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STATE OF WISCONSIN
Legislative Audit Bureau

REPORT HIGHLIGHTS

Report 17-14
August 2017

State Auditor
Joe Chrisman

Wisconsin Veterans Home at King

The Wisconsin Veterans Home at King (King), located in Waupaca County, is operated by the Department of Veterans Affairs (DVA). DVA also operates the Wisconsin Veterans Home at Union Grove in Racine County, and it contracts for the operation of the Wisconsin Veterans Home at Chippewa Falls in Chippewa County. King provides care to eligible veterans, their spouses, surviving spouses, and the parents of veterans. In 2016, King provided skilled nursing care to an average of 685 veterans and their spouses each day.

In response to concerns about the physical conditions and care provided to residents at King, as well as questions about staffing and the transfer of revenue from King to the Veterans Trust Fund and other accounts, the Joint Legislative Audit Committee directed us to conduct an evaluation of King. Report 17-8 included our analyses of revenues, expenditures, and capital projects. This report is the second phase of that evaluation and includes analyses of:

- changes in resident care needs over time;
- staffing issues, including the use of overtime;
- compliance with state and federal nursing facility requirements;
- complaints made by residents, employees, and others; and
- the opinions of employees regarding the provision of resident care, working conditions, and employee morale.

Overall, we found that the care needs of residents at King increased from 2007 through 2016 based on several measures, such as the extent to which they needed assistance with dressing and eating. Although King was authorized more than 80 additional nursing positions by 2013 Wisconsin Act 20, it has not been able to keep many of the additional positions filled, and in fiscal year (FY) 2015-16, King's use of overtime for nursing staff exceeded the amount it used immediately prior to the creation of the additional positions.

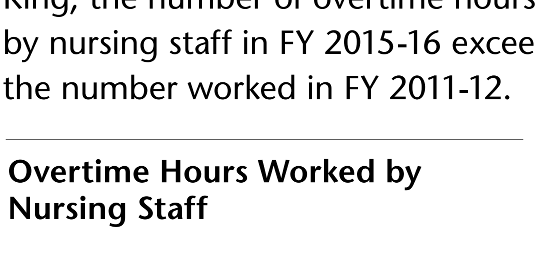
From 2012 through 2016, we found that, on average, the Department of Health Services (DHS) issued King fewer citations for violations of federal nursing facility regulations than it issued to other skilled nursing facilities in Wisconsin. Similarly, based on a federal five-star rating system, we found that the combined overall rating for King's four residence facilities exceeded the average ratings for other skilled nursing facilities in Wisconsin. In addition, those King employees who responded to our survey generally indicated that the overall care provided at King was good, but raised concerns with issues such as the manner in which overtime is assigned, employee morale, and management responsiveness to employee concerns.

Staffing

The number of full-time equivalent (FTE) positions that King was authorized increased from 737.8 FTE positions in FY 2011-12 to 884.3 FTE positions in FY 2015-16, or by 19.9 percent. The largest increase occurred from FY 2012-13 to FY 2013-14, when 2013 Wisconsin Act 20 authorized the creation of an additional 110.6 FTE positions for King, including an additional 82.6 FTE nursing positions. However, King has not been able to keep many of the additional positions filled, and the number of vacant nursing positions increased from 33.0 FTE positions in June 2012 to 46.8 FTE positions in June 2016.

To help address its staffing needs, King relies on extra time worked by part-time employees and overtime worked by full- and part-time employees. Overtime worked by nursing staff declined from 64,300 hours in FY 2011-12 to 36,800 hours in FY 2013-14. However, the amount of overtime worked by nursing staff at King has grown since then. Despite DVA being granted the authority in July 2013 to create an additional 82.6 FTE nursing positions at King, the number of overtime hours worked by nursing staff in FY 2015-16 exceeded the number worked in FY 2011-12.

Overtime Hours Worked by Nursing Staff



Compliance with State and Federal Regulations

King's nursing facilities are overseen by the federal Department of Veterans Affairs and DHS, which also performs inspections on behalf of the federal Centers for Medicare & Medicaid Services (CMS).

The federal Department of Veterans Affairs conducts annual inspections to ensure compliance with care and service requirements. From 2012 through 2016, it issued King a total of 15 citations as part of its annual inspection process. In addition, it conducted an additional inspection of King in January 2017 and issued five citations, including two related to an incident in which a resident fell from his bed and was seriously injured.

From 2012 through 2016, DHS issued King a total of 184 citations. One was in the highest severity category, for which King was assessed a civil penalty of $76,900 in June 2016. We compared the citations DHS issued to King with those it issued to other skilled nursing facilities. King's four residence halls averaged 9.2 citations per year during this period, which was less than the average number DHS issued to other Wisconsin Veterans Homes, to other skilled nursing facilities in DHS's Northeastern Region with 100 or more licensed beds, or to all skilled nursing facilities statewide.

Addressing Complaints

We reviewed available information on complaints received by several entities. From 2012 through 2016, King received 80 formal complaints from residents or their representatives. The most common type of complaint involved resident care, such as dissatisfaction with caregiver attitudes and concerns regarding the services provided, which accounted for 37 (46.3 percent) of the 80 complaints it received. When King determined action was needed, the most common action taken was re-education of employees, which occurred for 22 of the complaints.

From 2012 through 2016, the Board on Aging and Long Term Care opened 90 complaint cases related to King residents, but not all involved concerns about King. The largest number of cases involved resident rights, such as the right to be included in care decisions and the right of unrestricted mobility, which accounted for 23 (25.6 percent) of the cases. Of the 90 complaint cases opened, it determined 59 (65.6 percent) were accurate as reported.

From April 2015 through April 2017, the Legislative Audit Bureau received a total of 47 complaints regarding King. The largest category involved staff-related issues, mostly concerning overtime, which accounted for 16 complaints. Administrative issues, which included topics such as hiring and contracting practices, was the second-largest category and accounted for 15 complaints. Of the 47 complaints we received, we substantiated 13 (27.7 percent), including 10 related to overtime.

Employee Opinions and Satisfaction

We conducted an anonymous survey of all King employees in November 2016. Of the 956 employees to whom we sent our survey, 449 (47.0 percent) completed at least a portion of it. Among respondents providing direct care or interacting directly with residents, 97.5 percent described the overall care provided to residents at King as "good" or "very good," and 95.7 percent "agree" or "strongly agree" that residents are treated with respect. However, 86.1 percent of respondents indicated that they "disagree" or "strongly disagree" that King has sufficient resident care staff to handle the workload.

Among all King employees who responded to our survey question, 63.8 percent "disagree" or "strongly disagree" that management at King actively seeks input from employees on how operations and resident care can be improved, and 57.0 percent "disagree" or "strongly disagree" that positions at King are filled through a fair and transparent process. In addition, while 66.0 percent of respondents indicated they are "satisfied" or "very satisfied" with King as a place of employment, 75.1 percent indicated the overall morale of employees at King was "poor" or "very poor."

Recommendations

We include recommendations for DVA to report to the Joint Legislative Audit Committee by January 8, 2018, on:

☑ its efforts to work with DHS to ensure King is able to benefit from a federally funded initiative to recruit and train nursing assistants and that they receive the retention bonuses for which they are eligible (*p. 42*);

☑ the vacancy rates and overtime hours of registered nurses, licensed practical nurses, and nursing assistants; and whether it intends to pursue options to further reduce the number of residents it serves (*p. 42*);

☑ its review of King's informal processes for addressing resident concerns, fully documenting actions taken in response to formal complaints, and improving procedures with respect to its suggestion boxes (*p. 65*);

☑ how it is addressing concerns expressed by residents, such as improving access to doctors and nurse practitioners and improving communication regarding changes to residents' care plans (*p. 71*);

☑ its assessment of, and plans to address, the current training needs of employees at King who provide direct care or interact directly with residents (*p. 79*);

☑ its efforts to ensure adequate steps are taken to encourage King employees to routinely report concerns regarding residents, including occurrences of resident abuse, neglect, and misappropriation of resident property (*p. 83*);

☑ its efforts to ensure appropriate and adequate training is provided to all supervisors and managers in encouraging and supporting employees in reporting these occurrences, and ensuring that all supervisors and managers are aware of the importance of complying with state and federal laws prohibiting retaliation against employees (*p. 83*); and

☑ its efforts to address issues of employee morale and the perception that King's hiring practices are not fair and transparent (*p. 88*).

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Legislative Audit Bureau
www.legis.wisconsin.gov/lab

(608) 266-2818

22 East Mifflin Street
Suite 500
Madison, Wisconsin 53703