GAO@100 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.