

6/13/16
Chair of Oversight
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OAG

Office of the Auditor General

Report Summary

Performance Audit

Report Number:
511-0170-15

Grand Rapids Home for Veterans

Michigan Veterans Affairs Agency

Released:
February 2016

Department of Military and Veterans Affairs

The Grand Rapids Home for Veterans provides nursing care and domiciliary services to military veterans and widows, widowers, spouses, former spouses, and parents of State veterans. The mission of the Home is to provide compassionate, quality, interdisciplinary care for the members to achieve their highest potential of independence, self-worth, wellness, and dignity. As of August 31, 2015, the Home had 389 members receiving nursing care, 43 members residing in the domiciliary units, and 601 State and contract employees. The Home expended \$49.1 million for fiscal year 2015 (\$14.5 million from State funding, \$19.5 million from federal funding, and \$15.1 million from member assessments and private donations).

| Audit Objective | | | Conclusion |
|--|--------------------|----------------------|-----------------------------|
| Objective #1: To assess the sufficiency of the Home's provision of member care services. | | | Not sufficient |
| Findings Related to This Audit Objective | Material Condition | Reportable Condition | Agency Preliminary Response |
| We confirmed via surveillance video that 43% of the member location checks and 33% of the fall alarm checks in our samples did not occur. However, the Home provided documentation as if the checks occurred 100% and 96% of the time, respectively. Further, supervisory staff certified 17 of the 25 location check sheets for checks that did not actually occur (<u>Finding #1</u>). | X | | Agrees |
| The contractor did not meet the required staffing needs 81% of the time during 4 sampled months. Shortages were as much as 22 staff on a given day (<u>Finding #2</u>). | X | | Agrees |
| The Home did not properly administer nonnarcotic pharmaceuticals prescribed to members, causing insurance reimbursement inefficiencies and potential quality of care issues. During the 23-month period reviewed, 39% of the nonnarcotic prescriptions were refilled late or more than 5 days early (<u>Finding #3</u>). | X | | Agrees |
| The Home did not effectively develop, execute, and monitor all comprehensive care plans. The Home did not timely complete 25% of the Minimum Data Set assessments and did not timely and sufficiently complete 25% and 59% of the comprehensive care plans, respectively (<u>Finding #4</u>). | | X | Agrees |

| Audit Objective | | | Conclusion |
|---|--------------------|----------------------|-----------------------------|
| Objective #2: To assess the effectiveness of the Home's administration of pharmaceuticals. | | | Moderately effective |
| Findings Related to This Audit Objective | Material Condition | Reportable Condition | Agency Preliminary Response |
| The Home had not established adequate controls over its nonnarcotic pharmaceuticals, valued at an estimated \$5.2 million for the 23-month period reviewed, to ensure that they were properly accounted for and protected against loss and misuse (Finding #5). | X | | Agrees |
| The Home did not bill members' insurance companies for all eligible prescriptions dispensed and did not follow up prescriptions billed to and rejected by members' insurance companies. The Home is at risk of losing eligible insurance reimbursements of up to \$883,700 for the 23-month period reviewed (Finding #6). | | X | Agrees |

| Audit Objective | | | Conclusion |
|---|--------------------|----------------------|-----------------------------|
| Objective #3: To assess the effectiveness of the Home's management of complaints and incidents regarding member care. | | | Moderately effective |
| Findings Related to This Audit Objective | Material Condition | Reportable Condition | Agency Preliminary Response |
| The Home did not track or properly investigate or respond to member complaints, including allegations of abuse and neglect. The Home forwarded all 91 complaints documented during the 23-month period reviewed to the manager of the department against whom the complaints were filed and did not forward 9 of 10 complaints alleging abuse or neglect to the director of nursing (Finding #7). | X | | Agrees |

| Audit Objective | | | Conclusion |
|---|--------------------|----------------------|-----------------------------|
| Objective #4: To assess the sufficiency of the Home's controls over collection of assessments, donations, and member funds. | | | Sufficient with exceptions |
| Findings Related to This Audit Objective | Material Condition | Reportable Condition | Agency Preliminary Response |
| The Home had not implemented sufficient controls over the disbursement of deceased or discharged members' funds and may not have disbursed up to \$167,700 of members' funds in a timely manner (Finding #8). | | X | Agrees |
| The Home did not effectively document and resolve past due member assessments, leaving at least \$248,800 of past due member assessments outstanding for up to 3 years (Finding #9). | | X | Agrees |

A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: www.audgen.michigan.gov

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**Auditor General Report Recommendation
by the
House Oversight and Ethics Committee**

The Committee agrees with the findings in the Auditor General's report on the Grand Rapids Home for Veterans. There are areas noted in this report that indicate a need for improvement and further review. Further review should include, but not be limited to, the following:

1. The establishment of an independent ombudsman's office. This individual or individuals should be available on a full time basis to respond to complaints or other grievances. In addition, they should not report to an individual in a position of power or control at the Grand Rapids Home for Veterans.
2. The establishment of a rigorous protocol to address complaints and appeals of complaints. The Appropriations Committee should consider inclusion of a reporting requirement detailing the complaint protocol, its implementation, and successes or failures.
3. The alteration of state law to require continuing inspections of the Grand Rapids Home for Veterans. Though the Department disclosed pursuance of Centers for Medicare & Medicaid Services (CMS) licensing, there is not currently any minimum requirement that the Home be held to the same standard as other nursing homes in the state. This is of particular concern if CMS licensing is either not attained or were to be subsequently dropped. Licensing and inspection of the Home would ensure the statewide standards are being upheld. These standards and inspections could be similar to those required by CMS but ought to be housed in another department such as LARA. The regular standards for state nursing homes may not be entirely applicable to the Home as it is not simply a nursing home.
4. The review of the structure, role and makeup of the Board of Managers. Further discussion on the proper role of the Board of Managers could assist in resolving governance related issues. Concerns have been voiced regarding their proper role in the oversight of the Home.
5. The review of the budgeting process. To ensure that funds are appropriated and utilized in the manner intended by the legislature, a return to the line item formatting should be implemented. The auditing process has repeatedly shown a failure to follow through with state budget plans for appropriated funding. Specifically, the two most recent audits included evidence of funding allocated and not used to purchase Pyxis pharmaceutical machines during those specific budget cycles.
6. The program currently utilized for security cameras should be reviewed to allow for the flexibility of the Home to save available footage into a portable electronic storage device. Evidence has been presented that suggests the footage is unavailable for offsite review or verification, resulting in a failure for the legislature or any other legally appropriate entity to review the data anywhere but at

the Home. Further, this inability to offload data could ultimately inhibit the Home's ability to save its own footage and protect itself from liability. The Appropriations Committee could consider assisting in the exploration of new security camera technology and a reporting requirement ensuring implementation of proper technology.

7. The review of contracting and employment overall. Several consecutive audits have indicated both the apparent inability to enforce a contract as well as obvious difficulties in dealing with discipline or removal of employees, both state civil service and contracted, who were either deceptive, negligent, or indifferent. Further, a discussion should be had regarding competitive, marketplace wages to promote and attract the most qualified full cohort of employees.
8. The review of protocols surrounding the final handling of the bodies of deceased members. Testimony indicated some inconsistencies about when autopsies are performed. While autopsies are certainly not always necessary, there ought to be a transparent process applied. The Appropriations Committee could consider requiring a reporting requirement to ensure implementation of a transparent, family oriented, respectful practice.
9. A full review of the Veterans Home model in this state. It may be wise for the policy committee, with the Department of Military and Veterans Affairs, to create a special work group to explore a complete overhaul of the system to make sure it has not become archaic. This review might include finding ways to provide a more comprehensive model for providing housing and medical care for veterans to more diverse levels of need.

Following diligent assessment by the House Military and Veterans Affairs Committee and the House Appropriations Committee, the House Oversight and Ethics will request a formal follow up audit of the Grand Rapids Home for Veterans. Committee members agree that the role of the Auditor General is integral to identifying areas of concern and to effectuate accountability measures. The Committee recommends a six month and twelve month follow up review, as well as a formal audit to be completed by August 2018.

The Oversight and Ethics Committee will provide copies of this report to the Attorney General's office. Testimony indicated a number of very troubling allegations, including the misuse of certain powerful drugs, abuse and neglect of home members, and other potentially serious malfeasance. It is the opinion of the Oversight and Ethics Committee that the Attorney General is the proper individual to further review those allegations.

The Oversight and Ethics Committee has diligently performed its duty under House Rule 36 and submits this report to the House Appropriations Committee and the House Military and Veterans Affairs Committee.

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SUBSTITUTE FOR
HOUSE BILL NO. 5639

A bill to amend 1885 PA 152, entitled

"An act to authorize the establishment of facilities for former members of the armed forces of the United States in the state of Michigan; to create funds; and to provide for the promulgation of rules,"

(MCL 36.1 to 36.12) by adding section 9.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 SEC. 9. (1) NO LATER THAN JANUARY 1, APRIL 1, JULY 1, AND
2 OCTOBER 1 OF EACH YEAR, THE MICHIGAN VETERANS AFFAIRS AGENCY, ITS
3 SUCCESSOR AGENCY, OR THE DEPARTMENT OF MILITARY AND VETERANS
4 AFFAIRS SHALL REPORT IN WRITING ALL OF THE FOLLOWING INFORMATION
5 CONCERNING ANY STATE VETERANS' FACILITY TO THE GOVERNOR, THE SENATE
6 AND HOUSE COMMITTEES ON VETERANS AFFAIRS, AND THE SENATE AND HOUSE
7 APPROPRIATIONS SUBCOMMITTEES FOR THE DEPARTMENT OF MILITARY AND
8 VETERANS AFFAIRS:

9 (A) STAFFING LEVELS AND THE EXTENT TO WHICH STAFFING LEVELS DO

1 OR DO NOT MEET INDUSTRY STANDARDS.

2 (B) NUMBER OF PATIENT COMPLAINTS, AVERAGE TIME TO REVIEW A
3 COMPLAINT AND RESPOND, AND RESPONSE TO EACH COMPLAINT.

4 (C) TIMELINESS OF DISTRIBUTION OF PHARMACEUTICAL DRUGS.

5 (D) SECURITY PROVIDED FOR PHARMACEUTICAL DRUGS IN THE
6 FACILITY, INCLUDING THE TITLE OF THE INDIVIDUALS PROVIDING THE
7 SECURITY.

8 (E) HOW PATIENT MONEY IS ACCOUNTED FOR, INCLUDING THE NAME AND
9 TITLE OF THE INDIVIDUAL WHO SUPERVISES PATIENT SPENDING ACCOUNTS.

10 (F) NUMBER OF FACILITY RESIDENT DEATHS THAT OCCURRED SINCE THE
11 MOST RECENT REPORT.

12 (2) THE DEPARTMENT OF MILITARY AND VETERANS AFFAIRS SHALL
13 PLACE THE REPORTS REQUIRED UNDER SUBSECTION (1) ON ITS PUBLIC
14 WEBSITE IN A PROMINENT AND CONSPICUOUS MANNER.

15 Enacting section 1. This amendatory act takes effect 90 days
16 after the date it is enacted into law.

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SUBSTITUTE FOR
SENATE BILL NO. 809

A bill to create the office of the Michigan veterans' facility ombudsman; and to prescribe the powers and duties of the office, the ombudsman, the legislative council, and the department of military and veterans affairs.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 1. As used in this act:

2 (a) "Administrative act" includes an action, omission,
3 decision, recommendation, practice, or other procedure of the
4 department.

5 (b) "Complainant" means a resident veteran, family member of a
6 resident veteran, legal guardian or individual with power of
7 attorney for a resident veteran, or legislator who files a
8 complaint under section 4.

1 (c) "Council" means the legislative council established under
2 section 15 of article IV of the state constitution of 1963.

3 (d) "Department" means the department of military and veterans
4 affairs.

5 (e) "Legislator" means a member of the senate or the house of
6 representatives of this state.

7 (f) "Michigan veterans' facility" or "facility" means a
8 Michigan veterans' facility established under 1885 PA 152, MCL 36.1
9 to 36.12.

10 (g) "Office" means the office of the Michigan veterans'
11 facility ombudsman created under this act.

12 (h) "Ombudsman" means the Michigan veterans' facility
13 ombudsman.

14 (i) "Resident veteran" means a veteran who is a resident of a
15 Michigan veterans' facility or an individual who is a resident of a
16 Michigan veterans' facility by virtue of the individual's
17 relationship with a veteran.

18 (j) "Veteran" means that term as defined in section 2a of 1885
19 PA 152, MCL 36.2a.

20 Sec. 2. (1) The office of the Michigan veterans' facility
21 ombudsman is created within the legislative council.

22 (2) The principal executive officer of the office is the
23 Michigan veterans' facility ombudsman, who shall be appointed by
24 and serve at the pleasure of the council.

25 Sec. 3. The council shall establish procedures for approving
26 the budget of the office, for expending funds of the office, and
27 for the employment of personnel for the office.

1 Sec. 4. (1) The ombudsman may commence an investigation upon
2 his or her own initiative or upon receipt of a complaint from a
3 complainant concerning an administrative act, medical treatment of
4 a resident veteran, or a condition existing at a facility that
5 poses a significant health or safety issue for which there is no
6 effective administrative remedy or is alleged to be contrary to law
7 or departmental policy. The ombudsman may interview any of the
8 following individuals whom the ombudsman considers necessary in an
9 investigation:

10 (a) An individual employed by or retained under contract by
11 the department.

12 (b) An individual employed by or retained under contract by a
13 private contractor that operates a facility that houses resident
14 veterans.

15 (2) Subject to approval of the council, the ombudsman shall
16 establish procedures for receiving and processing complaints,
17 conducting investigations, holding hearings, and reporting the
18 findings resulting from the investigations.

19 Sec. 5. (1) Upon request and without the requirement of any
20 release, the facility shall provide access to all information, and
21 the ombudsman shall be given access to all information, records,
22 and documents in the possession of the department or a facility
23 that the ombudsman deems necessary in an investigation, including,
24 but not limited to, resident veteran medical health records,
25 resident veteran mental health records, and resident veteran
26 mortality and morbidity records.

27 (2) Upon request and without notice, the ombudsman shall be

1 granted entrance to inspect at any time any Michigan veterans'
2 facility.

3 (3) The ombudsman may hold informal hearings and may request
4 that any person appear before the ombudsman or at a hearing and
5 give testimony or produce documentary or other evidence that the
6 ombudsman deems relevant to an investigation.

7 Sec. 6. (1) The ombudsman shall advise a complainant to pursue
8 all administrative remedies available to the complainant. The
9 ombudsman may request and shall receive from the department or from
10 a facility a progress report concerning the administrative
11 processing of a complaint. After administrative action on a
12 complaint, the ombudsman may conduct further investigation on the
13 request of a complainant or on his or her own initiative.

14 (2) The ombudsman is not required to conduct an investigation
15 or hold a hearing on a complaint brought before the ombudsman.

16 Sec. 7. Upon receiving a complaint under section 4 and
17 deciding to investigate the complaint, within 10 business days the
18 ombudsman shall notify the complainant, the resident veteran or
19 resident veterans affected, and the department. If the ombudsman
20 declines to investigate, the ombudsman shall notify the complainant
21 within 10 business days, in writing, and inform the resident
22 veteran or resident veterans affected of the reasons for the
23 ombudsman's decision.

24 Sec. 8. Upon request of the ombudsman, the council may hold a
25 hearing. The council may administer oaths, subpoena witnesses, and
26 examine the books and records of the department or of a facility in
27 a matter that is or was a proper subject of investigation by the

1 ombudsman.

2 Sec. 9. (1) Correspondence between the ombudsman and a
3 complainant is confidential and is privileged communication.

4 (2) A report prepared and recommendations made by the
5 ombudsman and submitted to the council under section 10 and any
6 record of the ombudsman are exempt from disclosure under the
7 freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

8 (3) All records, reports, and communications relied upon,
9 referenced, or prepared are subject to the privacy provisions of
10 the health insurance portability and accountability act of 1996,
11 Public Law 104-191, and regulations promulgated under that act, 45
12 CFR parts 160 and 164.

13 Sec. 10. (1) The ombudsman shall prepare and submit a report
14 of the findings of an investigation and make recommendations to the
15 council within 10 business days after completing the investigation
16 if the ombudsman finds any of the following:

- 17 (a) A matter that should be considered by the department.
18 (b) An administrative act that should be modified or canceled.
19 (c) A statute or rule that should be altered.
20 (d) Administrative acts for which justification is necessary.
21 (e) Significant resident veteran health and safety issues.
22 (f) Any other significant concerns.

23 (2) Subject to section 11, the council shall forward the
24 report prepared and submitted under this section to the department,
25 the resident veteran or resident veterans affected, and to the
26 complainant who requested the report.

27 Sec. 11. Before submitting a report with a conclusion or

1 recommendation that expressly or by implication criticizes a person
2 or facility or the department, the ombudsman shall consult with
3 that person or facility or the department. When publishing an
4 opinion adverse to a person or facility or the department, the
5 ombudsman shall include in that publication a statement of
6 reasonable length made to the ombudsman by that person or facility
7 or the department in defense or mitigation of the finding if that
8 statement is provided within a reasonable period of time as
9 determined by the council. The ombudsman may request to be notified
10 by a person or facility or the department, within a specified time,
11 of any action taken on any recommendation presented. The ombudsman
12 shall notify the complainant of the actions taken by the person or
13 facility or by the department.

14 Sec. 12. The ombudsman shall submit to the council, the board
15 of managers, and the legislature a semiannual report on the conduct
16 of the office. A report under this section shall include all of the
17 following information for each Michigan veterans' facility during
18 the preceding 6 months, at a minimum:

19 (a) The number of complaints received.

20 (b) The number of complaints concerning each of the following
21 categories:

22 (i) The modification or cancellation of, or justification for,
23 an administrative act.

24 (ii) A statute or rule.

25 (iii) Significant veteran health issues.

26 (iv) Significant veteran safety issues.

27 (c) The number of complaints resulting in the initiation of an

1 investigation.

2 (d) The number of investigations initiated by the ombudsman.

3 (e) The number of hearings.

4 (f) The number of reports of findings issued.

5 Sec. 13. (1) A resident veteran shall not be penalized in any
6 way by a person or facility or the department as a result of filing
7 a complaint, communicating a complaint to a legislator, or
8 cooperating with the ombudsman in investigating a complaint.

9 (2) A person or facility or the department shall not hinder
10 the lawful actions of the ombudsman or employees of the office or
11 willfully refuse to comply with any lawful demand of the office.

12 Sec. 14. The authority granted the ombudsman under this act is
13 in addition to the authority granted under any other act or rule
14 under which a remedy or right of appeal or objection is provided
15 for a complainant, or any procedure provided for the inquiry into
16 or investigation of any matter concerning a facility. The authority
17 granted the ombudsman under this act shall not be construed to
18 limit or affect any other remedy or right of appeal or objection
19 and shall not be deemed to be exclusionary.

20 Enacting section 1. This act takes effect 90 days after the
21 date it is enacted into law.

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| 1 | House automated data processing..... | 2,200,000 |
| 2 | House fiscal agency..... | <u>3,779,600</u> |
| 3 | GROSS APPROPRIATION..... | \$ 99,878,800 |
| 4 | Appropriated from: | |
| 5 | State general fund/general purpose..... | \$ 99,878,800 |
| 6 | (3) LEGISLATIVE COUNCIL | |
| 7 | Legislative council..... | \$ 11,981,200 |
| 8 | Legislative service bureau automated data processing . | 1,426,600 |
| 9 | Worker's compensation..... | 151,400 |
| 10 | National association dues..... | 454,700 |
| 11 | Legislative corrections ombudsman..... | 729,200 |
| 12 | Michigan veterans facility ombudsman..... | <u>150,000</u> |
| 13 | GROSS APPROPRIATION..... | \$ 14,893,100 |
| 14 | Appropriated from: | |
| 15 | Special revenue funds: | |
| 16 | Private - gifts and bequests revenues..... | 400,000 |
| 17 | State general fund/general purpose..... | \$ 14,493,100 |
| 18 | (4) LEGISLATIVE RETIREMENT SYSTEM | |
| 19 | General nonretirement expenses..... | \$ <u>4,962,800</u> |
| 20 | GROSS APPROPRIATION..... | \$ 4,962,800 |
| 21 | Appropriated from: | |
| 22 | Special revenue funds: | |
| 23 | Court fees..... | 1,154,600 |
| 24 | State general fund/general purpose..... | \$ 3,808,200 |
| 25 | (5) PROPERTY MANAGEMENT | |
| 26 | Cora Anderson Building..... | \$ 11,426,700 |
| 27 | Farnum Building and other properties..... | <u>2,851,800</u> |

