLC-specific policies also do not include specific requirements for documentation of complaints.[24] Officials from VA's GEC told us that they are currently revising and consolidating CLC policies, but that they do not plan to incorporate requirements for addressing complaints about CLC care into this policy because they consider complaints policies to be a local responsibility.
- VA officials told us that CLCs can create their own local policies to require documentation of all complaints. These local policies could help address the complaint documentation requirement gap in VA's national policies and meet federal quality standards for nursing homes. However, we found that only one of the six selected CLCs

[23]VA officials explained that only complaints that are elevated to the patient advocate must be documented in PATS, but CLC staff who serve as service level advocates have the option of entering complaints into PATS even if the complaint can be resolved within the CLC and otherwise would not be elevated to the patient advocate. They further explained that all complaints in PATS—even those that CLCs opt to enter—must be addressed using the process in the Patient Advocacy policy.

[24]CLC -specific policies include Department of Veterans Affairs, Veterans Health Administration, *Admission Criteria, Service Codes and Discharge Criteria for VA Community Living Centers*, VHA Handbook 1142.02 (Sept. 2, 2012): *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set*, VHA Handbook 1142.03 (Jan. 4, 2013), and VHA Handbook 1142.01.

had created a local CLC-specific complaints policy at the time of our review.[25]

VA's insufficient policies have resulted in limited documentation on complaints about CLC care and their resolution, a situation that is contrary to VA's own strategic objectives and federal quality standards for nursing homes. VA's strategic objectives that VA (1) be transparent, maintain trust, and be openly accountable for its actions, (2) hold personnel accountable for delivering excellent service, and (3) swiftly and justly address inappropriate behavior, fraud, waste, and abuse. Further, VA's insufficient policies are inconsistent with federal quality standards for nursing homes, which VA applies to CLCs. These standards require nursing homes to establish a complaint policy that ensures they maintain documentation related to complaints for no less than 3 years.[26] However, VA does not clearly communicate how these federal quality standards related to complaints should apply to CLCs given that there are related VA policies—such as the Patient Advocacy policy—and differences in VA's and CMS's approach to complaint oversight.[27] Without a clear VA requirement to document all CLC complaints—not just those elevated to patient advocates—the agency cannot ensure that all complaints about CLC care are documented, tracked, and resolved as part of its quality improvement efforts for the vulnerable CLC population.

[25]This local CLC policy requires documentation of most complaints received and resolved directly by CLC staff—generally via paper grievance forms—and defines specific instances when CLC staff may directly resolve minor complaints without formally documenting the results. Specifically, such complaints (1) are non-recurring minor issues (e.g., "I do not like my coffee"), (2) can be addressed at their level, (3) did not have a negative impact on the resident's condition, and (4) are immediately resolved and the resident or their representative verbalized satisfaction of the resolution. The policy still required CLC staff to notify clinical leadership of these resolved complaints to allow for monitoring of trends and patterns, but did not require entry of these complaints into PATS.

[26]Additionally, all written complaint decisions must include the date the complaint was received, a summary of the complaint, the steps taken to investigate, a summary of the pertinent findings, a statement as to whether the complaint was confirmed or not confirmed, any corrective action taken or to be taken by the facility, and the date the written decision was issued.

[27]We found in a related report that, while not specific to complaints, there were some exceptions when CLCs are evaluated against VA policies instead of federal quality standards for nursing homes. In that report, we found that VA does not clearly communicate when this is the case, which may reduce likelihood that CLCs follow the appropriate standards, and recommended that VA clarify these expectations. See GAO-22-104027.

In Addressing CLC Complaints, Some Staff Did Not Follow VA Policies, Reflecting Limited Monitoring of Adherence to Complaint Policies

We found that in addressing complaints about CLC care that were entered into PATS, staff at some selected CLCs did not always follow VA policies governing how complaints should be documented and addressed. Specifically, our review of documentation in PATS from four of the selected CLCs identified issues with staff's implementation of policies—we found more than one of these issues at each of the four CLCs.[28]

- **Staff did not always appropriately categorize complaints for further review**. VA's Patient Advocacy policy requires staff to categorize complaints in PATS so they can be elevated and addressed appropriately. For example, it was apparent that a 2019 complaint at a CLC was miscategorized. A family member reported that a resident started choking and that CLC staff were unresponsive when the family member pushed the call button alarm to request help multiple times. The family member thought the resident may have died if the family member was not there. When the family member made a complaint, the patient advocate categorized it as "preferences/decisions" and "emotional needs not met," despite the severity of incident and other available categories such as "safety concerns."
- **Staff did not always take immediate actions when necessary to ensure the resident's welfare**. VA's Patient Advocacy and related patient safety policies require staff to take immediate actions when necessary to ensure a resident's welfare.[29] For example, a complaint about abuse at a CLC in 2019 was not immediately addressed. In this

[28]Two of the selected CLCs could not identify or provide data on any complaints about CLC care that had been entered into PATS in recent years. As a result, our review of complaints documentation in PATS is limited to the four selected CLCs that had such data available.

[29]VA's Patient Advocacy policy instructs patient advocates to work with local patient safety officers for incidents involving patient safety. The VHA National Patient Safety Improvement Handbook requires these patient safety managers to ensure that immediate actions are taken to protect residents. Immediate actions may include, but are not limited to, taking appropriate care of the patient, making the situation safe, preventing immediate recurrence, notifying police or security if appropriate, and preserving evidence and relevant information that will aid in fully understanding the situation. Department of Veterans Affairs, Veterans Health Administration, *National Patient Safety Improvement,* VHA Handbook 1050.01 (March 4, 2011).

situation, a resident complained staff were harassing, verbally abusing, and being neglectful in the resident's care over a 7-month period. The resident also said staff were being aggressive in retaliation for the resident filing a complaint. These staff were not immediately removed from caring for the resident, as required by VA policy. Instead, 2 weeks later, the facility removed some of the staff from the resident's care.

- **Staff did not always document the steps taken to investigate complaints**. VA's Patient Advocacy policy requires staff to document the steps taken to investigate complaints entered into PATS. For example, we did not find documentation that staff took steps to address a 2018 complaint. In this situation, a family member complained that a resident's nurse did not provide adequate care. When the family member asked the nurse to help with toileting or the resident's medications, the nurse refused. The patient advocate documented that CLC staff would reach out to the family member but did not document what steps, if any, were taken to investigate the complaint or staff member.
- **Staff did not always address complaints in a timely manner**. VA's Patient Advocacy policy requires staff to document and resolve complaints entered into PATS within 7 business days. For example, we found that staff took over a month to address a 2019 complaint. In this situation, a resident complained to CLC staff about unsanitary conditions in the CLC, including staff providing resident care and handling food without sanitizing their hands. A month later, the resident complained to the patient advocate after hearing no response from CLC staff regarding the original complaint. The patient advocate directed the complaint to CLC staff for investigation, who subsequently met with the resident to hear and begin addressing the resident's complaints.
- **Staff did not always record the resolution of complaints**. VA's Patient Advocacy policy requires staff to record the resolution of complaints and communicate the result to the complainant. For example, we found that staff did not record the resolution of a 2019 complaint. In this situation, a resident complained to a patient advocate about poor quality of care from a particular provider. The PATS complaint record was closed with a note that the patient advocate intended to contact the provider but did not state whether this happened or if any actions were taken in response to the contact. We found no documentation indicating that the resident was informed about the resolution of the complaint, and the complaint likely was not addressed in a timely manner, as the record showed that the resident

called a second time to ask for an update. A patient advocate at one CLC said that he considered complaints resolved when they had been referred to staff for investigation.

This nonadherence to policy reflects VA's limited monitoring of CLCs' implementation of VA's complaints-related policies. First, VA does not monitor information in PATS to ensure that CLCs and associated VAMCs adhere to VA's Patient Advocacy policy, VA's national policy for complaints. VA's OPA implemented a tool for periodic reviews of complaints entered into PATS in response to issues identified in our prior work; however, the tool would not allow VA to ensure CLCs are following VA policy because, according to VA officials, it is not possible to isolate complaints about CLC care from those about other long-term care settings.[30]

Second, we found the monitoring VA conducts through its annual inspections does not provide assurance that CLCs have policies and processes for addressing complaints. Representatives from VA's contracted inspector told us they do not typically verify that CLCs are using complaints policies that meet federal quality standards as part of their annual inspection—they said they would only review these policies if they identified an issue through interviews or observations in the course of their inspection.[31] As previously discussed, only one of the six selected CLCs created a CLC-specific complaints policy that complied with federal quality standards for nursing homes, indicating that VA's approach to inspections is not adequate for monitoring the CLC complaints policies.

[30]We recommended that VA monitor data-entry practices across VAMCs to ensure all complaints are documented and that veterans' feedback is coded consistently. VA concurred with our recommendation and addressed it in July 2021 when it began monitoring PATS data entry practices using its new tool for periodic reviews. See GAO. *VA Health Care: Improved Guidance and Oversight Needed for the Patient Advocacy Program,* GAO-18-356. (Washington, D.C.: Apr. 12, 2018).

[31]In its review of a draft of this report, VA noted that "although CLCs are required to comply with all Federal regulations and quality standards, these may not necessarily be reviewed in every survey absent an explicit need." VA's inspection (i.e., survey) methodology involves observing direct care provided to a sample of residents and citing specific deviations from quality standards based on that observation. As a result, the inspection may not examine all policies, which is consistent with CMS guidelines, according to VA. However, in the CMS process, complaint policy issues may be more readily identified because (1) inspectors conduct complaint investigations throughout the year; (2) inspectors are encouraged to review complaints filed since the last inspection before they arrive at the nursing home; and (3) inspectors select residents in the sample for observation who have unresolved complaints.

VA's current approach to monitoring complaints about CLC care does not meet VA's strategic objectives that VA (1) be transparent, maintain trust, and be openly accountable for its actions, (2) hold personnel accountable for delivering excellent service, and (3) will swiftly and justly address inappropriate behavior, fraud, waste, and abuse. VA's approach also does not meet federal standards for internal control related to control activities—which require management to monitor performance to achieve objectives, including monitoring that CLC and VAMC staff follow VA and federal quality standard requirements for documenting complaints.[32] With more robust monitoring efforts, such as modifying the OPA tool to specifically review PATS entries about CLC complaints and directing inspectors to routinely review CLC complaints policies and processes, VA could identify and correct errors in how CLCs address complaints.

VA's Guidance to CLCs about When to Report Complaints Using Issue Briefs Is Unclear

VA's guidance about when CLC and VAMC staff should elevate serious complaints to VA leadership through issue briefs is unclear and appears to result in underreporting of serious complaints.[33] Issue briefs are a critical mechanism for local CLC and VAMC staff to report serious concerns, including serious complaints, to VA leadership such as the GEC officials responsible for CLC oversight. VA's current guidance on issue briefs instructs CLC and VAMC staff to report "untoward events at CLCs" to VA through issue briefs but does not define what events are considered "untoward." GEC officials told us that they expect CLCs to report allegations of abuse through issue briefs, but the guidance does not specifically state this expectation.[34]

GEC officials expressed confidence that issue briefs reported to them provided an accurate representation of incidents happening at the CLCs. However, when we compared complaints in PATS to issue briefs submitted to VA leadership in fiscal years 2018 and 2019, we found that

[32]GAO-14-704G.

[33]Department of Veterans Affairs, Veterans Health Administration, Deputy Undersecretary for Health Operations and Management (10N), *10N Guide to VHA Issue Briefs.*

[34]VA's guidance contains some specific types of events that should be reported via issue brief, such as suicide or suicide attempts, sexual assaults, breach of information security, employee events that may generate media interest, controlled substance losses, sentinel events, and "anything VISNs want VA Central Office leadership to know."

complaints related to abuse may have been underreported. Additionally, our interviews with officials and review of policies from the six selected CLCs revealed misinterpretation of VA's guidance about what to report through issue briefs, indicating that this guidance is unclear.[35] Specifically, we found the following.

- Almost none of the complaints related to abuse we identified at the six selected CLCs were elevated to VA through an issue brief. Across the six CLCs, only one of the 19 complaint records we reviewed that contained allegations of abuse in fiscal years 2018 and 2019 resulted in an issue brief.
- CLC and VAMC staff procedures for addressing allegations of abuse did not consistently include reporting to GEC through an issue brief. When we asked patient safety staff and patient advocates at the six selected CLCs about how they would elevate complaints, officials from only two CLCs said that the abuse-related complaints would be reported to GEC through an issue brief. Similarly, only one CLC's complaints policies and policies related to abuse mentioned reporting allegations of abuse through issue briefs.

Issue briefs are used to help GEC ensure that serious complaints and other issues are addressed. GEC officials told us that if they receive an issue brief, they track the issue until it is resolved and may reach out to VISN or VAMC staff to ensure it is addressed. According to GEC officials, they will also use issue briefs to dispatch inspectors to investigate serious complaints, starting in January 2022. These inspectors can assess and address quality issues as needed when they occur, rather than relying on annual inspections to identify conditions that may put residents at risk of continued harm. However, if serious issues continue to go unreported through issue briefs, GEC may fail to identify these situations that need more attention.

Without clear guidance to CLC and VAMC staff that specifies the types of complaints that should be reported through issue briefs—such as complaints alleging abuse—VA's GEC increases the likelihood that it will not have complete information on complaints about CLC care. This information is needed to promptly investigate and resolve serious complaints at CLCs. This approach is inconsistent with VA's strategic

[35]Similarly, we found in 2019 that CMS lacked guidance to community nursing homes about information they should include in their reports about serious incidents such as abuse. We recommended that CMS develop and disseminate this guidance, but as of September 2021, CMS had not done so. See GAO-19-433.

objectives that VA (1) be transparent, maintain trust, and be openly accountable for its actions; (2) hold personnel accountable for delivering excellent service; and (3) will swiftly and justly address inappropriate behavior, fraud, waste, and abuse. It is also inconsistent with federal standards for internal control related to information and communications, which require agencies to use quality information, such as relevant data from reliable sources, to achieve the agency's objectives.[36]

Data Limitations Hamper VA's Ability to Use Complaints to Oversee Quality of Care at CLCs

VA uses data on serious complaints reported in issue briefs to oversee quality of care at CLCs, but these data are limited, and VA could use other complaint data to improve its oversight. Complaints are a valuable source of information about the quality of care in nursing homes because investigations of these complaints can identify and resolve issues promptly for this vulnerable population. However, we found limitations in the complaint data VA uses to inform its oversight of quality of care at CLCs.

VA officials rely on complaints reported through issue briefs to identify and respond to trends in serious complaints about CLC care. GEC officials told us that they use a spreadsheet to track information from issue briefs and identify trends in these data. For example, officials told us they used this approach in fall 2020 to identify an increase in staff verbal abuse toward residents and designed a national training for CLC staff in response. However, as previously discussed, VA's unclear issue brief guidance may lead to underreporting of serious complaints about CLC care, which limits VA's ability to use these data to reliably identify trends in serious complaints. Further, because issue briefs only reflect serious complaints, VA's oversight lacks information on a broader range

[36]GAO-14-704G.

of complaints that could help them intervene before issues become serious.[37]

Although other complaint data could be used to oversee CLCs, VA officials told us their approach to oversight has been sufficient. VA officials could use complaints data from PATS to enhance the agency's understanding of quality of care in CLCs, such as by identifying trends in complaints across CLCs. However, as previously discussed, PATS lacks comprehensive information on CLC complaints because most complaints about CLC care are resolved at CLC level and are not documented in PATS. Furthermore, even those complaints that are documented in PATS are not useful in identifying trends, because they are not consistently linked to a specific CLC. Despite recent updates made to PATS to enable more detailed data analysis, VA's OPA officials who manage the complaint system said they could not analyze data specific to CLCs. According to these VA officials, PATS does not include a consistent designation to distinguish the location of services provided (e.g., in CLCs, medical-surgical, or intensive care units). Though officials told us that it was possible to analyze data on complaints about long-term care—such as care provided in CLCs or in state veterans homes—it is not possible to identify complaints about care across CLCs.

VA's inability to specifically analyze complaints data for CLCs limits its oversight capabilities and is inconsistent with VA's management objective of using data-supported decision-making to improve outcomes. Per VA policy, patient advocates at each VAMC should document complaints to enable a comprehensive understanding of veterans' issues and concerns, and ultimately identify potential system-wide improvements. Without a comprehensive centralized source for complaints data that allows VA to analyze complaints specific to CLC care, VA lacks key information on complaints about the quality of care provided at its CLCs, cannot identify trends in complaints about CLC care, and therefore may be limited in its ability to take actions to address common complaints across its CLCs.

[37]Per VA Directive 0321, VA leadership must be informed of serious incidents within 2 hours of staff becoming aware of the incident. VA defines multiple types of serious incidents, including suspicious deaths on VA property and incidents on VA property that result in serious illness or bodily injury, including sexual assault or aggravated assault. According to VA guidance, VISN and VA leadership must be informed of all other incidents that require an issue brief, such as serious events that occur at the CLCs, within 1 business day. See VA Directive 0321 and Department of Veterans Affairs, Veterans Health Administration, Deputy Undersecretary for Health Operations and Management (10N), *10N Guide to VHA Issue Briefs*.

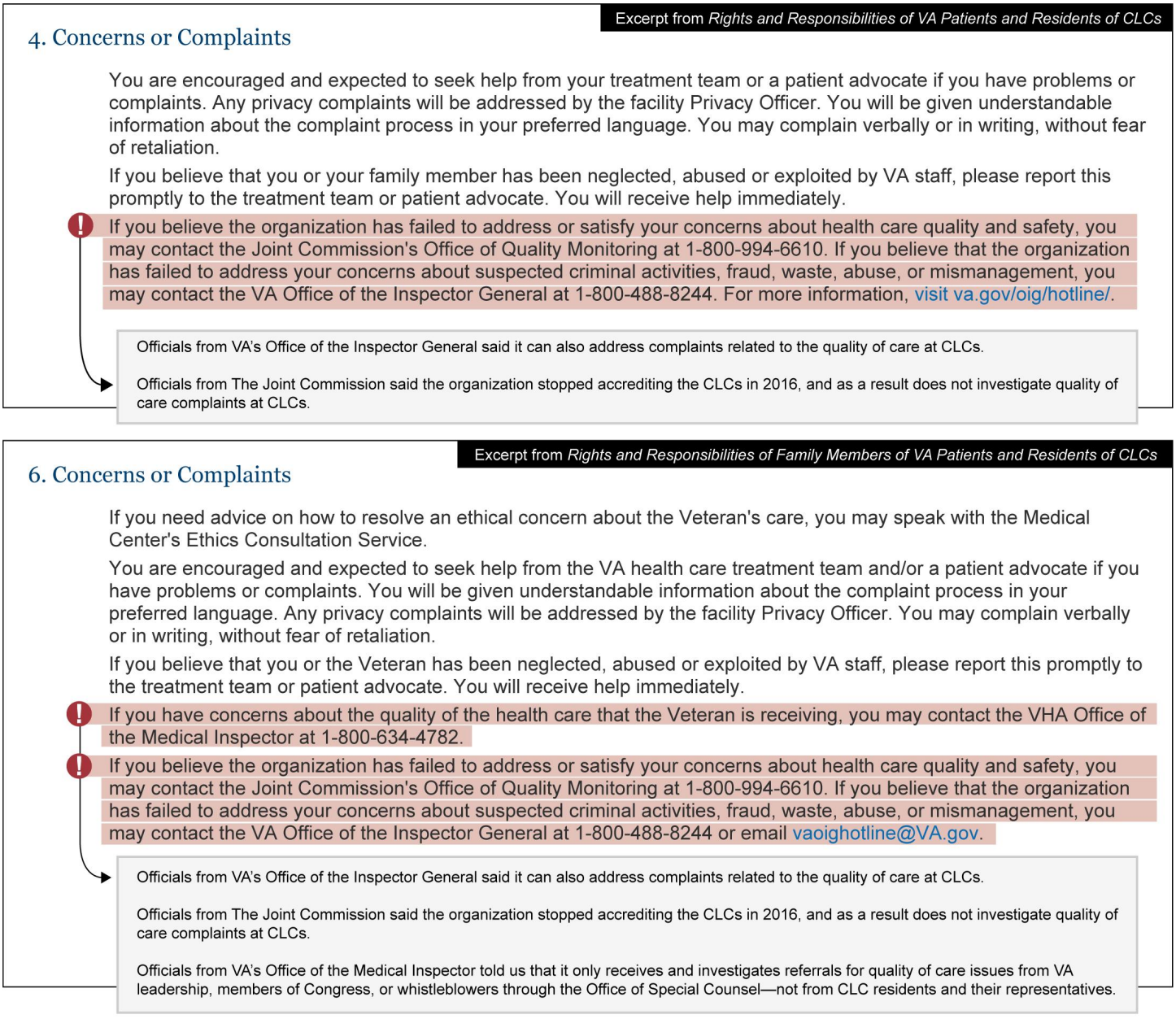
VA's Instructions for Filing Complaints about CLC Care Are Inaccurate and Incomplete

Our review of VA's communications to CLC residents and their representatives revealed that they have not been receiving accurate, complete documents about how to file complaints. Officials told us that CLC residents may learn about filing complaints in VA's Rights and Responsibilities document for all VA patients—including CLC residents. VA also produces a Rights and Responsibilities document for family members, and makes both documents available on VA's website.[38] CLC residents and their representatives can file complaints through CLC staff, patient advocates, and VA OIG, according to VA officials.[39] However, instructions in these documents on how to file a complaint through independent entities are inaccurate, as highlighted in figure 2.

[38]Department of Veterans Affairs, Veterans Health Administration, "Rights and Responsibilities of VA Patients and Residents of Community Living Centers" (Oct. 9, 2020), accessed Nov. 2, 2021, https://www.va.gov/health/rights/patientrights.asp and "Rights and Responsibilities of Family Members of VA Patients and Residents of CLCs" (May 11, 2015), accessed Nov. 2, 2021, https://www.va.gov/health/rights/familyrights.asp.

[39]Officials said that inspectors are also available to receive complaints in the 2 to 3 days they are on site inspecting the CLC each year.

Figure 2: Excerpt on Complaints from Patient and Family Member Rights and Responsibilities Documents Showing Inaccurate Guidance as of September 2021



Source: GAO review of Department of Veterans Affairs information. | GAO-22-105142

Notes: Community Living Centers (CLC) are nursing homes operated by the Department of Veterans Affairs (VA). CLC residents and their representatives can voice their concerns about the care in the CLC by filing a complaint. VA officials told us that CLC residents may learn about filing complaints in VA's Rights and Responsibilities document for all VA patients—including CLC residents. There is also

a Rights and Responsibilities' document for family members. These documents are typically provided to CLC residents and their family members when they are admitted to CLCs, and are also available on VA's website.

The Rights and Responsibilities documents misdirected CLC residents and their representatives to complain to The Joint Commission and the VA Office of the Medical Inspector, neither of which receives nor investigates complaints about CLC care. Officials from The Joint Commission said the organization stopped accrediting the CLCs in 2016, and as a result does not investigate quality of care complaints at CLCs.[40] Officials from VA's Office of the Medical Inspector told us that they only receive and investigate referrals for quality of care issues from VA leadership, members of Congress, or whistleblowers through the Office of Special Counsel—not from CLC residents and their representatives.

The Rights and Responsibilities documents also did not contain complete information about another entity available to receive and address complaints about CLC care at the time of our review. As of September 2021, the documents did not identify the VA OIG's ability to investigate quality of care concerns, and instead listed them as a resource only for complaints related to suspected criminal activities, fraud, waste, abuse, or mismanagement.[41] According to VA OIG officials, the description of their work in the document was not accurate, and they were well-staffed to address complaints related to quality care.

Second, VA's Rights and Responsibilities documents did not contain information about what residents should expect after filing a complaint, such as expected timeframes for investigation or resolution at the time of our review. We identified multiple situations where a resident or family member reported feeling as if the complaint filing process was not transparent, or would not result in their complaint being resolved, which this information could address. For example, a resident told an inspector

[40]The Joint Commission is a nonprofit organization that accredits and certifies health care organizations and programs in the United States, including VAMCs and private hospitals. The Joint Commission previously accredited CLCs based on its quality standards for nursing care centers and continues to accredit VAMCs. The Joint Commission remains an appropriate place for VAMC patients to raise complaints about their care. However, according to an official from The Joint Commission, the organization is no longer contracted to accredit the CLCs. They stated that if they did receive a CLC quality or safety complaint, they would not send a survey team into a CLC due to the lack of contract. If they received a complaint about CLC care—which they could not recall happening in recent years—they stated that they would reach out to the appropriate contact within VA.

[41]In July 2021, GEC officials stated that they are in the process of revising the guidance documents but could not provide a timeframe for completing the update.

that they were scolded for making a complaint outside the CLC, and another stopped making complaints altogether because their complaints were not addressed. A representative from a veterans service organization stated that delays in the process after a complaint about CLC care is filed can be infuriating for residents and their representatives.

Officials from VA's GEC told us that they were aware that the documents are inaccurate for CLC residents and, as of July 2021, were in the process of creating CLC-specific Resident Rights and Responsibilities documents that did not include contact information for The Joint Commission. However, the planned revisions do not include an accurate description of OIG's role in resolving complaints about CLC care or information on what residents can expect after filing a complaint. VA officials could not provide a timeline for completing these revisions.

Without providing accurate and complete information about options for filing complaints about care at CLCs, it is unlikely that all complaints of residents and their representatives are received and resolved by the appropriate offices in a timely manner, and that the concerns of residents and their representatives about CLC care are heard. This is inconsistent with VA's strategic objectives and federal quality standards for nursing homes. Specifically, VA strives for veterans to be informed of, understand, and get the benefits, care, and services they earned in a timely manner, and for VA to be transparent and openly accountable for its actions. In addition, federal quality standards, which VA applies to CLCs, require nursing homes to have policies that, among other things, notify residents individually or through postings in prominent locations throughout the facility of the right to file complaints orally or in writing, the contact information of the official within the facility with whom a complaint can be filed, the contact information of independent entities with whom complaints may be filed, and a reasonable expected time frame for resolution. (See app. I for more information on these requirements).

Conclusions

VA's policies and oversight are inadequate for ensuring complaints about CLC care are appropriately addressed and must be improved to ensure the veterans living in CLCs are protected. Without a national policy requiring specific documentation of complaints about CLC care, a process for monitoring complaints, and clarification of its guidance on when serious issues need to be elevated, VA cannot ensure that all complaints about CLC care are appropriately tracked and resolved, that CLC staff

are correctly implementing policies, and that VA is aware of serious issues. Further, without using a comprehensive source of data on complaints about CLC care in its oversight, VA's ability to identify and take action on complaints about CLC care will continue to be hindered. Finally, veterans and their families will continue to have inaccurate information about how and where to complain about CLC care unless VA fixes errors in the key documents and on its website for informing CLC residents and their representatives. Until VA addresses each of these issues related to complaints about CLC care, VA cannot ensure that that the agency is able to monitor and improve quality of care for this vulnerable population.

Recommendations for Executive Action

We are making the following five recommendations to VA:

The Department of Veterans Affairs Under Secretary of Health should require, through national policy, that complaints about CLC care be documented for tracking and resolution. (Recommendation 1)

The Department of Veterans Affairs Under Secretary of Health should establish a process for monitoring complaints about CLC care to ensure that staff are following VA policy in documenting, resolving, and elevating CLC complaints. (Recommendation 2)

The Department of Veterans Affairs Under Secretary of Health should clarify guidance to specify when complaints about CLC care should be elevated beyond the VAMC to GEC through issue briefs. (Recommendation 3)

The Department of Veterans Affairs Under Secretary of Health should develop a centralized source to contain comprehensive information on complaints about CLC care and that allows VA to distinguish complaints about CLC care from care provided in other settings—such as by modifying PATS to consistently capture complaints about CLC care—and should use the information to inform its oversight of CLCs. (Recommendation 4)

The Department of Veterans Affairs Under Secretary of Health should revise its rights and responsibilities documents to ensure information provided is accurate for complaints about care at CLCs, and that

documents contain information about what residents and their representatives can expect after filing a complaint. (Recommendation 5)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in appendix II, VA concurred with our recommendations and identified steps it will take to implement them. For example, VA stated that it will create a standard operating procedure to clarify guidance on when to elevate CLC complaints about care to GEC through issue briefs. VA also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov/.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at SilasS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Sharon M. Silas
Director, Health Care

Appendix I: Excerpt from CMS's Protocol for Inspecting Long-Term Care Facilities, Which VA Applies to CLCs

Excerpt from Centers for Medicare & Medicaid Services' Protocol for Inspecting Long-Term Care Facilities

The facility must establish a grievance policy to ensure the prompt resolution of all grievances…the grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or

to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

Source: Centers for Medicare & Medicaid Services' State Operation Manual. | GAO-22-105142

Appendix II: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

November 15, 2021

Ms. Sharon M. Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***COMMUNITY LIVING CENTERS: VA Needs to Strengthen Its Approach for Addressing Resident Complaints*** (GAO-22-105142).

The enclosure contains technical comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Tanya J. Bradsher
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to the
Government Accountability Office (GAO) Draft Report
COMMUNITY LIVING CENTERS: VA Needs to Strengthen Its Approach for Addressing Resident Complaints
(GAO-22-105142)

Recommendation 1: The Department of Veterans Affairs Under Secretary for Health should require through national policy that complaints about CLC care be documented for tracking and resolution.

VA Response: Concur. The Veterans Health Administration (VHA), Office of Geriatrics and Extended Care (GEC), will implement VHA Directive 1003.04, VHA Patient Advocacy, in VA Community Living Centers (CLC) for documenting complaints for tracking and resolution within the Patient Advocate Tracking System (PATS). CLC Veterans Integrated Service Networks (VISN) and facility leadership will be provided the necessary access. In order to have a clear understanding of the system requirements, all new participants must complete new user training on PATS provided by their local Patient Advocate Office. GEC will collaborate with the VHA Office of Patient Advocacy (OPA) to provide guidance to the field on implementing this recommendation.

Target Completion Date: June 2022

Recommendation 2: The Department of Veterans Affairs Under Secretary for Health should establish a process for monitoring complaints about CLC care to ensure that staff are following VA policy in documenting, resolving, and elevating CLC complaints.

VA Response: Concur. GEC and OPA will collaborate to create a standardized report structure utilizing PATS data. This report will be provided to GEC facility-based care and sent to the VISN Rehabilitation and Extended Care Integrated Clinical Community leads for review to ensure complaints are being documented, addressed and resolved.

Target Completion Date: April 2022

Recommendation 3: The Department of Veterans Affairs Under Secretary for Health should clarify guidance to specify when complaints about CLC care should be elevated beyond the VAMC to GEC through issue briefs.

VA Response: Concur. GEC will create a standard operating procedure (SOP) clarifying guidance on when to elevate CLC complaints about care to the GEC office through the Issue Brief process. The SOP will be disseminated to CLC VISN and facility leadership.

Target Completion Date: June 2022

Enclosure

Department of Veterans Affairs (VA) Response to the
Government Accountability Office (GAO) Draft Report
COMMUNITY LIVING CENTERS: VA Needs to Strengthen Its Approach for Addressing Resident Complaints
(GAO-22-105142)

Recommendation 4: The Department of Veterans Affairs Under Secretary for Health should develop a centralized source to contain comprehensive information on complaints about CLC care and that allows VA to distinguish complaints about CLC care from care provided in other settings – such as by modifying PATS to consistently capture complaints about CLC care – and should use the information to inform its oversight of CLCs.

VA Response: Concur. At present, CLC staff are able to obtain access to PATS to meet the need for a centralized source that contains comprehensive information on complaints about CLC care. To support this, GEC will update VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers, to reference VHA Directive 1003.04, VHA Patient Advocacy, as the standard process for documenting complaints for tracking and resolution within PATS. This will create the consistency referenced in this recommendation. In order to distinguish complaints about CLC care from other settings of long-term care, OPA will collaborate with GEC and work with the PATS development team to break the broader category down into more specific settings. This work will ensure patient complaint data can be used to inform oversight activities of CLCs at all levels.

Target Completion Date: June 2022

Recommendation 5: The Department of Veterans Affairs Under Secretary for Health should revise its rights and responsibilities documents to ensure information provided is accurate for complaints about care at CLCs, and that documents contain information about what residents and their representatives can expect after filing a complaint.

VA Response: Concur. OPA has initiated the revision process for the VA Patient Rights and Responsibilities document. The revision process includes reviewing current information, updating out-of-date information and including new information (such as the overall complaint process through closure) provided from other VHA program offices based on various mandates and requirements. GEC will collaborate with OPA to ensure all critical elements are captured. Once the revision is complete, the updated version must go through the Federal regulations process for review, public comment, approval and publication.

Target Completion Date: December 2022

Text of Appendix II: Comments from the Department of Veterans Affairs

Ms. Sharon M. Silas Director

Health Care

U.S. Government Accountability Office

441 G Street, NW Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (YA) has reviewed the Government Accountability Office (GAO) draft report: COMMUNITY LIVING CENTERS: VA Needs to Strengthen Its Approach for Addressing Resident Complaints (GAO-22-105142).

The enclosure contains technical comments and the actions to be taken to address the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Tanya J. Bradsher Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to the Government Accountability Office (GAO) Draft Report, COMMUNITY LIVING CENTERS: VA Needs to Strengthen Its Approach for Addressing Resident Complaints (GAO-22-105142)

Recommendation 1: The Department of Veterans Affairs Under Secretary for Health should require through national policy that complaints about CLC care be documented for tracking and resolution.

VA Response: Concur. The Veterans Health Administration (VHA), Office of Geriatrics and Extended Care (GEC), will implement VHA Directive 1003.04, VHA Patient Advocacy, in VA Community Living Centers (CLC) for documenting complaints for tracking and resolution within the Patient Advocate Tracking System (PATS). CLC Veterans Integrated Service Networks (VISN) and facility leadership will be provided the necessary access. In order to have a clear understanding of the system requirements, all new participants must complete new user training on PATS provided by their local Patient Advocate Office. GEC will collaborate with the VHA Office of Patient Advocacy (OPA) to provide guidance to the field on implementing this recommendation.

Target Completion Date: June 2022

Recommendation 2: The Department of Veterans Affairs Under Secretary for Health should establish a process for monitoring complaints about CLC care to ensure that staff are following VA policy in documenting, resolving, and elevating CLC complaints.

VA Response: Concur. GEC and OPA will collaborate to create a standardized report structure utilizing PATS data. This report will be provided to GEC facility-based care and sent to the VISN Rehabilitation and Extended Care Integrated Clinical Community leads for review to ensure complaints are being documented, addressed and resolved.

Target Completion Date: April 2022

Recommendation 3: The Department of Veterans Affairs Under Secretary for Health should clarify guidance to specify when complaints about CLC care should be elevated beyond the VAMC to GEC through issue briefs.

VA Response: Concur. GEC will create a standard operating procedure (SOP) clarifying guidance on when to elevate CLC complaints about care to the GEC office through the Issue Brief process. The SOP will be disseminated to CLC VISN and facility leadership.

Target Completion Date: June 2022

Recommendation 4: The Department of Veterans Affairs Under Secretary for Health should develop a centralized source to contain comprehensive information on complaints about CLC care and that allows VA to distinguish complaints about CLC care from care provided in other settings – such as by

modifying PATS to consistently capture complaints about CLC care – and should use the information to inform its oversight of CLCs.

VA Response: Concur. At present, CLC staff are able to obtain access to PATS to meet the need for a centralized source that contains comprehensive information on complaints about CLC care. To support this, GEC will update VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers, to reference VHA Directive 1003.04, VHA Patient Advocacy, as the standard process for documenting complaints for tracking and resolution within PATS. This will create the consistency referenced in this recommendation. In order to distinguish complaints about CLC care from other settings of long-term care, OPA will collaborate with GEC and work with the PATS development team to break the broader category down into more specific settings. This work will ensure patient complaint data can be used to inform oversight activities of CLCs at all levels.

Target Completion Date: June 2022

Recommendation 5: The Department of Veterans Affairs Under Secretary for Health should revise its rights and responsibilities documents to ensure information provided is accurate for complaints about care at CLCs, and that documents contain information about what residents and their representatives can expect after filing a complaint.

VA Response: Concur. OPA has initiated the revision process for the VA Patient Rights and Responsibilities document. The revision process includes reviewing current information, updating out-of-date information and including new information (such as the overall complaint process through closure) provided from other VHA program offices based on various mandates and requirements. GEC will collaborate with OPA to ensure all critical elements are captured. Once the revision is complete, the updated version must go through the Federal regulations process for review, public comment, approval and publication.

Target Completion Date: December 2022

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Sharon M. Silas at (202) 512-7114 or silass@gao.gov

Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director), Summar C. Corley, and A. Elizabeth Dobrenz made key contributions to this report. Also contributing were Laurie Pachter, Dhara Patel, Ethiene Salgado-Rodriguez, Brienne Tierney, Cathleen H. Whitmore, and Jennifer Whitworth.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/about/what-gao-does/fraudnet

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

A. Nicole Clowers, Managing Director, ClowersA@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

Stephen J. Sanford, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548