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Vulnerable Veterans

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Lawmakers ask for review of troubled Wisc. veterans home

By John Diedrich, Milwaukee Journal Sentinel

Federal lawmakers from both political parties have asked for an investigation and more oversight of the troubled state veterans home in Union Grove and a state senator is calling for a hearing on the facility.

Democratic Gov. Tony Evers, whose administration oversees the nursing home, said in an interview Thursday he welcomes additional oversight and will cooperate with any federal investigation.

"If you get fined, it is because you've done something wrong. And in this case, we have been unable to fulfill our duties to these great veterans, by having adequate staff and adequately trained staff," he said.

"We have to do a better job. Obviously, we're concerned. Our veterans served our country with great honor and dignity, and they deserve that."

The calls for more oversight and accountability come in the wake of a Milwaukee Journal Sentinel investigation last week that revealed a pattern of violations at the Union Grove veterans home reaching back five years.

Union Grove ranked in the top five out of 117 federally certified state veterans facilities for having the most violations and fines, the Journal Sentinel found.

The Union Grove facility, one of three veterans homes in the state, was cited for 62 violations and received fines totaling

$250,000 since 2017, records show. Federal regulators are still reviewing the latest five violations from March and considering a possible additional fine.

The violations include medication mistakes, failing to keep patients hydrated, not investigating patient abuse, infection control, poor food and filthy conditions. Residents and family members said care has steadily declined as leadership frequently changed and the home struggles with chronic understaffing.

Union Grove and other veterans homes like it are run by states, but they are funded with federal dollars.

U.S. Sen. Tammy Baldwin, D-Wis., and U.S. Rep. Bryan Steil, R-Wis., separately sent letters to Denis McDonough, secretary of Veterans Affairs. Steil also included Chiquita Brooks-LaSure, administrator of the Centers for Medicaid and Medicare Services.

In a statement Thursday, U.S. Sen. Ron Johnson, R-Wis., said the findings of poor care and abuse at Union Grove "must be fully investigated."

In her letter, Baldwin asked the VA to review conditions at Union Grove and identify ways the facility could be better held accountable. She noted the state has been trying to improve recruitment and retention of staff since 2019.

"Despite these efforts, complaints regarding treatment of residents highlight the need for additional oversight and inspections by the VA," Baldwin wrote.

Steil, whose district includes the Union Grove facility, said he wrote the letter to make sure officials in Washington know about these problems and seek solutions.

"My work is to now get the eyes and ears and the attention of decision-makers in Washington so that we can hold folks accountable. But also and equally importantly, make sure that a situation like this never happens again, anywhere in the United States," Steil said.

State Sen. Van Wanggaard, R-Racine, is calling for hearings on issues highlighted in the Journal Sentinel investigation. He also plans to seek a state investigation or audit into the home.

"We have got to get this moving forward as quickly as we can because there is no excuse for this," Wanggaard said in an interview.

State Sen. Eric Wimberger, R-Green Bay, chairman of the Committee on Veterans and Military Affairs and Constitution and Federalism, where a hearing would be held, called the Journal Sentinel investigation "beyond troubling."

"We are getting a full accounting of the facts and will use all levers of the state to make sure

this nightmare is over for our vets and that the promise made to these heroes is restored," he said in a statement.

Wanggaard and Assembly Speaker Robin Vos, R-Rochester, whose districts include the home, toured the facility in early May and heard from residents about poor care and short-staffing.

They have pressed Mary Kolar, secretary of the state Department of Veterans Affairs, which operates the veterans homes, to allow more volunteers back in the facility as COVID has eased, which could help with the staff shortages.

Laurie Miller, who has volunteered at the home for more than five years, said there are good staff members at Union now; there just aren't enough of them.

"They are not the problem — the administration is," she said.

Evers backed Kolar, whom he appointed in 2019, saying she is doing "as good a job as possible." He said he hoped a new commandant, who is in charge of the facility, will be in place soon in Union Grove and the state will continue to push to increase hiring with bonuses and advertising.

"This is an urgent issue that everybody should care about," he said. "We need to solve it. It started several years ago, even before my time, but that doesn't matter. It doesn't matter if it started 100 years ago. We have to change it today. And that's where we're headed."

Journal Sentinel reporters Daphne Chen and Katelyn Ferral contributed to this report.

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Residents of home not well hydrated, email says

By John Diedrich and Katelyn Ferral,
Milwaukee Journal Sentinel

Residents at the troubled Wisconsin veterans home in Union Grove are not getting enough water, resulting in dehydration and patients being sent to the hospital, according to an internal email obtained by the Milwaukee Journal Sentinel.

The email, with the subject line "DEHYDRATION," was sent earlier this month, shortly after a Journal Sentinel investigation found a litany of problems in the facility, including veterans not getting enough water.

"Staff please be aware that we have been having a lot of members either be sent out or have labs completed here showing that members are Dehydrated!!" the email stated. "We have along had several members with impacted bowels. This is not acceptable. We can do better.

"PLEASE make sure that members are being offered fluids often throughout the shift, especially with the weather getting hotter and members sitting outside. Nurses report to aides the importance of fluids. Thanks for all you do every day."

Dehydration has been a chronic problem at the facility, which ranks among the worst state veterans homes in the country in terms of violations and fines, according to the Journal Sentinel investigation. The Union Grove facility was cited

for 62 violations and received fines totaling $250,000 since 2017, records show.

Following the newspaper's investigation, U.S. Sen. Tammy Baldwin, D-Wis., and U.S. Rep. Bryan Steil, R-Wis., separately sent letters to federal authorities asking for outside reviews and additional oversight. U.S. Sen. Ron Johnson, R-Wis., also called for an investigation. State Sen. Van Wanggaard, R-Racine, has sought hearings on the facility.

In addition, co-chairs of the Legislature's Joint Audit Committee last week asked Mary Kolar, secretary of the state Department of Veterans Affairs, for details about the violations, complaints and staffing numbers since 2018. They gave Kolar, who oversees Union Grove and the two other veterans nursing homes, until the end of this week to respond.

Union Grove and other veterans homes like it across the country are run by states but funded with federal dollars.

Democratic Wisconsin Gov. Tony Evers called the situation at Union Grove an urgent issue and said his administration has to do a better job. Evers said he would cooperate with any outside investigation into conditions at Union Grove. He did not offer new initiatives but vowed to continue efforts to address staffing shortages.

The internal email, sent by Amanda Ross, who works at the facility and evaluates the quality of care provided to residents, went to the facility's nursing staff. Ross did not respond to emails and calls.

Colleen Flaherty, a Department of Veterans Affairs spokeswoman, called emails like Ross' "fairly standard practice" and said all nursing homes must remain diligent about ensuring residents have enough water.

"As a skilled nursing facility dedicated to quality care, Union Grove staff is trying to ensure our members are comfortable and well-taken care of at all times," Flaherty wrote in an email to the Journal Sentinel on Wednesday.

Flaherty noted some medical conditions and medications can cause dehydration and that staff accounts for that.

"Currently at Union Grove, water pass is done three times daily with each shift, and members always have continuous access to water and ice," she said. "Any member who needs assistance is routinely offered fluids during cares, during snack/activities, and with meals. This is best practice in long term care."

Flaherty did not immediately respond as to whether this is a new hydration practice or about how many residents Ross was referring to when she

wrote that "a lot of members" have been found to be dehydrated at Union Grove.

Staffing shortage affecting care

Flaherty said care at the Union Grove facility has been hampered by short staffing that predates the pandemic and has gotten worse. Among efforts to improve hiring and retention, the state in May extended a $5-an-hour pay raise for nurses at Union Grove and other state facilities that started last year through at least next year. In addition, the state has closed a wing of Union Grove and also part of a veterans home in King to consolidate patients because of short staffing, she said.

The violations at the Union Grove home have included medication mistakes, failure to investigate allegations of patient abuse, poor food, filthy conditions, infection control and a lack of water for residents.

Hydration for elderly people, especially in nursing facilities, is crucial.

Numerous medical studies conclude that older adults are especially vulnerable to dehydration, which can cause high death rates and other medical problems, including severe constipation, acute confusion, falls and delayed wound healing.

It can be especially problematic in hospitals and nursing homes, where patients have complex medical conditions that make them more at risk, the studies show.

Failing to ensure residents were hydrated resulted in a violation at the Union Grove facility in early 2021. Months earlier, resident Randy Krall was rushed to the hospital after his wife, Luane, was told he had not had water for much of the day. He was so dehydrated, his wife said, that doctors had trouble getting a urine sample to diagnose what was wrong with him.

Randy Krall returned to the Union Grove facility and died on Dec. 19, 2020.

Residents interviewed in May told a Journal Sentinel reporter they had problems getting water.

Veteran Gordon Voss, 91, said he has trouble getting enough water at night. By morning, "I am spitting cotton balls," he said.

Flaherty, the veterans affairs spokeswoman, said a search of records revealed no deaths or hospitalizations among residents in the last 90 days due to dehydration at the veterans home.

Quran Qaasim, 75, also a resident, ended up in the hospital in April in part because of a lack of water at the veterans home, according to his daughter, Nyesha Qaasim.

She said her father was admitted to a Burlington hospital nearly in sepsis with severe kidney issues and a urinary tract infection that doctors attributed to a lack of water.

"It was abuse and negligence," said Nyesha Qaasim, who has filed a complaint with the state Department of Health Services. "It was unbelievable, really unbelievable because stuff like that is preventable."

Quran Qaasim, a Vietnam veteran who suffered a stroke before coming to the home, spent nearly a month in the hospital recovering and then returned to the veterans home in Union Grove late last month, said his daughter.

"I believe he is in imminent danger there," she said.

But Nyesha Qaasim, who lives in Phoenix, said she is not his guardian; her brother is.

She said she learned late Tuesday that her father was again in the hospital. The cause, according to the doctor treating him? Dehydration.

Reporter Daphne Chen contributed to this report.

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Care at veterans home called 'inhuman'

By John Diedrich, Milwaukee Journal Sentinel

Randy Krall wasn't in the state veterans nursing home in Union Grove very long before, his widow says, problems began: medication errors, botched catheter insertions and unexplained bruises.

Then, in late 2020, she said, staff failed to ensure Krall was hydrated, leading to his death at age 69.

Now, Luane Krall is suing, saying staff at the troubled state veterans' home in Union Grove provided "reckless, wanton, demeaning and inhuman treatment" of her husband, resulting in his death in late 2020.

Krall's death was highlighted in a Milwaukee Journal Sentinel investigation in May that revealed a pattern of violations at the Wisconsin Veterans Home at Union Grove reaching back five years.

The lawsuit names the facility, the Wisconsin Department of Veterans Affairs, which oversees the home; Secretary Mary Kolar, head of the department, as well as 14 of the home's employees involved in Krall's care. The lawsuit, filed earlier this month in Dane County, seeks unspecified financial damages.

Krall entered the nursing home in September 2016. Shortly after his admission, the problems began, according to the lawsuit.

"I would have to be there constantly," Luane Krall told a Journal Sentinel reporter earlier this year. "I swear to God they would have killed him if I wasn't."

It was during a time that

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Luane Krall was not there because of COVID, the lawsuit says, that staff failed to ensure her husband was hydrated.

Records show a pattern of staff failing to ensure Krall was hydrated in the days prior to his hospitalization, according to the lawsuit. He was rushed to the hospital after Luane was told her husband had not had water for much of the day. Krall survived and was transferred back to the veteran's home on December 10, 2020. He died nine days later. The cause of death on the death certificate: "failure to thrive."

A Department of Veterans Affairs spokeswoman wrote in an email: "Providing high-quality care for the veterans in our homes is the Department of Veterans Affairs' top priority. The department denies the allegations in the lawsuit and will defend itself. DVA's medical director previously reviewed the case and determined that appropriate care was provided. As with any ongoing litigation, we cannot comment further on the lawsuit."

Dehydration has been a chronic problem at the facility, which ranks among the worst state veterans homes in the country in terms of violations and fines, according to the Journal Sentinel investigation. The Union Grove facility was cited for 62 violations and received fines totaling $250,000 since 2017, records show.

Dehydration continued to be an issue more than a year after Krall's death. In late June of this year, an email went out to employees saying, in part, "Staff please be aware that we have been having a lot of members either be sent out or have labs completed here showing that members are Dehydrated!! We have along had several members with impacted bowels. This is not acceptable. We can do better."

Care at the Union Grove facility has been hampered by short staffing that predates the pandemic and has gotten worse, a state spokeswoman said earlier this year. Among efforts to improve hiring and retention include the state extending a $5-an-hour pay raise for nurses at Union Grove and other state facilities.

Following the Journal Sentinel investigation, federal lawmakers from both political parties asked for an investigation and more oversight of the troubled home; a state senator called for a hearing.

Democratic Gov. Tony Evers, whose administration oversees the home and two other veterans facilities, said in an interview in June that "we've been unable to fulfill our duties to these great veterans, by having adequate staff and adequately trained staff. We have to do a better job."

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Troubled veterans home not improving

By Sarah Volpenhein, Milwaukee Journal Sentinel

The state-run veterans home at Union Grove was cited for six violations in its latest yearly inspection – including several repeats of recurring issues – adding to a laundry list of violations leveled against the facility in the last five years.

A Milwaukee Journal Sentinel investigation in May found the Union Grove home was one of the most troubled state veterans homes in the nation, according to an analysis of data from the U.S. Centers for Medicare and Medicaid Services. The Union Grove home ranked in the top five out of 117 CMS-certified veterans homes for having the most violations and fines, the Journal Sentinel analysis found.

The state veterans nursing home, Wisconsin Veterans Home, Boland Hall in Union Grove on Tuesday, April 19, 2022.

Past violations include failing to keep residents hydrated, not investigating patient abuse, infection control issues, medication mistakes, poor food and not doing enough to keep residents from falling. Residents and family members said care has declined as leadership

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frequently changed and the home struggles with chronic understaffing.

The Journal Sentinel's reporting prompted calls by federal lawmakers from both political parties for more oversight of the veterans home – which is run by the state, but funded by federal dollars.

State officials have blamed the problems at Union Grove on a lack of staff, especially during the pandemic when nursing homes across the nation faced staffing shortages. Officials have increased pay for some employees in an effort to recruit and retain staff and have relied on contracted workers and – at times – temporary help from other agencies, such as the Wisconsin National Guard, to supplement staff.

However, in a written reply to lawmaker inquiries, it was revealed Wisconsin had failed to apply for federal dollars specifically for veterans homes that could have helped with staffing.

State lawmakers have been exploring the possibility of an audit of the veterans home since June. The problems at the state-run home have also been highlighted in the run-up to Election Day by Republican candidates up and down the ballot.

The latest inspection, which was conducted over a week in August, brings the total number of violations issued against Union Grove since 2017 to 76. The inspection report was made public in October.

In it, inspectors found instances where the facility did not thoroughly investigate an allegation of abuse or report it to state regulators, did not do enough to prevent a couple of residents from falling and did not properly train two nursing aides. The facility was also cited for giving residents potentially unnecessary medications, including antipsychotics – which have long been the focus of scrutiny for their misuse in nursing homes as a chemical restraint to subdue residents with behavioral issues.

The facility has been cited in the past for some of the same violations, including for not reporting allegations of abuse or exploitation in a timely manner three other times in the last five years. The home has also been cited on three previous occasions for giving residents anti-anxiety medication without a documented reason for doing so. Failures to protect residents from falling have also prompted previous citations.

Most of the latest violations were classified as low-level infractions. None of them were found to have resulted in "actual harm" to residents.

Colleen Flaherty, a spokeswoman for the Wisconsin Department of Veterans Affairs, said the latest citations were

related "primarily to clerical and reporting duties" and that the veterans home had already taken steps to correct the issues identified in the report.

"The leadership at Union Grove are continually working to improve the quality of care they provide to residents," she wrote in an email.

Flaherty also noted that none of the latest violations had to do with dehydration. The state was sued earlier this year in the death of Navy veteran Randy Krall, whose widow said he suffered from a litany of problems in care. Krall died because the staff failed to ensure he was getting enough water, the lawsuit says.

Flaherty did not give any information about a separate inspection conducted by the federal Department of Veterans Affairs in July, saying those results are not yet available to the public.

Union Grove and other veterans homes like it are subject to inspections not only by CMS and the state agencies that work on its behalf, but also by the federal VA.

Wisconsin had never applied for a federal grant to improve staffing retention

In May, U.S. Sen. Tammy Baldwin, D-Wis., and U.S. Rep. Bryan Steil, R-Wis., separately sent letters to Denis McDonough, secretary of the VA, voicing concern about conditions at Union Grove. In her letter, Baldwin called on federal officials to step up oversight and to identify any resources that could be leveraged to improve conditions.

It turned out Wisconsin had never taken advantage of a federal grant program that could have helped shore up low staffing levels blamed for many of the issues at the Union Grove home, according to the VA's response in August.

Other states have used the program to offer sign-on bonuses, retention bonuses, tuition assistance programs, student loan repayment programs and other financial incentives to help attract and retain nurses and nursing aides at state veterans homes.

In the August letter, an assistant secretary of the VA encouraged Wisconsin officials to apply for the grant, which is available to all states.

Wisconsin officials have since submitted a pair of applications to the program – their first – for about $670,000 in all, to help address "significant staffing shortages" at the veterans homes at Union Grove and at King, in central Wisconsin.

"The Wisconsin Veterans Homes at Union Grove and at King have experienced caregiver staffing concerns going back to 2016," says a joint letter

from Baldwin and Gov. Tony Evers in support of the state's application. "The situation was exacerbated and became much more critical during the pandemic. Veterans homes ... are dealing with record high vacancy rates in all direct care classifications."

Under the program rules, the state would provide a 50% match, if awarded to the grant.

This is the first time Wisconsin has applied to the program, which has been in existence since before Evers' tenure, Flaherty confirmed. She did not respond to a question asking why the Evers administration had not applied for the funding before.

Republicans running for state and Congressional offices have seized on problems at the veterans homes in their overtures to voters. Tim Michels, the Republican businessman running against Evers for governor, blamed Evers for a lack of leadership and pledged to change the culture of the state Department of Veterans Affairs if elected.

"What happens in organizations that are failing or broken? People don't like to work there, and that all starts at the top," Michels said last week from outside the veterans home in Racine County. "People don't quit their job; they quit their boss. I think right now the shortage of staff here is because the staff is quitting the governor of Wisconsin."

He did not offer any more specific steps for how he would change the work environment or improve staffing levels.

Britt Cudaback, a spokesperson for Evers, said states across the country are experiencing severe shortages of health care workers and that Wisconsin is no exception.

"The governor's priority continues to be ensuring our veteran homes have the necessary staffing and support to provide our veterans the best services and care anyone can offer while also working to find long-term solutions to our state's workforce challenges," she said in an email.

She pointed to the Evers' administration's efforts to recruit and retain workers across the health care sector by contracting with staffing agencies, directing federal pandemic aid to workforce development initiatives and training National Guard members as nursing aides, among other initiatives.

Lawmakers on the Joint Legislative Audit Committee, led by two Republicans, have submitted several inquiries to the state Department of Veterans Affairs since June, asking for information on citations, complaints and staffing levels at the Union Grove home.

No audit has been opened,

but committee members are still evaluating the potential for one, said Jason Mugnaini, chief of staff for the committee's co-chair, state Sen. Robert Cowles, R-Green Bay.

What the latest inspection report found

In the latest inspection, the veterans home at Union Grove was cited for not doing a thorough investigation of an August incident in which a resident accused a nursing aide of abusing him while changing his brief.

The inspection report says the resident repeatedly told the aide she was hurting him and told her to stop. After she didn't, he tried to move her hands away by slapping or pushing her hands away, the report says.

The resident had a video and audio recording of the incident, but a copy of the recording was not included in the investigation file. Nor did the investigation include a statement from the resident or from other residents who had been cared for by the aide in question, according to the report. Inspectors couldn't find any evidence the aide was removed from caring for residents while facility officials further investigated the incident.

Officials with the facility did not report the incident to state regulators when it occurred, as they are required to do. The Division of Quality Assurance, part of the state's Department of Health Services, is in charge of investigating incidents of alleged abuse, neglect or exploitation of nursing home residents.

Inspectors also found a resident who was on two antipsychotic medications, but did not have proper diagnoses for those medications. A pharmacist first raised questions about the use of antipsychotics in the resident, who had dementia.

The diagnosis used to prescribe the medications was "delirium." The pharmacist noted that, "Since delirium is considered to be an emergency, short-term diagnosis, it is not considered to be appropriate for long-term use of psychotropic agents."

Another resident was on anti-anxiety medication, even though there was no documented reason for his continued use of the medication.

The facility was also cited for not taking steps to prevent two residents with difficulty walking from falling down. One of the residents fell twice within a two-week time period last year and was found on the floor near their bed, the report says. Inspectors faulted the facility for not properly investigating what caused the resident to fall down and how to prevent future falls.

The final violation was for two nursing aides who had worked at the veterans home for more than a year and had not completed any in-service training, including in dementia management or resident abuse prevention.

No fines have been imposed for the latest violations, according to a CMS spokesperson. The Union Grove home was also cited for violations stemming from inspections in March and June, though it is unclear whether those resulted in any fines.

The facility has incurred nearly $252,000 in fines from violations between 2017 and 2021, according to the CMS spokesperson.

Reporter John Diedrich, of the Milwaukee Journal Sentinel staff, contributed to this report.