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Almost 30 Violations Not "Minor," Says Patients' Rights Advocate Group

Fayetteville Veterans Home Should Be Model of Nursing Home Care According to Arkansas Advocates for Nursing Home Residents

FAYETTEVILLE, AR (Dec. 13, 2011) ï A Dec. 11, 2011 article in the *Northwest Arkansas Times* reporting on the state of violations at the Department of Veteransô Affairs Fayetteville Veterans Home has a patients-rights advocate group enraged.

Martha Deaver, President of Arkansas Advocates for Nursing Home Residents, a nonprofit organization focused on patientsô rights and reform in nursing homes in the state, said the 22 violations reported in March as well as the five violations noted in June of this year is more than two times the average of nursing homes in the state.

ñThis is completely unacceptable, and I find it appalling that the administrator of the facility trivialized the violations,ò Deaver said. ñAnother nursing home administrator in the area said the report was ôbad, but not awful.ô The residents in this facility are men and women who put their very lives on the line for every one of us in this country, and the best we can offer them now is ôbad, but not awfulõ? The administrators should be ashamed. As the only veteransô nursing home owned by the State of Arkansas, it should be setting the standard for care.ò

In addition to the violations outlined in the reports, Deaver says she has uncovered other abuses at the Fayetteville Veteransô Home, including failure to properly treat wounds, dispense medications according to federal law and perform background checks on 10 employees. The violation reports also observed the facilityôs nurses were not following Arkansas State Board of Nursing standards or guidelines.

ñThe administrator of the Fayetteville Veterans Home called the following violations ôminor,ò Deaver said. ñShe also acknowledged that *'to someone reading this report out of the blue, these things sound shocking, yes. But there are many variables to each of these things, and the answer is monitoring and observation.'* I have worked with nursing home residents and facilities for decades and read reports just like these so I have the context in which these violations were reported, and I have never read anything as horrific as this one.ò

A list of the violations is outlined on the next page. For more information about Arkansas Advocates for Nursing Home Residentôs response to this story, please contact Martha Deaver at 501-450-9619/501-269-4626 or e-mail MarthaDeaver@aanhr.org or visit www.aanhr.org.

eville Veterans Home Cited for:

- failure to do wound care,
- failure to ensure pain management for wound treatments,
- failure to ensure wounds were assessed properly,
- failure to dispense medications according to federal law - 26.3 percent medication error rate when federal law requires a below five percent error rate,
- failure to keep residents free of significant medication errors,
- failure to insure diabetic residents received the proper dose of insulin,
- failure to treat bedsores,
- failure to supply enough food for the veteran,
- failure to do background checks on 10 employees,
- failure to follow doctorôs orders in dealing with catheters,
- failure to clean catheter residents properly,
- failure to follow doctorôs orders in dealing with oxygen,
- failure to insure residents with oxygen in use had current physician order for oxygen therapy,
- failure to ensure a licensed nurse monitored administration of updraft treatments,
- failure to ensure residents were given oxygen therapy according to doctor's orders,
- failure to ensure doctor's orders and care plans were accurate and complete,
- failure to give diabetics a diabetic diet,
- failure to give doctor ordered pain medication to an amputee before doing wound care,
- failure to have a system in place for dispensing medications for all residents,
- failure to treat the veterans with dignity and respect,
- failure to investigate allegations of abuse,
- failure to protect confidential medical records,
- failure to follow doctorôs orders when dispensing medications,
- failure to follow doctorôs orders in dealing with catheters,
- failure to contact doctor when bedsores deteriorated,
- failure to ensure medications were labeled and stored in accordance with state law,
- failure to meet pharmaceutical standards and guidelines, and
- failure to follow Arkansas State Board of Nursing standards and practices.

In all, 15 pages of poor infection control also are noted in the reports.
*Surveys are included in this correspondence.