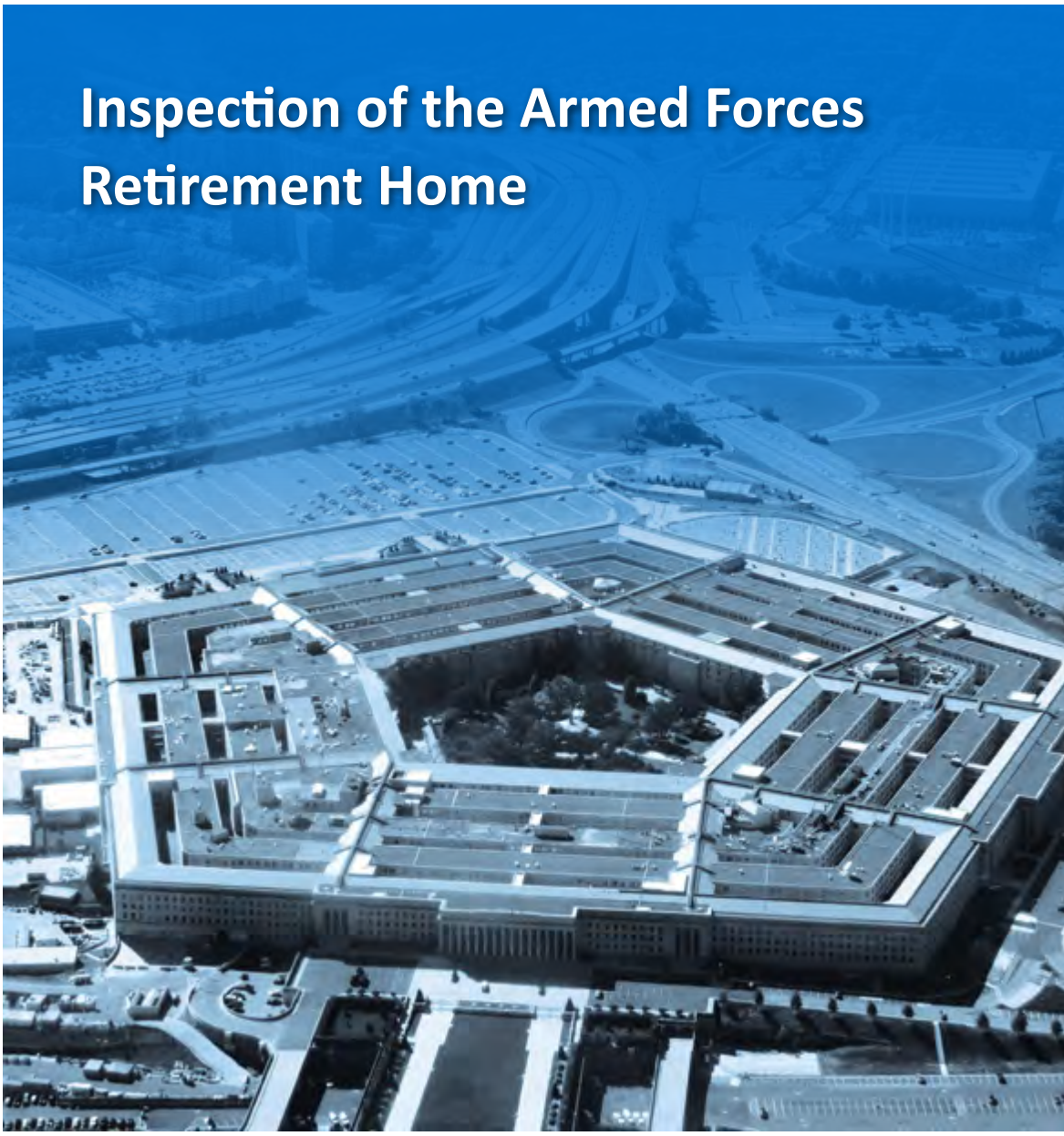
Report No. DODIG-2014-093

INSPECTOR GENERAL

U.S. Department of Defense

JULY 23, 2014

Inspection of the Armed Forces Retirement Home



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Vision

Our vision is to be a model oversight organization in the Federal Government by leading change, speaking truth, and promoting excellence—a diverse organization, working together as one professional team, recognized as leaders in our field.

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Inspection of the Armed Forces Retirement Home

July 23, 2014

Who Should Read This Report

Personnel in the Office of the Secretary of Defense, the Defense Health Agency (formerly TRICARE Management Activity), and the Armed Forces Retirement Home (AFRH) who are responsible for and engaged in oversight, management, and operations of the AFRH should read this report.

Background

Section 1518 of the "Armed Forces Retirement Home Act of 1991," November 15, 1990, as amended by Public Law 112-81, "National Defense Authorization Act for FY 2012," December 31, 2011 (24 U.S.C. § 418) legislates that:

> *Not less often than once every three years, the Inspector General of the Department of Defense shall perform a comprehensive inspection of all aspects of each facility of the Retirement Home, including independent living, assisted living, long term care, medical and dental care, pharmacy, financial and contracting records, and any aspect of either facility on which the Advisory Council or the Resident Advisory Committee of the facility recommends inspection.*

Paragraph b(2) of the amended 24 U.S.C. § 418 (2012) also states that "The Inspector General shall be assisted in inspections under this subsection by a medical inspector general

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Background (cont'd)

of a military department designated for purposes of this subsection by the Secretary of Defense." (See Appendix B for project announcement.)

The Office of the Under Secretary of Defense for Personnel and Readiness [OUSD (P&R)] designated the Army Medical Command (MEDCOM) to provide medical inspection assistance for this inspection. Subsequently, the DoD Inspector General (IG) entered into a memorandum of understanding (MOU) with Army MEDCOM to delineate each agency's role in the conduct of this inspection. (See Appendix C for DoD IG/Army MEDCOM MOU.)

What We Did

In preparation for the inspection, the DoD IG Inspection Team discussed the general scope of the inspection with the Chief Operating Officer (COO) of the AFRH, representatives from the OUSD (P&R) and Assistant Secretary of Defense (Health Affairs)/Defense Health Agency (ASD(HA)/DHA), and the AFRH IG. In addition, we met with the Deputy Director of the Defense Health Agency, who is the Senior Medical Advisor (SMA) to AFRH. We also contacted the chairpersons of the following council and committees to ascertain their concerns or desired focus areas for inclusion within the DoD IG's inspection scope:

- AFRH Advisory Council,
- AFRH Washington, D.C. (AFRH-W) Resident Advisory Committee (RAC), and
- AFRH Gulfport (AFRH-G) RAC.

The DoD IG's Inspection Team developed the scope and methodology for this inspection based on discussions with representatives from the OUSD (P&R) and Office of

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What We Did (cont'd)

the Deputy Director of the Defense Health Agency, as well as written input received from the Chairman of the AFRH Advisory Council, and chairpersons of the two RACs.

We also took into consideration observations and recommendations from its previous AFRH inspection, described in the 2010 DoD Inspector General report (No. IE-2010-002), "Inspection of the Armed Forces Retirement Home," February 25, 2010 (hereafter referred to as the 2010 DoD IG Inspection Report). Our objectives and methodology are discussed in the subsequent sections of this report. Upon review of all relevant research data, we conducted the on-site inspections and reviews of the AFRH management programs, the AFRH medical programs, and facilities of AFRH-W and AFRH-G during the weeks of August 27-31 and September 10-14, 2012. Multiple follow-on discussions were held with the AFRH-W staff. During the on-site phase of the inspection, we also conducted employee sensing sessions and DoD IG confidential feedback sessions to ascertain employee perceptions of quality-of-work life for the staff and to receive confidential feedback from residents and employees.

The DoD IG Inspection Team inspected various areas of AFRH operations and management, as listed in the Objectives section of this report. Following the on-site inspections, the Inspection Team area leads reviewed all the documents and information collected during the on-site inspection and requested additional documents from the AFRH points of contacts (POCs) for various phases. Some of the DoD IG inspectors, particularly the medical inspectors, sought additional data and clarifications. In October 2012, as the inspectors were analyzing data from field work, we received a confidential communication regarding a case of patient neglect allegedly caused by the failure of AFRH staff to meet standards of oral care at the AFRH-W facility.

We consulted other relevant components in the DoD Office of the Inspector General (DoD OIG), including the Directorate for Investigations of Senior Officials, Office of Whistleblower Protection, and the DoD IG Hotline office. After a series of DoD OIG multi-component meetings and additional data collection, the DoD IG Deputy Inspector General for Special Plans and Operations sent a "Notice of Concern" regarding the oral care negligence case to the Principal Deputy Under Secretary of Defense, Personnel & Readiness [PDUSD[(P&R)] on November 20, 2012.

In mid-January of 2013, the DoD OIG was informed about the death of one of the residents at the AFRH-W facility. There were questions raised about the cause of the resident's death and AFRH had begun a "root cause analysis" investigation. Although the AFRH COO stated that the investigation report would be shared with the DoD IG, the AFRH General Counsel later refused to provide the report to DoD OIG, citing protection from disclosure, as stated in DoD Directive 6040.37, "Confidentiality of Medical Quality Assurance Records," July 9, 1996.

In late February 2013, DoD OIG received additional communications regarding alleged deteriorating conditions of nursing and medical care at the AFRH-W facility that were increasing the risk of patient neglect and patient injury due to inadequate nursing and medical staff. The DoD OIG decided to bring the issue to

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What We Did (cont'd)

the attention of the Acting Under Secretary for Personnel and Readiness [USD[(P&R)]. On March 21, 2013, the DoD OIG provided a briefing to the Acting USD (P&R) and recommended that the Acting USD (P&R) send a team of medical professionals to review the quantitative and qualitative aspects of nursing and medical operations at the AFRH-W facility.

Parts A through O of this report provide more detailed information about the specific activities performed by the DoD IG Inspection Team on each of the identified areas of inspection.

Observations

Notable Progress/Accomplishments

AFRH management has effectively managed the construction of major facilities:

- The new AFRH-G facility, with state-of-the-art features and amenities, was reopened on October 4, 2010, as scheduled.
- The AFRH-W facility Scott Building demolition and re-building was nearing completion on schedule.
- Other old, unusable buildings and structures in the AFRH-W facility were either being shut down, demolished, or considered for demolition.

AFRH management was focused on development and execution of long-range facility management programs, including potential use of vacant land on the AFRH-W facility, energy savings, and operational cost savings.

We found that AFRH personnel gave adequate due diligence and care to facility engineering and safety issues. The modern, interconnected three-tower building of the Gulfport facility, with numerous in-house amenities, was a state-of-the-art retirement facility. The new Scott Building at the AFRH-W facility will significantly enhance the quality of life for the residents, particularly the residents of the Assisted Living and Long-Term Care units.

AFRH has been accredited under the Commission on Accreditation of Rehabilitation Facilities (CARF) Aging Services programs that included the Assisted Living, Person-Centered[1] Long-Term Care Community, Continuing Care Retirement Community, and Dementia Care Specialty Program.

Other areas where AFRH made significant progress include:

- screening new applicants,
- prioritizing applicants on the waiting list,
- developing a contract with the U.S. Department of Interior, National Business Center for information technology management, and
- adjudicating and ensuring the integrity of veterans' preference.

We found that, despite the concerns expressed by them during the inspection, most residents of the retirement home were pleased to be living there, particularly the residents of the Independent Living units.

[1] Person-Centered Care is a philosophy of care that requires thinking about and planning with and for people who require assistance in their daily lives and providing that assistance in such a way that the person is honored and valued and is not lost in the tasks of care-giving.

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Observations (cont'd)

The quality of life for the Independent Living residents, with numerous recreational activities planned by the Resident Recreational Services office, was quite high.

Challenges

The DoD IG Inspection Team inspected 13 different areas of AFRH operations and management, to include medical operations. A summary of important observations concerning the 13 areas is provided below. The report itself provides a detailed description of all observations and discussions on those observations which is essential for obtaining a comprehensive picture of the AFRH enterprise.

In Part M (Employee Sensing Sessions) and Part N (DoD IG On-site Confidential Feedback Sessions) of this report, we have provided a summary of information obtained through the employee sensing sessions and the on-site DoD IG confidential feedback sessions, for the knowledge of AFRH and DoD management. We did not write up any separate observations in these two sections of the report because the parts had incorporated the important aspects of the data into the observations in other related sections of the report.

Medical (Part A)

- AFRH was not accredited by a recognized civilian accrediting organization in the areas of medical care, dental care, rehabilitation, and pharmacy services even though the DoD IG recommended accreditation of these areas in the 2010 inspection report.
- Medical record documentation, nursing notes, and documentation of medication were incomplete.
- Short acting opioids, instead of more appropriate long acting opioids, were being used to manage chronic pain.
- There was no documentation of counseling of Coumadin patients on drug interactions and some providers did not have access to necessary information at Coumadin Clinics.
- There was no routine interaction between the SMA and the USD (P&R) on AFRH operations, except in times of crisis. In addition, there was no effective system in place for the SMA to raise the issue with the USD (P&R) when the SMA disagreed with, or was concerned by, a decision made by the AFRH COO.
- Credentialing and privileging processes included the following deficiencies:
    - lack of definition of qualification requirements,
    - lack of appropriate training for the credentialing and privileging personnel,
    - lack of data tracking necessary for re-privileging, and
    - the granting of privileges for services that were out of scope for the AFRH.
- AFRH had numerous standard operating procedures (SOPs), many of which were contradictory, difficult to understand, and/or used references that were not pertinent to the subject. Many SOPs were also markedly out of date. Additionally, no SOPs existed for two high-risk activities: (1) the Coumadin Clinic, and (2) end-of-shift narcotic counts.

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Observations (cont'd)

- AFRH Agency and AFRH-W lacked sufficient/ competent physician leadership. Personnel practices at the AFRH tended to promote from within rather than open the positions to outside physicians who may be more qualified. The DoD IG Inspection Team also noted that the position description, in at least one case, was altered to allow selection of an internal candidate who did not meet the original qualification requirements. These and other issues contributed significantly to the questionable quality of medical operations, particularly at the AFRH-W facility.
- The employee occupational health program was generally ineffective. The AFRH Agency and the two facilities were not fully complying with AFRH Agency directives on "Medical Qualification Determination" and the "AFRH Reasonable Accommodation Policy and Plan." As a result, some of the nursing staff were incapable of performing the duties that required certain physical and medical fitness.
- AFRH Agency and AFRH-W lacked personnel with adequate training in quality management and performance improvement.
- Both the AFRH clinical performance improvement and quality management programs were in their infancies. Performance improvement (PI) metrics, many of which were not meaningful, were imposed from the AFRH Agency down to the respective facilities. In addition, peer reviews were not routinely conducted and data was not tracked for re-privileging.

Human Resources (Part B)

- AFRH could not verify that the Career Transition Assistance Plan (CTAP)[2] was cleared during the application process or that well-qualified CTAP candidates received priority over non-CTAP candidates in the selection process as directed by 5 CFR (1999).
- The AFRH Agency administration was not accurately following required Human Resources procedures, Office of Personnel Management guidelines, or effectively communicating its hiring practices to employees.

Financial Management (Part C)

- A purchase card holder had utilized convenience checks for improper transactions that were prohibited by the U.S. Department of Treasury and were in violation of AFRH Agency Directive 3-1, "Financial Management," July 18, 2012.
- Although required by AFRH-W SOPs, AFRH-W Business Center personnel were not conducting required audits/cash counts of some of the AFRH funds.

[2] CTAP is a career transition program that provides priority for the AFRH Agency's eligible and displaced employees when filling vacancies. U.S. Office of Personnel Management, "*The Employee's Guide to Career Transition,*" July 2003.

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Observations (cont'd)

Armed Forces Retirement Home Inspector General (Part D)

- The COO assigned the AFRH Public Affairs Officer the additional duties of the AFRH IG, relegating the AFRH IG position to a dual-hatted position with other primary responsibilities. As a result, there is a possibility of conflict of interest between the duties of the IG and the duties of the Public Affairs Officer when the issues under investigation pertain to the Public Affairs office.
- The AFRH IG program may lack credibility because it does not have quality standards defined for AFRH IG audits and investigations.

Admissions and Eligibility (Part E)

- The AFRH Pre-admission Team was not using financial factors to determine whether an applicant was eligible under the "Incapable of Earning a Livelihood" category, as directed by AFRH Agency Directive 8-13, "Incapable of Earning a Livelihood Designation," July 3, 2012.
- Current methods used to screen and verify eligibility may not adequately eliminate applicants who have a drug abuse problem.
- AFRH personnel were not accurately following agency directives or facility SOPs in conducting the pre-admissions function.

Facilities Engineering and Safety (Part F)

- AFRH-W was not performing adequate testing/ monitoring of the "Home Free" devices to identify any defects or issues with the system. This created an unsecured area at the AFRH-W where monitored residents at risk of wandering could leave without the knowledge of AFRH-W personnel.
- The CISCOR Resident Monitoring System (RMS) at AFRH-G experienced at least 39 outages from June 5, 2012 to September 12, 2012. Because the RMS system produced such a high number of outages in a 3-month period, the system may be unreliable.

Information Assurance (Part G)

- More than 50 high and moderate security control weaknesses were identified in the AFRH System Security Plan (SSP) and Plan of Actions and Milestones (POA&M).
- The General Support System (GSS) did not comply with the National Institute of Standards and Technology (NIST) SP 800-53 Revision 3, "Recommended Security Controls for Federal Information Systems," May 1, 2010.

Resident / Recreation Services (Part H)

- AFRH-W personnel could not provide evidence that they were following all SOPs in a manner sufficient to meet the criteria addressed in the 2012 Inspection Checklist.

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Observations (cont'd)

- AFRH-W personnel were not conducting daily walk-through inspections,[3] as required by established SOPs. Additionally, inspection documentation lacked consistency.

Contracts Management (Part I)

- Thirty-two of the 47 contracts inspected did not have Independent Government Cost Estimates (IGCE) or supporting documentation with enough clarity to articulate how the estimate was ascertained.
- The market research was not consistently documented in a manner appropriate to the size and complexity of the acquisition.
- At least 6 of the 47 contracts inspected did not have a recommendation for award memorandum (or a similar document) on file describing how the contracting officer determined the award outcome.
- AFRH Contracting Officer's Representatives (CORs) lacked documentation to support modification transactions.
- AFRH facilities were not consistently managing or providing oversight to interagency agreements between AFRH and other Federal agencies. The interagency agreements did not clearly define whether the Bureau of Public Debt (BPD) or AFRH was required to monitor over interagency agreements.
- AFRH Contracting Officer's Technical Representative (COTR) background/experience was not adequate to support all the contracts they were managing and COTR responsibility was not evenly distributed.
- The contract files reviewed lacked documented Quality Assurance Surveillance Plans (QASP), as directed by corresponding contracts, and, in several cases, contract files lacked documentation of evidence that COTRs were providing oversight over the contractor performance.

Security (Part J)

- Security of the AFRH-W Scale Gate facility entrance, controlled by Department of Veterans Affairs (VA) Police, did not meet the security standards established in SOP No. W-OA-SEC-5-27, "Perimeter Security," July 6, 2012.
- Although a baseline security training program with SOPs and a master training task list existed, the AFRH-W and AFRH-G guards were not adequately trained nor empowered to provide traditional Federal security services according to recognized Federal standards.

Estate Matters and Disposition of Effects (Part K)

- AFRH could not assure the delivery of decedent's wills to the appropriate court of record, as specified by section 420 (a)(1), title 24, United States Code (24 U.S.C. § 420(a)(1) [2012]). AFRH

[3] "…To monitor usage, resident safety, and maintenance to ensure that regulations and procedures are followed." (Based on DoD IG analysis of Directive 8-7 and AFRH SOPs).

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Observations (cont'd)

employees involved in the disposition of effects and estates were not accurately following AFRH Agency Directive 8-8, "Estate Matters," September 2, 2008, or AFRH facility SOPs. There was potential for lawsuits against AFRH for failing to properly handle the decedents' belongings.

- AFRH-G employees were unprepared in cases where the retirement home may have had a legal interest, as described in section 420(b)(1)(C), title 24, United States Code, (24 U.S.C. § 420(b)(1)(C) [2012]).

AFRH Hotline Activity (Part L)

- AFRH IG did not issue implementing guidance for the Hotline program as required by AFRH Agency Directive 1-9, "AFRH Inspector General Program," June 2, 2009. As a result, AFRH's Hotline investigations could not be evaluated against any AFRH-identified/developed standards.

Senior Management (Part O)

- DoD Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010, did not address the amendments to the Armed Forces etirement Home Act introduced by Public Law 112-81, "National Defense Authorization Act FY 2012," December 31, 2011.
- The AFRH COO hired insufficiently competent medical personnel to run the medical operations of the agency and the facilities and did not fill two key supervisory nursing positions at the AFRH-W facility for approximately 6 months.
- The SMA from DHA lacked clear authority and responsibility to effectively address medical operations issues at the AFRH.
- The SMA was not aware of many important medical operational issues at AFRH and was unable to decisively intervene in AFRH management decisions related to medical operations.
- USD (P&R) did not identify the specific DoD and/or VA policies, procedures, and guidelines that were appropriate for the AFRH, as recommended in the 2010 DoD IG Inspection report, and did not direct the AFRH to follow those policies, procedures, and guidelines.
- There was frustration among some of the AFRH employees, particularly the nursing staff at the AFRH-W facility, about working conditions and the fear of retaliation if they voiced opinions at odds with management. Some senior officials also expressed fear of retaliation from upper management.
- The combined position of Deputy COO and the Chief Financial Officer (CFO) had been vacant for more than 2 years. The AFRH COO was simultaneously performing these duties.
- The lower-level staff, particularly the nursing assistants at the AFRH-W facility, expressed their frustrations about lack of assistance from upper management for professional development or advancement at the AFRH.

Management Comments (cont'd)

- The AFRH COO created an unmandated agency-level Ombudsman position which will divert funds needed to hire competent medical and nursing personnel.

Recommendations, Management Comments, and Our Response

This report contains 131 recommendations addressing issues in the 13 management areas described in this Executive Summary. A summary of management's comments and our response are immediately after each recommendation. The full set of management's comments are at the end of the report. Appendix G provides a cross reference of the Observations and Recommendations numbering from the draft to the final report.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Office of Under Secretary of Defense (Personnel and Readiness)	6.a(1), 6.a(2), 6.a(3), 50, 53.a, 53.b	1.a, 2.a, 7.a, 8.a, 14.a, 20.a, 30.a, 52
Deputy Director of Defense Health Agency	6.b	
Chief Operating Officer, Armed Forces Retirement Home	1.b(2), 3.c, 5.a, 8.b(1), 9.b, 9.c, 9.d, 12.c, 12.d, 17.a, 18.c, 22, 25.b, 31, 32, 35.a, 35.b, 46.b, 47.a, 47.c, 48.b, 48.c, 57	1.b(1), 2.b(1), 2.b(2), 3.a, 3.b, 4.a, 4.b, 5.b, 5.c, 5.d, 5.e, 7.b(1), 7.b(2), 8.b(2), 9.a, 10.a, 10.b, 10.c, 10.d, 11.a, 11.b, 11.c, 11.d, 12.a, 12.b, 12.e, 13.a, 13.b, 13.c, 14.b(1), 14.b(2), 14.b(3), 14.b(4), 15, 16.a, 16.b, 16.c, 16.d, 16.e, 17.b, 18.a, 18.b, 19, 20.b, 21, 23, 24, 25.a, 25.c, 26, 27.a, 27.b, 28, 29, 30.a, 30.b(1), 30.b(2), 30.b(3), 30.b(4), 30.b(5), 30.b(6), 30.b(7), 33, 34, 36, 37, 38, 39, 40, 41, 42, 43.a, 43.b, 44.a, 44.b, 45, 46.a, 46.c, 47.b(1), 47.b(2), 47.d, 47.e, 48.a, 49.a, 49.b, 49.c, 51.a, 51.b, 54.a, 54.b, 54.c, 55, 56

Please provide comments by August 25, 2014.

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

July 23, 2014

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
DIRECTOR, DEFENSE HEALTH AGENCY
CHIEF OPERATING OFFICER, ARMED FORCES RETIREMENT HOME

SUBJECT: Inspection of the Armed Forces Retirement Home
(Report No. DODIG-2014-093)

The Deputy Inspector General, Special Plans and Operations, is providing this final report for information and appropriate action. We considered management comments to a draft of this report when preparing the final report.

We request additional information and comments as identified in the Table on page x. Please provide comments that conform to the requirements of DoD Directive 7650.3. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the "Signed" symbol in place of the actual signature.

We should receive your comments by August 25, 2014.

We appreciate the courtesies extended to our staff. Please direct questions to [redacted] at [redacted], [redacted] or [redacted], [redacted].

Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations


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Introduction

Section 418, title 24, United States Code (24 U.S.C. § 418 [2012]) legislates that:

> Not less often than once every three years, the Inspector General of the Department of Defense shall perform a comprehensive inspection of all aspects of each facility of the Retirement Home, including independent living, assisted living, long term care, medical and dental care, pharmacy, financial and contracting records, and any aspect of either facility on which the Advisory Council or the Resident Advisory Committee of the facility recommends inspection.

The Department of Defense Inspector General (DoD IG) performed the last inspection of the Armed Forces Retirement Home (AFRH) in August of 2009. Therefore, the DoD IG was required to perform the subsequent inspection in August 2012.

Paragraph b(2) of the amended 24 U.S.C. § 418 (2012) also states:

> The Inspector General shall be assisted in inspections under this subsection by a medical inspector general of a military department designated for purposes of this subsection by the Secretary of Defense.

Office of the Under Secretary of Defense for Personnel and Readiness [OUSD (P&R)] designated the Army Medical Command (MEDCOM) to provide the medical inspection assistance for this inspection. Subsequently, the DoD IG entered in to a memorandum of understanding (MOU) with Army MEDCOM to delineate roles and responsibilities of each of the organizations.

Paragraph d (1) of the amended section 411, title 24, United States Code (24 U.S.C. § 411 [2012]) states:

> The Chief Operating Officer of the Armed Forces Retirement Home is the head of the Retirement Home. The Chief Operating Officer is subject to the authority, direction, and control of the Secretary of Defense.

The newly created Paragraph d (3) of the amended 24 U.S.C. § 411 (2012) gives additional authority to the Secretary of Defense:

> The administration of the Retirement Home, including administration for the provision of health care and medical care for residents, shall remain under the control and administration of the Secretary of Defense.

Objective

The objective of this project was to perform a comprehensive inspection of all aspects of each facility of the AFRH, including independent living, assisted living, long term care, medical and dental care, pharmacy, financial and contracting records, and any aspect of either facility on which the Advisory Council or the Resident Advisory Committee (RAC) of the facility recommends inspection.

The DoD IG Inspection Team finalized the scope and detailed approach for the on-site inspection on the basis of discussions with representatives from the OUSD (P&R) and Office of the Deputy Director of the Defense Health Agency (DHA), AFRH Chief Operating Officer (COO), AFRH IG, as well as the written input received from the Chairman of the AFRH Advisory Council, and Chairpersons of the two RACs.

The general inspection areas were kept the same as the 2009 inspection. However, we excluded "Voting," as it was not a required area of inspection. The list of inspection areas are as follows:

- Medical,
- Human Resources Management,
- Financial Management,
- AFRH IG
- Admissions/Eligibility,
- Facilities Engineering and Safety,
- Information Assurance,
- Resident Recreation Services,
- Contracts Management,
- Security,
- Estate Matters and Disposition of Effects,
- Armed Forces Retirement Home Hotline Activity, and
- Senior Management.

We also conducted employee sensing sessions and confidential feedback sessions.

Methodology

In March 2012, the DoD IG Inspection Team began to review the amendments made to the AFRH Act of 1991 by Public Law 112-81. The actual amended version was not available as the amendments were not codified. The DoD IG Inspection Team used the unofficial amended version on the Web as criteria for the inspection.

At the same time, we initiated the review of all relevant prior documents, including the 2010 DoD IG Inspection Report (No. IE-2010-002) (hereafter referred to as the 2010 DoD IG Inspection Report). The DoD IG Inspection Team also contacted the Government Accountability Office (GAO), the DoD IG Hotline office, and the DoD IG Defense Criminal Investigative Services (DCIS) office to perform an index search to identify any reports and/or cases relevant to AFRH.

On May 3, 2012, we met with the stakeholders—the COO of the AFRH, representatives from the OUSD (P&R) and the Assistant Secretary of Defense (Health Affairs)/Defense Health Agency (ASD(HA)/DHA), and the AFRH IG. The Office of the Deputy Inspector General for Special Plans and Operations (SPO) issued the project announcement letter on May 15, 2012.

On June 13, 2012, we briefed the Deputy Director of DHA, who is the Senior Medical Advisor (SMA) to AFRH, about the impending inspection of AFRH. During this briefing, we discussed the duties and responsibilities of the Deputy Director of DHA in the role of SMA to AFRH, as assigned by section 413a, title 24, United States Code (24 U.S.C. § 413a [2012]).

In early August 2012, we contacted the chairpersons of the following council and committees to ascertain their concerns or desired focus areas for inclusion within the DoD IG's inspection scope:

- AFRH Advisory Council,
- AFRH Washington, D.C. (AFRH-W) RAC, and
- AFRH Gulfport (AFRH-G) RAC.

We received responses from all three chairpersons.

We finalized the scope and detailed approach for the on-site inspection on the basis of discussions with representatives from the OUSD (P&R) and Office of the Deputy Director of DHA, AFRH COO, AFRH IG, as well as the written input received from the Chairman of the AFRH Advisory Council, and chairpersons of the two RACs.

To address compliance with Federal laws and regulations for each inspection focus area, the DoD IG Inspection Team developed an inspection criteria guide list for each inspection area.

The on-site inspection of the AFRH Agency was conducted from August 27-28, 2012; the AFRH-W from August 29-31, 2012; and the AFRH-G from September 10-14, 2012.

During the inspection, we interviewed key personnel from the AFRH Agency, AFRH-W facility, and AFRH-G facility. We also interviewed management and staff points of contact (POCs) for each inspection element delineated in the inspection scope and objectives. We focused on the overall administration and management of the AFRH Agency, AFRH-W, and AFRH-G, in addition to reviewing medical, dental, and pharmacy operations, and resident satisfaction with services provided by AFRH-W and AFRH-G. We inspected the records of the AFRH Agency, AFRH-W, and AFRH-G to ensure compliance with applicable laws and regulations pertaining to each area delineated in the inspection scope and objectives.

During the on-site phase of the inspection, we also conducted employee sensing sessions and DoD IG confidential feedback sessions to ascertain employee perceptions about quality of work environment for the staff and to receive confidential feedback from the residents and employees.

The DoD IG Inspection Team inspected the identified areas of AFRH operations and management (listed in the Objectives section of this report). Following the on-site inspections, Inspection Team area leads reviewed all the documents and information collected during on-site inspections and requested additional documents from the AFRH POCs in various phases. Some of our inspectors, particularly the medical inspectors, sought additional data and clarifications. We also interviewed AFRH senior officials and functional area chiefs. In October 2012, as the inspectors were analyzing data from field work, we

received confidential communication regarding a case of patient neglect allegedly caused by the apparent failure of AFRH staff to meet standards of oral care at the AFRH-W facility.

We consulted other relevant components in the DoD Office of the Inspector General (OIG), including the Investigations of Senior Officials, Office of Whistleblower Protection, and the DoD IG Hotline office. After a series of multi-component meetings and additional data collection, the DoD IG Deputy Inspector General SPO sent a "Notice of Concern" regarding the oral care negligence case to the Principal Deputy Secretary of Defense for Personnel and Readiness [PDUSD (P&R)] on November 20, 2012.

In mid-January of 2013, the DoD OIG was informed that AFRH was performing a"root cause analysis" investigation of the recent death of a resident. In late February 2013, the DoD OIG received additional AFRH staff communications regarding the alleged deteriorating capacity of nursing and medical staff at the AFRH-W facility, which could continue to increase the risk of patient neglect and injury. On March 21, 2013, the DoD OIG provided a brief to the Acting USD (P&R) about the risk of potential patient neglect and injury at the AFRH-W facility and recommended that the Acting USD (P&R) form a team of healthcare professionals to evaluate the capability to provide sufficient medical care to residents at the AFRH-W facility.

Parts A through O of this report provide more detailed information about the specific inspection activities performed by the DoD IG Inspection Team in each of the identified areas of inspection. The DoD IG inspection was conducted in accordance with the standards established by the Council of Inspectors General on Integrity and Efficiency, published in the "Quality Standards for Inspection and Evaluation," January 2012.


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Background

The Armed Forces Retirement Home

In 1834, the Navy opened a retirement facility in Philadelphia, Pennsylvania, to serve former enlisted sailors. The U.S. Naval Retirement Home moved to Gulfport, Mississippi, in the late 1960s. The Army established the Soldiers' Home in 1851 for former enlisted soldiers at its present location in Washington, D.C. (Airmen were added when the Air Force became a separate service.)

In 1991, Congress incorporated the U.S. Naval Retirement Home in Gulfport, Mississippi, and the U.S. Soldiers' and Airmen's Retirement Home into an independent organization—the Armed Forces Retirement Home. By 2001, Congress renamed the U.S. Naval Retirement Home and the U.S. Soldiers' and Airmen's Retirement Home as the Armed Forces Retirement Home – Gulfport and the Armed Forces Retirement Home – Washington, D.C., respectively. Section 411, title 24, United States Code, established the AFRH as an independent establishment under the Executive branch, with two continuing care facilities—AFRH-W and AFRH-G—maintained as separate facilities of the Retirement Home.

These facilities provided a range of accommodations structured to meet the changing needs of eligible former military members as they age. At both AFRH facilities, residential units are designated by levels of care, with the level of care increasing in the following order: Independent Living (IL),[4] Independent Living Plus (ILP),[5] Assisted Living (AL),[6] and Long Term Care (LTC).[7]

On August 29, 2005, Hurricane Katrina severely damaged the AFRH-G facility. Many of the residents were evacuated to AFRH-W and lived there until the AFRH-G facility was rebuilt. After the new AFRH-G facility was opened in late 2010 (October-November), most of the residents of the AFRH-G returned to Gulfport, Mississippi. At the May 31, 2012, AFRH briefing to DoD IG Inspection Team, AFRH-W reported a population of 568 residents and AFRH-G reported a population of 582 residents.

[4] IL – Residents are able to choose their level of participation in the programs and services provided without additional monitoring or support by staff.

[5] ILP – Residents require minimal support by staff in areas of medication administration, housekeeping and/or bathing

[6] AL – Residents require assistance in choosing their level of participation in the programs and services provided without additional monitoring or support by staff. In addition, moderate support is needed by staff to complete activities of daily living and to participate in the programs the resident chooses.

[7] LTC – Residents are provided nursing and other services 24 hours/day.

A number of services at AFRH are outsourced to two major Government organizations—the U.S. Department of Treasury Bureau of Public Debt (BPD) and U.S. Department of Interior National Business Center (NBC). (See Figure E.1 in Appendix E.)

The BPD provides the following services to AFRH:

- financial management accounting services,
- human resources services,
- procurement services, and
- travel services.

The NBC hosts and operates all AFRH information systems and networks.

AFRH also partners with other Government healthcare organizations, such as Walter Reed National Military Medical Center (WRNMMC), which serves AFRH-W, and the 81st Medical Group at Keesler Air Force Base, Mississippi, which serves AFRH-G. (See Figure E.1.)

Results – Part A

Medical

Medical

At the AFRH, residents are initially admitted to IL level where they reside independently until assistance with Activities of Daily Living[8] and Instrumental Activities of Daily Living[9] is required. As the care requirements for a resident increase, he/she is transitioned to a unit supporting the appropriate higher level of care as determined by a Needs Assessment Team (NAT)[10] and the Interdisciplinary Team (IDT).[11] At the time of the inspection, both AFRH-W and AFRH-G added an "Independent Living Plus" component which allowed residents to remain in IL and continue favorite activities, while getting additional medical support. In addition, each facility's LTC also included a Memory Support program, which offered specialty care to those who develop memory problems, dementia, or Alzheimer's disease. Both facilities provide primary care, dental care, behavioral healthcare, optometry, nutrition care, and rehabilitation services to their residents. Residents also have the choice of using the available healthcare services or receiving care from outside the AFRH.

Figure 1. Sherman Building (AFRH-W)
Source: AFRH Photo Archive

AFRH residents included both military retirees and non-retirees. At AFRH-W, residents who were not otherwise eligible for military healthcare, such as non-retirees, were covered as Secretarial Designees.[12] The Secretarial Designee status granted by the Secretaries of the Army and Air Force authorized care at certain military facilities. Although the memorandum granting Secretarial

8 "Activities of Daily Living" are basic self-care tasks such as toileting, feeding, grooming etc. *The Continuum of Long Term Care*, 3rd Edition, 2005 by Connie J. Evashwick.

9 "Instrumental Activities of Daily Living" are complex skills needed to live independently such as shopping, managing medication, house work etc. *The Continuum of Long Term Care*, 3rd Edition, 2005 by Connie J. Evashwick.

10 NAT – AFRH Team that assesses the ability of a resident to maintain their independence after a deficit is reported. Assessment may result in the arranging for support services purchased by the individual or a transition into a higher level of care.

11 IDT – AFRH Team that develops individual care plans that outlines the specific kinds of care needed and how care can be accomplished.

12 Secretarial Designee Program – established under 10 U.S.C. § 1074(c), grants, under certain conditions, certain individuals noted in 32 CFR 108.4, such as foreign military personnel/dependents, foreign diplomatic or senior officials/dependents, research subjects, emergency patients, and designated members of the Armed Forces, eligibility to receive medical/dental treatment in military facilities.

Designee status did not include Navy facilities, the Navy and the Joint Task Force National CapitalMedical Command had agreed to honor existing Army agreements. AFRH-G did not yet have Secretarial Designee status for its non-retiree residents, but had started this process at the time of the inspection.

Under the authority and control of the Secretary of Defense, the AFRH COO serves as the head of the retirement home and works at the agency level (Section 411(d)(1), title 24, United States Code (24 U.S.C. § 411(d)(1) [2012])). At each facility, an administrator is responsible for overall facility operations, which includes all medical functions. Although the administrators are responsible for the facilities, section 411(d)(3), title 24, United States Code (24 U.S.C. § 411(d)(3) [2012]) required that the administration of the AFRH, including administration for the provision of healthcare and medical care for residents, remain under the "direct authority, control, and administration of the Secretary of Defense." In 2011, the COO added a Medical Director position to oversee all medical functions from the agency level. In addition, each facility had a Chief of Healthcare Services (CHS) and a Chief Medical Officer (CMO). Although not clearly delineated in policy, the CMO falls under the CHS, as per the organizational structure diagram. (See Appendix E: Figure E-4.)

By statute, the COO is required to "secure and maintain accreditation by a nationally recognized civilian accrediting organization for each aspect of each facility of the retirement home, including medical and dental care, pharmacy, IL, AL, and nursing care." However, no single civilian accrediting organization offered a program that could sufficiently cover all of AFRH's characteristics and services. The AFRH was, at the time of the inspection, accredited by the Commission on Accreditation of Rehabilitation Facilities/Continuing Care Accreditation Commission (CARF/CCAC). Prior to 2007, the AFRH was accredited by The Joint Commission (TJC)[13] for both LTC and Ambulatory Care (outpatient clinics).

During the inspection, the DoD IG Inspection Team[14] reviewed all AFRH Agency policies, notices, and directives related to healthcare. All healthcare services SOPs were also reviewed. The findings were discussed with the AFRH Agency Medical Director and facility staff members throughout the inspection. Most

[13] The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

[14] The inspection and evaluation of the medical operations at AFRH was performed by two military medical evaluators, a physician (O-6) and a nurse (O-5), selected by the Army Medical Command, in response to a DoD IG request for personnel with medical subject matter expertise to augment the DoD IG Inspection Team. See Appendix F for further details on the medical evaluators.

policies were dated between June 2012 and July 2012. Additionally, several AFRH Agency policies had a 120-day implementation period, so the DoD IG Inspection Team could not review complete implementation of policies by the date of the inspection.

As we reviewed policies, we looked for implementation of applicable healthcare standards of the Department of Veterans Affairs (VA) or any other applicable standards, as required bysection 413a (c)(2), title 24, United States Code (24 U.S.C. § 413a(c)(2) [2012]). The Inspection Team also sought to identify the use of DoD policies in developing AFRH Agency and facility policy. Additionally, the team evaluated the implementation of policies through interviews and observation.

We also reviewed the findings from the 2007 GAO report, "Armed Forces Retirement Home Healthcare Oversight Should be Strengthened," May 30, 2007; the 2010 DoD IG Inspection Report; the 2011 CARF accreditation findings; and applicable standards of CARF and The Joint Commission. Additionally, we reviewed resident medical records and interviewed staff and residents.

Observation 1

Armed Forces Retirement Home Agency and Facility Policies on Pain Management

The AFRH Agency policy directive on pain management exceeded the scope of AFRH facilities' operational capabilities. This policy contained no requirement to implement current national medical standards of practice, such as those contained in clinical practice guidelines. Furthermore, the policy had not been implemented by the facilities.

This occurred because of a lack of appropriate oversight by the AFRH medical leadership in the development and implementation of agency-level policy.

Residents were not receiving appropriate care based on the latest clinical practices. Specifically, they were not receiving appropriate, evidence-based care for pain management.

Discussion

AFRH Agency Directive 9-5, "AFRH Pain Management Program," April 12, 2012, contained descriptions and requirements for services that were not offered at AFRH and were not part of their operational capabilities. The document required facility administrators to develop SOPs and to start a pain management committee within 120 days of the directive issuance date. However, both facilities failed to develop a pain management SOP with appropriate pain management guidelines and failed to establish a pain management committee. Also, the AFRH Agency Medical Director should have been listed as a party responsible for the implementation or monitoring of this program.

During the review of LTC records at AFRH-W, our medical inspectors identified an issue with chronic opioid use in an 85-year-old resident with chronic pain. He was prescribed and taking two Percocet tablets (5 mg oxycodone/325 mg acetaminophen per tablet) every 4 hours. This regimen controlled his pain, but also resulted in him receiving 3,900 mg of acetaminophen per day. This was too large a dose for an 85-year-old with significant potential for

adverse effects, based on guidelines discussed in the next paragraph. Our medical inspectors discussed the case with the nurse responsible for this resident's care and recommended changing the dosage to a long acting opioid that did not contain acetaminophen.

Recent evidence-based VA/DoD clinical practice guidelines on opioid therapy and pain management may be useful in future instances requiring pain management and should be considered. Additional pain management guidelines may be found in the National Guideline Clearinghouse,[15] the Agency for Healthcare Research and Quality (AHRQ),[16] and in the Annals of LTC.[17] These guidelines would have provided excellent guidance on a more appropriate dosage based on characteristics of the patient and reduced the risk of adverse effects.

Recommendations, Management Comments, and Our Response

Recommendation 1.a

Under Secretary of Defense for Personnel and Readiness, determine applicable medical standards of the Department of Veterans Affairs and the Department of Defense, such as Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines, and ensure the Armed Forces Retirement Home meets those standards.

Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) non-concurred, stating that AFRH would follow national medical standards, as does the DoD and VA, when developing medical policies. AFRH should consider incorporating relevant information from VA/DoD Clinical Practice Guidelines. Requiring AFRH to follow DoD/VA medical standards for which they have no input to the content would create risk for noncompliance with national recognized medical standards focused on the population and organization of the AFRH.

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[15] National Guidelines Clearinghouse is an accessible database, publically offered by the Agency for Healthcare Research and Quality on their website (http://www.guideline.gov/index.aspx) to assist physicians and other health professionals, healthcare providers, health plans, integrated delivery systems, purchasers, and others in obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation, and use. Retrieved from http://www.guideline.gov/about/index.aspx, October 21, 2013.

[16] The AHRQ is an agency within the Department of Health and Human Services that seeks ". . . to improve the quality, safety, efficiency and effectiveness of Healthcare" in the United States through research. Retrieved from http://www.ahrq.gov/about/index.html, October 21, 2013.

[17] "The Annals of Long Term Care: Clinical Care in Aging is a peer reviewed journal of the Geriatrics Society focused on the clinical and practical issues related to the diagnosis and management of long term care residents." Retrieved from http://www.annalsoflongtermcare.com/about-us, October 21, 2013.

Our Response

Although they non-concurred, management's comments are responsive to the intent of the recommendation. We agree with AFRH following national medical standards and support AFRH consideration of incorporating relevant information from VA/DoD Clinical Practice Guidelines into medical standards and operations. We will request an update on this effort at a later date.

Recommendation 1.b

Armed Forces Retirement Home Chief Operating Officer:

(1) Ensure appropriate corrections to AFRH Agency directives, including the incorporation of evidence-based Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines related to pain management. Utilize other Clinical Practice Guidelines, such as those published by the Annals of Long Term Care, as appropriate.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, reporting that implementation of the recommendation was in progress. The COO noted that the VA/DoD Clinical Practice Guideline referenced in the draft report had been published after the onsite fieldwork. They would also review the existing VA/DoD clinical practice guidelines to determine whether they would be useful references.

Our Response

Management's comments were responsive. We adjusted the narrative to indicate the Clinical Practice Guideline should be considered in development of future SOPs. We will request an update on progress at a later date.

(2) Ensure that the Armed Forces Retirement Home – Washington, D.C., and Armed Forces Retirement Home – Gulfport facilities implement the revised AFRH Agency directive to ensure residents with pain receive appropriate assessment, treatment, and re-assessment of pain.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, reporting that the recommendation was complete.

Our Response

Management's comments were partially responsive. We ask that management describe the actions taken to ensure that both facilities implemented the revised AFRH Agency Directive on pain management.

Observation 2

Agency Suicide Awareness and Prevention Program Directive

The AFRH Agency directive on suicide awareness and prevention had not been tailored to the mission of the AFRH and included references that were unrelated to the topic.

This occurred because AFRH medical leadership lacked expertise in the subject matter, failed to consult the AFRH SMA for guidance, and failed to display attention to detail in the development of agency-level policy.

This resulted in agency policy that was inappropriate and that did not provide adequate guidance on resident suicide prevention.

Discussion

AFRH Agency Directive 9-6, "AFRH Suicide Awareness and Prevention Program," July 11, 2012, lists three references:

- DoD Directive 1010.10, "Health Promotions and Disease/Injury Prevention," August 22, 2003,
- United States Department of Homeland Security/United States Coast Guard – Commandant Instruction 1734.1A, "Suicide Prevention Program," December 7, 2009, and
- Depression and Bipolar Alliance, Bipolar Disorder and Suicidal Behavior, Psychiatric Clinic of North America, Volume 2, Issue 3, September 1999, Zoltan Rihmer and Peter Pestality.

The DoD Directive 1010.10 did not mention suicide or suicide prevention. The article on bipolar disorder was dated and had nothing to do with development of a suicide awareness and prevention program. AFRH Agency Directive 9-6 appeared to be taken directly from the Coast Guard instruction. Unfortunately, the instruction was not tailored to fit AFRH residents' needs. In addition, the performance improvement measures taken from the Coast Guard instruction were not readily measureable.

While AFRH-G had some on-going training for privileged[18] healthcare providers on suicide and related issues, ("Provider's Wellness Manual" for the Summer/ Fall 2012), the DoD IG Inspection Team could not document similar training at AFRH-W. This is a requirement by industry standards, as well as for accreditation. The AFRH-G manual is a good resource that included sections on depression, psychotherapeutic medications, grief and mourning, and suicide. Additionally, the manual included assessment tools. Also, recently published VA/DoD Clinical Practice Guidelines (CPGs) would be useful in providing guidance for a more effective program in the future. Multiple VA/DoD CPG guidelines (for example, depression, bipolar disorder, and post-traumatic stress disorder) addressed suicide, as well as the VA/DoD CPG on suicide prevention, which was issued in June 2013.

Recommendations, Management Comments, and Our Response

Recommendation 2.a

Under Secretary of Defense for Personnel and Readiness, require that the Armed Forces Retirement Home Agency Directive 9-6 on Suicide Awareness meet applicable standards of the Department of Veterans Affairs, such as Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines.

Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) concurred, commenting that AFRH would incorporate relevant information from VA/DoD Clinical practice guidelines for the assessment and management of patients at risk for suicide, as policy is updated.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

[18] "Privileged Healthcare Provider" is one who is granted authorization to provide specific services to their patients at a specific healthcare facility. "Privileges" define the scope and limits of practice for individual providers and are based on the capabilities of the healthcare organization and the credentials of the provider.

Recommendation 2.b

Armed Forces Retirement Home Chief Operating Officer:

(1) Ensure appropriate corrections to AFRH Agency Directive 9-6 on Suicide Awareness, including the incorporation of evidence-based Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines related to suicide evaluation and prevention.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that AFRH Agency Directive 9-6 was tailored for the population of the AFRH. USD (P&R) stated, in response to the previous recommendation, that AFRH would incorporate relevant information from the June 2013 VA/DoD Clinical practice guidelines for the assessment and management of patients at risk for suicide, as policy is updated.

Our Response

While management's comments were only partially responsive, we view the USD (P&R) comments as meeting the intent of the recommendation. We will request a status on the update of the agency directive at a later date.

(2) Ensure the Armed Forces Retirement Home – Gulfport handbook for privileged providers is shared with, and appropriately applied by, the Armed Forces Retirement Home – Washington, D.C.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that the AFRH-G "Provider's Wellness Manual" would be distributed for use on both campuses.

Our Response

Management's comments were responsive. We will request a status of the distribution of the "Provider's Wellness Manual" at a later date.


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Observation 3

Facility Healthcare Services Standard Operating Procedures

AFRH had numerous medical SOPs, many of which were overlapping, contradictory, and difficult to understand. Some SOPs used references that were not pertinent to the subject or were markedly out of date. The SOPs, which should be specific to the individual facility, often were not. Furthermore, facilities were not in compliance with many of the SOPs. The DoD IG Inspection Team did not find any SOPs for two high-risk activities: (1) Coumadin[19] Clinic,[20] and (2) End of Shift Narcotic Counts.[21]

This occurred because the medical and clinical leadership lacked either knowledge or authority (or both) to improve policies and procedures.

Because SOPs were too broad, vague, or non-existent:

- Staff was unable to obtain and/or understand necessary AFRH requirements and guidance on appropriate and current healthcare policy and practice.
- Residents were not receiving current evidence-based care and services in many areas of healthcare.
- In the absence of the Coumadin Clinic Nurse Practitioner, patients might not receive timely management of anticoagulation.

The absence of clear policy on end of shift narcotic counts could lead to drug diversion. Also, it would be difficult to take disciplinary action if staff members took advantage of the situation.

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[19] Coumadin is a prescription anticoagulation brand of the warfarin medication used to treat existing blood clots and to prevent blood clots formation in the body that cause strokes, heart attacks, and other serious conditions depending on location of formation. Retrieved from the FDA website: www.fda.gov/downloads/drugs/drugsafety/ucm088578.pdf, October 10, 2013.

[20] The Coumadin Clinic (also called Anticoagulation Clinic) is a service established to monitor and manage the medication(s) taken [by a patient] to prevent blood clots. Retrieved from the Cleveland Clinic online health library: http://my.clevelandclinic.org/drugs/coumadin/hic_anticoagulation_clinic.aspx, October 22, 2013. At both AFRH facilities, the Coumadin Clinic is staffed by a nurse practitioner who checks the results of the patient's blood test and adjusts the dose of Coumadin, as well as other medicines that may be needed.

[21] End of Shift Narcotics Count is a reconciliation process conducted at the end of a shift where nursing staff counts drugs in stock and accounts for any deficiencies from the total starting amount.

Discussion

The SOPs for AFRH-W and AFRH-G were generally identical. The AFRH Agency wanted to have standardized operations at both facilities. However, the facilities were different, not only in physical layout, but also in aspects of their healthcare operations, such as pharmacy. Therefore, in many situations, the AFRH-G SOPs needed to be different from AFRH-W SOPs. This is an ongoing issue for the AFRH-G staff.

The DoD IG Inspection Team reviewed all the available SOPs. The SOPs were grouped into five different areas of healthcare:

1. Healthcare Services Administration,
2. Health Information Services,
3. Medical Services,
4. Nursing Services, and
5. Rehabilitation Services.

The DoD IG Inspection Team discussed their concerns with the CHS at the two facilities.

As a result of the DoD IG Inspection Team's review and discussions, the DoD IG Inspection Team identified the following issues with various SOPs.

Healthcare Services Administration Area

Infection Control SOP

The infection control policy was similar to one used in acute care hospitals (instead of tailored for AFRH)[22] and included references to infections caused by devices not used at the AFRH. In addition, the policy did not mention urinary catheters, a device very important to the AFRH. Furthermore, the policy included information on chemical spills and operation of sharp hand tools—topics that were unrelated to infection control.

[22] Acute care hospitals diagnose and treat more acute types of conditions/illnesses in contrast to long term care facilities such as AFRH which seeks to manage an individual's decline in health as they age.

Sentinel Events[23] SOP

The Sentinel Event SOP used multiple references that were not related to the sentinel events, including references on:

- research conducted at a Federal facility,
- investigational new drug applications, and
- documentation of consent in human research subjects.

Sentinel events which did not apply to the AFRH, such as transfusion reactions and radiation therapy overdoses, were also included in this policy.

Skin Integrity SOP

Although the Skin Integrity SOP required a "Wound Prevention Committee," there was no evidence that this committee existed at either facility.

Weight Management SOP

The Weight Management SOP required a "Weight Management Committee." Although AFRH-G had established this committee, chaired by the dietitian, AFRH-W did not have such a committee.

Medical Services Area

Competency-Performance Assessment SOP

The Competency-Performance Assessment SOP required use of a standard form to evaluate privileged providers. This was inadequate because the form did not require an evaluation of peer review data, performance data, and prior privileges during the privileging/re-privileging process, all common practice in the industry. Additionally, AFRH could eliminate the Nurse Practitioners SOP if they conducted the privileging process in a thorough manner to define the scope of practice for nurse practitioners.

[23] Sentinel Event—an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Health Information Services Area

AFRH-W Health Information Services SOPs often duplicated or contradicted other SOPs. In addition, some AFRH-W Health Information Services SOPs did not meet requirements for common industry practices and accreditation, and/or had incorrect references.

Release of Patient Health Information

Each of the following SOPs—AFRH-W Standard Operating Procedure W-HIM-4-02, "Consent for Use of Individual Identifiable Health Information," June 8, 2013; W-HIM-4-05, "HIPAA Compliance," June 8, 2013; W-HIM-4-07, "Medical Information Request," June 8, 2013; W-HIM-4-11, "Privacy Practice," June 8, 2013; and W-HIM-4-13, "Records of Residents - Copying," June 8, 2013 all gave instruction about the release of patient health information. These SOPs should be combined to form one cohesive SOP, written in an easier to understand manner.

Abbreviations – Medical SOP

For example, AFRH-W Standard Operating Procedures W-HC-HIM-4-01, "Abbreviations – Medical," July 6, 2012, stated that only approved abbreviations were to be used, but the AFRH-W Standard Operating Procedure W-HC-HIM-4-09 "Medical Records," June 8, 2012, stated that no abbreviations were allowed. The AFRH-G policy that listed "DO NOT USE" abbreviations was more appropriate. This contradiction should be eliminated.

Medical Records SOP

The AFRH-W SOP W-HC-HIM-4-09, "Medical Records," June 8, 2012, was being used as the sole basis for AFRH's peer review process, but it does not meet industry standards for clinical peer review. In addition, the results were not tracked by the provider. Additionally, it referred to "Army Regulation 40-340." No such regulation existed at the time of the inspection. Army Regulation (AR) 40-66, "Medical Record Administration and Healthcare Documentation," January 4, 2010, was determined to be the correct title for the Army medical record regulation in use at the time of the inspection.

Rehabilitation Services Area

Between the Washington and Gulfport facilities, there were 13 SOPs on rehabilitation services. These SOPs listed a 22-year old textbook as their only reference. Given the advances in rehabilitation services, the DoD IG Inspection Team recommends that AFRH use a more up-to-date and recognized reference, such as *Physical Rehabilitation,* 6th edition, August 4, 2006, by Susan O'Sullivan and Thomas Schmitz. This reference is the single most cited source for the physical therapy licensure examination and was recommended by both the Director of the U.S. Army Baylor University Doctoral Program in Physical Therapy and the Consultant to the Army Surgeon General on Rehabilitation Medicine. The Consultant to the Army Surgeon General also concurred with the recommendation to use the VA/DoD CPG as guidance for Cerebrovascular Accident/Stroke Rehabilitation. The DoD IG recommends that AFRH adopt the VA/DoD CPG for its Cerebrovascular Accident/Stroke Rehabilitation program.

Nursing Services Area

AFRH Nursing SOPs were numerous and confusing. For example:

9-1-1 Calls SOP

Multiple AFRH SOPs related to emergency procedures/response differed as to when 911 should have been called.

Emergency Process SOP

AFRH-G's SOP, G-HC-NUR-4-025, "Emergency Process," July 6, 2012, did not list contents of the emergency medication box. SOP W-HC-NUR-4-025, "Emergency Process," June 12, 2012, (AFRH-W) did list medications in the box, including some used in advanced cardiac life support, such as atropine and epinephrine.

However, AFRH did not have appropriate monitoring equipment required for use of those drugs and did not have individuals authorized/qualified to administer Advanced Cardiac Life Support.

Medication SOPs

AFRH-G had 11 Nursing SOPs (SOPs G-HC-NUR-4-038, July 6, 2012, thru G-HC-NUR-4-048, July 6, 2012,) related to medication. With so many SOPs, it was difficult for the staff to find which one applied in a given situation. These SOPs should have been combined into fewer documents or organized in systematic manner for easy reference.

Nursing Responsibilities – All Shifts SOP

Although AFRH-G SOP G-HC-NUR-4-052, "Nursing Responsibilities – All Shifts," July 6, 2012, covered nursing responsibilities, there were duplicate SOPs covering some of the same tasks (SOP G-HC-NUR-4-008, "Assignment Sheets," July 6, 2012, and G-HC-NUR-4-063 "Shift Report (24 Hour) – Nursing Supervisors," July 6, 2012). At AFRH-W, there also was a separate SOP—W-HC-NUR-4-065 "Skipped Medication Reports," June 12, 2012—which overlapped AFRH-W SOP W-HC-NUR-4-052, "Nursing Responsibilities – All Shifts," July 12, 2012. These SOPs should be combined.

Transfer Techniques – Ergonomic SOP

SOPs W-HC-NUR-4-068, "Transfer Techniques – Ergonomic," June 12, 2012, and G-HC-NUR-4-068, "Transfer Techniques – Ergonomic," July 6, 2012, included a section on mechanical lifts, yet separate SOPs—G-HC-NUR-4-036, Lift Devices," July 6, 2012, and SOPs W-HC-NUR-4-036, "Lift Devices," June 12, 2012—also existed. These SOPs should be combined.

All of the above SOPs, covering nursing responsibilities, could have been covered completely in one single SOP. During site inspections, administrators, and staff members were questioned about their knowledge/use of the nursing SOPs. Actual practices/procedures were compared to the written nursing SOPs in place and the DoD IG Inspection Team determined that many of the SOPs did not reflect current practice. Also, practices which can present substantial safety concerns to residents had no standard procedures in place. When nursing staff members were questioned about procedures for specific activities, many were unaware of the SOP or unaware of the contents of the SOP. The CHS at both AFRH-W and AFRH-G were aware that they were not in compliance with all policies and SOPs related to the handling of patients.

Two high-risk areas which would have benefitted from SOPs were (1) Anticoagulation Management, and (2) end of shift narcotic reconciliation (narcotic counts).

Anticoagulation Management (AFRH Coumadin Clinics)

Both facilities offer "Coumadin Clinics" managed by nurse practitioners. Coumadin is one method of anticoagulation. Neither facility had a SOP on anticoagulation. An SOP that included tracking the desired International Normalized Ratio (INR)[24] range for each patient (based on the clinical indication for anticoagulation) would have better enabled other healthcare providers to appropriately manage the patients in the absence of the nurse practitioners. The tracking logs for each patient should also be available to all healthcare providers at the facility.

End-of-Shift Narcotic Reconciliation

In addition, end-of-shift narcotic reconciliation, another high-risk area, had the potential for medication diversion. The DoD IG Inspection Team did not find any AFRH policy related to this area. Although "signing the narcotic book" was listed as a requirement in the SOPs—W-HC-NUR-4-052, "Nursing Responsibilities," July 6, 2012, and G-HC-NUR-4-052, "Nursing Responsibilities," July 6, 2012—the procedure was not specific. For example, both nurses were directed to count the items and sign. There were no specific directions to compare the counts or how to handle count variances. Policies on end-of-shift reconciliations should either be developed as a separate SOP or incorporated into the existing SOP.

Recommendations, Management Comments, and Our Response

Recommendation 3

Armed Forces Retirement Home Chief Operating Officer:

a. Ensure medical standard operating procedures are re-written by individuals with subject matter expertise, including knowledge of current medical evidence-based practice, and that the Armed Forces Retirement Home staff is trained on the updated standard operating procedures.

[24] "International Normalized Ratio" (INR) is used to determine the clotting tendency of blood. The normal range is between 2 and 3.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the Medical SOPs would be reviewed, consolidated when applicable, and rewritten, where necessary, using evidence-based practice guidelines. The medical staff would then be trained on the latest SOPs.

Our Response

Management's comments were responsive. We will request an update on this process at a later date.

b. Develop appropriate standard operating procedures for the identified high-risk areas.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was in progress.

Our Response

Management's comments were responsive. We will request an update on this process at a later date.

c. Revise Armed Forces Retirement Home – Gulfport standard operating procedures to make them specific to Armed Forces Retirement Home – Gulfport needs and requirements.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, reporting that the recommendation was complete.

Our Response

Management's comments were responsive. We request a copy of the revised AFRH-G SOPs in response to the final report.

Observation 4

Policies on Credentialing,[25] Privileging,[26] and Medical Staff Bylaws

The agency notices on medical staff bylaws, credentialing, and privileging:

- were not specific to the scope and organizational function of the AFRH,
- conflicted with Federal requirements,
- were not based upon applicable accreditation standards or DoD policy,
- conflicted with facility SOPs, and
- did not delineate a process for investigating nursing care and reporting disciplinary actions to state licensure boards.

Additionally, none of the agency policies and facility SOPs included a process for investigating the quality of care provided by a nurse to determine if he/she failed to meet standards of practice.

The above conditions existed because of the insufficient oversight by the AFRH medical leadership in developing appropriate agency-level credentialing/privileging policies.

As a result, AFRH was not in compliance with common industry standards for credentialing, privileging, and reporting requirements in instances of sub-standard performance by healthcare providers (including nursing personnel) to state and Federal authorities.

[25] "Credentialing" is the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of clinicians to ensure that clinicians provide safe high quality health-care services in accordance with good practice and legal requirements. Gurgacz, S. L., Smith, J. A., Truskett, P. G., Babidge, W. J., & Maddern, G. J. (2012). Credentialing of surgeons: a systematic review across a number of jurisdictions. *ANZ Journal of Surgery*, 82(7/8), 492-498. doi:10.1111/j.1445-2197.2012.06115.x.

[26] "Privileging" is the process that healthcare organizations employ to authorize practitioners to provide specific services to their patients. It defines the scope and limits of practice for individual providers and is based on the capabilities of the healthcare organization and the credentials of the provider. Gagliano, R. D. (2010). Adverse Privileging Actions in the Army Medical Department. *U.S. Army Medical Department Journal*, 48-55.

Discussion

AFRH Agency Notice 12-12, "AFRH Medical Staff Bylaws, Rules and Regulations," June 30, 2012, and AFRH Agency Notice 12-11, "AFRH Medical Credentialing and Privileging," July 30, 2012, were reviewed and compared to facility SOPs on credentialing. AFRH Agency Notice 12-12 appeared to be extracted from the SOP of a much larger in-patient acute care medical center. This was inappropriate because the AFRH has CARF and The Joint Commission requirements (LTC and Ambulatory Care) that are not required for large in-patient acute care medical centers.

AFRH Agency Notice 12-12 included services that were not offered at the AFRH and which exceeded the scope of the AFRH. The notice required multiple medical staff committees that did not exist within the AFRH. In addition, the guidance provided in AFRH Agency Notice 12-12 for reporting adverse actions to the National Practitioner Data Bank (NPDB)[27] did not meet the requirements delineated in the NPDB Guidebook. Moreover, the above guidance, together with the AFRH Agency Notice 12-11, laid out an adverse action process that differed from the facility SOPs on the same subject.

Both AFRH Agency Notice 12-11 and 12-12 failed to require privileging of nurse practitioners (although the facilities were privileging nurse practitioners). Also, these notices failed to address many of the other providers who were appropriately being privileged by the facilities, such as:

- psychologists,
- dietitians,
- social workers,
- physical therapists,
- occupational therapists,
- optometrists, and
- speech pathologists.

[27] National Practitioner Data Bank is a confidential information clearinghouse created by Congress, used in conjunction with other sources to facilitate a comprehensive review and verification of the professional credentials of healthcare practitioners who seek to be privileged at a healthcare organization. Retrieved from the NPDB website: http://www.npdb-hipdb.hrsa.gov/hcorg/aboutQuerying.jsp, 22 October 2013.

Similarly, AFRH facility SOPs G-HC-MED-4-03, "Credentialing," July 29, 2012, and W-HC-MED-4-03, "Credentialing," June 6, 2012, did not address the credentialing and privileging of many of the providers already privileged at AFRH.

None of the agency policies and facility SOPs included a process for investigating the quality of care provided by a nurse to determine if he/she failed to meet standards of practice. Such a process is usually necessary to file a report to state licensing and certification boards when a nurse is removed from practice due to competency or other issues.

Although 24 U.S.C. §411(d)(3) (2012) stated that "the administration of the Retirement Home, including administration for the provision of healthcare and medical care for residents, must remain under the control and administration of the Secretary of Defense," the USD (P&R) had not directed the AFRH to follow DoD instructions or regulations that were determined to be applicable to the AFRH. Consequently, the 2010 DoD IG Inspection report recommended that the USD (P&R), "promulgate all desired DoD guidance deemed applicable to AFRH." This had not occurred because the USD (P&R) declined to identify DoD instructions and regulations applicable to the AFRH, citing DoD Instruction 1000.28, "Armed Forces Retirement Home (AFRH)," February 1, 2010, paragraph 4.b, which stated that AFRH, "is not subject to DoD policy and issuances except when expressly made applicable to the AFRH." This USD (P&R) position missed the intent of the recommendation in that USD (P&R) was supposed to identify the applicable DoD policy and issuances and expressly direct AFRH to follow them. Failure to implement the recommendation in the 2010 DoD IG Inspection report was a significant contributing factor in the issues identified during this DoD IG inspection.

Recommendations, Management Comments, and Our Response

Recommendation 4

Armed Forces Retirement Home Chief Operating Officer:

a. Ensure appropriate corrections to agency and facility policies, including bringing the policy into compliance with applicable Department of Defense medical instructions, directives, and regulations.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that, while standards of The Joint Commission and CARF would be the lead consideration in policy development at the AFRH, medical instructions, directives, and regulations from other Federal agencies would be referenced in development of AFRH policy.

Our Response

Management's comments were responsive. We will evaluate this area again during our next inspection.

b. Provide a process for the investigation of nursing practice and subsequent reporting to state boards of nursing.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that Nurse Practitioner policy would be broadened, to include investigation of incidents and subsequent reporting to state boards of nursing.

Our Response

Management's comments were responsive. We will request an update on this process at a later date.

Observation 5

Credentialing and Privileging Process at Armed Forces Retirement Home

The DoD IG Inspection Team observed that privileges granted to providers included types of services that were not offered at the AFRH facilities. The DoD IG Inspection Team also found that no data was being tracked for use in re-privileging decisions.

This occurred because of a lack of appropriate medical oversight to the credentialing and privileging process at the agency and AFRH-W levels, and because of a failure to obtain appropriate training for staff involved in the process.

Consequently, inadequate credentialing and privileging allowed one unqualified healthcare provider to work at AFRH and could allow other similar cases in future.

Discussion

Although, the credentialing and privileging process at AFRH had improved from the 2010-2011 timeframe, significant issues still existed. The lack of definition of qualification requirements by specialty made it more difficult for those without training in credentialing to adequately perform their tasks. The credentials file review identified one social worker at AFRH-G who did not have the correct level of licensure for the privileges she was granted. She also did not meet the licensure requirements in her job description.

The AFRH-G SOP G-HC-MED-4-03, "Credentialing," June 29, 2012, indicated that AFRH-G did their own privileging, although all privileging was actually done in AFRH-W by the AFRH-W credentials committee. The current procedure involves the Administrative Assistant to the AFRH Agency Medical Director verifying the credentials at AFRH-W and managing the credentials committee minutes. The AFRH Agency Medical Director gives guidance to the Administrative Assistant on credentialing and privileging.

Although an AFRH-W staff member attended a briefing on credentialing and privileging provided by the Chief of Quality Management (QM), U.S. Army MEDCOM, in March 2011 and hoped to attend the Army training that

was offered at that time, she did not receive the training. This happened because the agency Medical Director did not send any staff to attend this training. Staff members at both facilities indicated that they were still interested in attending further training and improving their skills.

At the time of the March 2011 MEDCOM Chief of QM briefing, the AFRH-W SOP 3-01, "Credentialing," December 6, 2010, incorporated some, but not all, guidance delineated in Army Regulation 40-68, "Clinical Quality Management," February 26, 2004, on credentialing and privileging. The SOP 3-01 required the use of only some of the forms required by AR 40-68 for use in the credentialing process and the decision to award privileges. AFRH staff members were not using the Department of the Army (DA) Form 5754 and SOP 3-01 did not require the use. Had they used DA Form 5754, it would allow AFRH to capture information about the seeking provider related to previous adverse actions taken against a provider's licensure and/or privileges, malpractice cases, and conditions that may impact the provider's ability to deliver care. In addition, AFRH staff members were not querying, and SOP 3-01 did not require, AFRH staff members to query, the NPDB prior to privileging medical providers, even though this was required by of both Army and DoD regulations. At the time of the 2012 inspection, the DoD IG Inspection Team noted that AFRH had initiated NPDB queries and were utilizing the equivalent of the DA Form 5754. The DoD IG Inspection Team was aware that this practice was only recently adopted and not in place in 2011. The DoD IG Inspection Team determined that, in or around March 2011, AFRH was not complying with the requirements of AR 40-68.

All the credentials files at both AFRH locations were reviewed. Throughout the review, the findings and recommendations were discussed with the Administrative Assistant at AFRH-W and the CHS at AFRH-G. Findings and recommendations were also discussed with the agency Medical Director. The credentials file review at AFRH-W was performed on two dates. On the first occasion, the DoD IG Inspection Team identified an issue with expired licenses and credential issuing organizations' verification of a credential of a dietitian. Upon notification of that issue, the AFRH-W staff member immediately recognized that she had other files with similar issues. By the time of the second visit, the staff member had completed or requested those verifications on the certifications/registrations of Dietitians, Occupational Therapists, Speech Therapists, and Educational Commission for Foreign Medical Graduates certifications on two physicians.

The most significant credentials finding was a social worker at AFRH-G who was not licensed to work independently. Both her job description and the privileges she was granted by the credentials committee required licensure at an independent level. She was licensed at the bachelor's degree level in the state of Mississippi, which limits the scope of practice, specifically stating that she must be under supervision (not independent) and "should not provide clinical social work services, psychotherapy, or engage in autonomous practice." Yet, the social worker was still privileged (via the AFRH-W credentials committee) to independently provide social work services and some therapies at AFRH-G. Other findings at AFRH-G included failure to perform primary source verification of residency training of two providers and failure to verify all licenses of several other providers.

Findings at AFRH-W included the need to verify the Educational Commission for Foreign Medical Graduates certification and the fellowship of a physician, and a dietitian whose file stated she was not required to have a license and did not require privileges. The Administrative Assistant did not know why this statement was in the file and neither did the AFRH Agency Medical Director, who was previously the CMO and Chair of the credentials committee at AFRH-W. The dietitian was registered through the Commission on Dietetic Registration. The supervisory dietitian was licensed, registered, and privileged. Although the Office of Personnel Management qualification standards required the registration, neither position descriptions (PDs) for the dietitians required the dietitians to be licensed or registered. The AFRH needs to decide how to implement licensure or registration.

No data was being collected and used to support effective re-privileging. Effective peer review was not being performed. At the time of the inspection, a peer would be asked to fill out a "peer appraisal" form, but it was not based on any data tracked by the facility on individual providers.

The AFRH had re-privileged all the providers at the 1-year mark. This was not necessary. It may be done every 2 years. Strictly speaking, the NPDB Guidebook allows organizations who renew privileges every year to only query the NPDB every 2 years, so the AFRH was not in violation of NPDB rules in this area. But it would be more efficient to synchronize completion of forms, NPDB queries, and re-privileging. At the time of re-privileging, AFRH did not require the providers to fill out the AFRH equivalent of the DA Form 5754, which required the provider to provide information about adverse licensure events,

malpractice, and other adverse events. According to the DoD IG Inspection Team's medical inspectors, this should have been done each time the provider was re-privileged. NPDB queries should have also been performed at the time of re-privileging.

Privileges must be specific to the medical capabilities of the facilities. Multiple providers from WRNMMC had been granted privileges by AFRH to provide services in areas that did not exist at AFRH. Some providers were privileged using standard DA forms, while others were privileged using improvised forms created by copying DA Form contents onto an AFRH letterhead. The AFRH-W Administrative Assistant noted that she had asked about modifying the content to delete items that did not apply, including the out-of-scope capabilities, but that was not approved by the AFRH Agency Medical Director.

Recommendations, Management Comments, and Our Response

Recommendation 5

Armed Forces Retirement Home Chief Operating Officer:

a. Ensure appropriate training for those personnel performing credentials verification and ensure oversight by qualified medical leadership to oversee the credentialing process.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that training for all personnel involved in credentialing verification was completed in April 2013.

Our Response

Management's comments were responsive. We ask that the AFRH COO provide a copy of training documentation in response to the final report.

b. Ensure that privileges on the Armed Forces Retirement Home forms are limited to those procedures and practices that are within the operational scope of the facilities.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that specialists in each discipline would review requests to ensure that all requests are within the scope of the facility.

Our Response

Management's comments were partially responsive, since they describe what was being done at the time of our inspection, which, at least at that time, was not sufficient. We ask that AFRH management review the forms they have developed and remove the procedures that are outside the scope of the facility from the forms, eliminating the ability to request procedures that are not done at AFRH. We will request an update on this process at a later date.

c. Immediately institute peer review and tracking of peer review data by provider for use in evaluation of their competence for re-privileging.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that data documentation would be reported in a manner that more clearly demonstrates its connection to the renewal of clinical privileges. He also disagreed with the inspectors statements that the AFRH was not using DA 5754 (Malpractice History Form) and did not query the NPDB prior to privileging medical providers. He reported that use of DA 5754 and query of the NPDB had been standard practice for 12 years.

Our Response

Management's comments were partially responsive. While our medical inspectors were not able to document use of the DA 5754 and query of the NPDB prior to 2011, we will not dispute management's contention. Additionally, our medical inspectors determined that peer review in connection to renewal of clinical privileges involved only a limited review of records that did not evaluate or track the content of the medical record, the assessment of the patient, the appropriateness of the treatment, etc. We will look at this again on our next inspection.

d. Include the qualification requirements in policy, by specialty. (Chapter 7 of Army Regulation 40-68 could be used as a guide to placing qualification requirements into the Armed Forces Retirement Home Agency guidance for those specialties employed or contracted to work at Armed Forces Retirement Home facilities.)

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that AFRH elected to not have a chapter in policy referring to qualifications, relying instead on position descriptions (PDs) for Federal employees and qualification on the Contractor's Performance Work Statement (PWS) to delineate qualifications. A copy of the position description or PWS qualification requirements will be included in each credentialing package.

Our Response

Management's comments were partially responsive. DoD IG medical inspectors' observations found indications that position descriptions were altered to lower the credentialing requirements or were not used at all. This could result in selection of less than best-qualified candidates for medical leadership positions. The PDs and PWS need to be written with knowledge of the requirements of the specialty. The requirements, by specialty need to be established first, not fully based on what may be outdated Office of Personnel Management (OPM) specialty requirements. We will look at this again on our next inspection.

e. Take immediate action to remove the privileges of the social worker with the incorrect level of licensure and notify her of the requirement to obtain licensure at the independent (non-supervised) level.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO reported that the employee in question no longer works for the AFRH.

Our Response

Management's comments were responsive. No further action is required.

Observation 6

Involvement of the Office of the Deputy Director, Defense Health Agency and the Under Secretary of Defense for Personnel and Readiness

The DoD IG Inspection Team observed that:

- There was no routine interaction between the Deputy Director of DHA and the USD (P&R) on AFRH operations. At the time of the inspection, interactions occurred only when there was a crisis-level issue at the AFRH.
- The Deputy Director of DHA had no formal recordkeeping process to document his/her visits to the AFRH and the recommendations made to the COO or Advisory Council.
- The USD (P&R) had not required AFRH to follow DoD instructions, regulations, or directives. Because of this condition, the Deputy Director of DHA could not require AFRH to follow DoD instructions, regulations, or directives.

This occurred because the language of section 411(a), title 24, United States Code (24 U.S.C. § 411(a) [2012]) and DoD Instruction 1000.28 (2010) state that AFRH is an independent agency. This caused confusion about the roles and responsibilities of OUSD (P&R) in performing oversight and providing guidance to the AFRH, as delegated to the Secretary of Defense by 24 U.S.C. § 411(d)(3) (2012).

As a result, when the Deputy Director of DHA disagreed with, or was concerned by, a decision made by the AFRH COO, there was no effective system in place to raise the issue with the USD (P&R) and no records system to document it.

Discussion

Section 413a, title 24, United States Code required that the:

- Secretary of Defense designate the Deputy Director of the DHA to serve as the SMA to the AFRH,
- SMA provide advice regarding the direction and oversight of medical administrative matters and the provision of care at the AFRH sites to the:
    - Secretary of Defense
    - USD (P&R)
    - COO
    - Advisory Council
- SMA advise the USD (P&R) regarding the operations of the AFRH, and
- SMA conduct periodic visits to the facilities to review medical facilities, operations, records and reports, the quality of care provided to residents, and ensure appropriate follow-up of inspections and audits occurred.

The Deputy Director of DHA (at the time of DoD IG inspection) assumed his position as the AFRH SMA in the summer of 2011. He visited the facilities once in 2012. He and his staff also visited AFRH-W and AFRH-G facilities in the months preceding the DoD IG inspection. However, documentation of the prior SMA visits to AFRH and involvement was primarily by e-mail and was generally unavailable once that SMA left the organization.

The previous SMA made several visits to the AFRH-W in 2009, including one on Thanksgiving Day. In late 2010, an issue arose at the AFRH-W facility and DHA assisted with evaluation of the issue. It was discovered that the AFRH leadership had allowed a psychiatrist, who had lost his license, to continue practicing at the AFRH-W. The SMA worked with the COO to develop a plan to manage the issue. On February 9, 2011, a physician and a nurse from DHA went to the facility and reviewed all credentials files. Among their recommendations was to have the staff at AFRH obtain formal training on credentialing.

At the time of this review, the AFRH was following some, but not all guidance delineated in AR 40-68, "Clinical Quality Management," February 26, 2004.

The DHA nurse requested that the MEDCOM Chief of QM review the AFRH SOP on credentialing and provide training on credentialing and privileging at AFRH-W. On March 24, 2011, the MEDCOM Chief of QM, gave a presentation on credentialing and privileging at AFRH Agency. A discussion of peer review and on-going monitoring of performance ensued. The MEDCOM Chief of QM's review of the AFRH SOP on credentialing and privileging also identified questions about the applicability of DoD policies and regulations to the AFRH. The MEDCOM Chief of QM offered to allow staff from AFRH to attend MEDCOM sponsored training on credentialing and privileging. The offer included use of the DoD Centralized Credentials Quality Assurance System under the Army section of that system. However, at the time of the DoD IG inspection, no staff members had attended this training.

In that same time period, the AFRH COO decided to designate a Medical Director at the agency level. The SMA and DHA staff reportedly advised the COO not to promote the AFRH-W CMO to this position because of his role in allowing the unlicensed psychiatrist to work and his reported inability to grasp the concepts of quality management and peer review (for which he would be responsible at the agency level). The AFRH COO states he did not receive this advice from the SMA or the DHA staff. The COO proceeded to promote the AFRH-W CMO to the Medical Director position at the agency level.

At the time of the DoD IG inspection, there were no regularly scheduled meetings between the SMA and the USD (P&R). There were also no regular reports by the SMA to the USD (P&R). The SMA spoke with the USD (P&R) only if an issue arose. The incumbent SMA noted that his role was only advisory and he could not require the AFRH to follow his advice. As a result, the SMA had no visibility of key hiring actions/internal promotions or medical issues occurring at the AFRH. Furthermore, the SMA was not consulted on budgetary issues which affected the adequacy of medical and nursing staff. Meetings and reports between the SMA and the USD (P&R) would be useful to ensure that the advice provided by the SMA would be followed (or at least seriously considered) by the COO.

Recommendations, Management Comments, and Our Response

Revised Recommendation 6.a

Under Secretary of Defense for Personnel and Readiness:

(1) Strengthen the advisory role of the Senior Medical Advisor by improving his/her oversight over medical issues and personnel issues associated with key medical positions at the Armed Forces Retirement Home.

Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) non-concurred with the recommendation as written in the draft report, which stated "…strengthen the oversight role of the Senior Medical Advisor by improving his/her authority over medical, budgetary, and personnel issues at the Armed Forces Retirement Home." USD (P&R) noted that statutory language establishes the SMA requirements, stating that the SMA shall provide advice to the Secretary of Defense, the USD (P&R), the AFRH COO, and the Advisory Council regarding the direction and oversight of medical administrative matters and the provision of medical and dental care services. The SMA has no authority over the AFRH, as stated in the recommendation. The SMA responsibilities do not include budgetary and personnel issues.

Our Response

Based on management's comments, we revised the recommendation as noted above, stating that USD (P&R) should strengthen the SMA's advisory role, removing the implication that he had authority over the AFRH COO. We ask that the USD (P&R) respond/comment on this revised recommendation in response to the final report.

(2) Establish routine communication and reporting requirements to the Under Secretary of Defense for Personnel and Readiness from the Armed Forces Retirement Home Chief Operating Officer and the Deputy Director of Defense Health Agency, including periodic reports on Defense Health Agency interactions with the Armed Forces Retirement Home.

Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) concurred, stating that the SMA developed an oversight plan that included communication and reporting requirements. This plan was approved by the USD (P&R).

Our Response

Management's comments were responsive. We request a copy of the SMA's oversight plan in response to the final report.

(3) Ensure that records of these reports are formalized and maintained.

Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) concurred, stating that the SMA's oversight plan contained documentation requirements.

Our Response

Management's comments were responsive. We request a copy of the SMA's oversight plan in response to the final report.

Revised Recommendation 6.b

Deputy Director of the Defense Health Agency, advise the Under Secretary of Defense for Personnel and Readiness and the Armed Forces Retirement Home Chief Operating Officer on which Veteran Affairs/DoD Clinical Practice Guidelines may be appropriate for incorporation into medical operations at the Armed Forces Retirement Home.

Deputy Director of the Defense Health Agency/Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) and the Deputy Director, DHA, non-concurred with the recommendation as written in the draft report, which stated "…advise the Under Secretary of Defense for Personnel and Readiness on which Department of Defense Medical Instructions, Regulations, and Directives are appropriate for the Armed Forces Retirement Home to follow/implement." USD (P&R) noted that statutory language establishes the SMA requirements, stating that the SMA shall provide advice to the Secretary of Defense, the USD (P&R), the AFRH COO, and the Advisory Council regarding the direction and oversight of medical administrative matters, provision of medical and dental care services. The SMA

has no authorityover the AFRH. USD (P&R) stated that AFRH would follow national medical standards, as does the DoD and VA, when developing medical policies. AFRH should consider incorporating relevant information from VA/DoD CPGs. Requiring AFRH to follow DoD/VA medical standards for which they have no input to the content would create risk for noncompliance with nationally recognized medical standards focused on the population and organization of the AFRH.

Our Response

Based on management's comments, we revised the recommendation as written above. We note that section 413a(2), title 24, United States Code (24 U.S.C. § 413a(2) [2012]) states that the SMA shall 'ensure compliance by the facilities of the retirement home with accreditation standards, applicable health care standards of the Department of Veterans Affairs, or any other health care standards and requirements (including requirements identified in applicable reports of the Inspector General of the Department of Defense." USD (P&R) stated, in response to recommendation 1.a and 1.b, that AFRH would incorporate relevant information VA/DoD CPGs for the assessment and management of patients at risk for suicide, as policy is updated. In response to the final report, we ask that the Deputy Director of the DHA respond/comment on this revised recommendation that supports the USD (P&R) position.

Observation 7

Medical Leadership

The DoD IG Inspection Team observed that:

- AFRH Agency and AFRH-W lacked sufficiently competent physician leadership. The incumbents did not:
    - have the knowledge and skills to perform the functions required of their job description, and
    - understand evidence-based practice, including clinical practice guidelines and national immunization recommendations.
- AFRH-G had a part-time contract physician who performed some of the CMO duties. He had the knowledge and skills required to perform the duties of CMO.

This occurred because AFRH upper management appeared to hire less qualified internal candidates, instead of opening positions to external applicants who might be better qualified. AFRH upper management placed very high priority on the candidate's length of service at AFRH rather than on the capability of the candidate. Also, the COO preferred to pay the lower end of the salary range to the staff, which resulted in the exclusion of more qualified candidates who were unwilling to accept the lower salary.

These issues were significant contributing factors to the overall issues with SOPs and were contributing to residents not receiving evidence-based care and recommended immunizations.

Discussion

The DoD IG Inspection Team conducted multiple interviews with the medical and healthcare leadership. The DoD IG Inspection Team also reviewed job descriptions, curriculum vitae, and policies. The interviews included the AFRH Agency Medical Director, the AFRH-W CMO, the AFRH-G part-time contract CMO, the AFRH-W Chief of Performance Improvement (PI), the DHA SMA, and the CHSs and Directors of Nursing (DON) of both facilities. The DoD IG Inspection Team also interviewed the COO, as a follow-up to previous interviews.

AFRH Agency Medical Director

The AFRH Agency Medical Director position was developed after an adverse event at the facility resulted in the SMA's staff identifying that AFRH-W was allowing a psychiatrist who had lost his license to continue to work at the facility. The individual responsible for that error in judgment was promoted to the AFRH Agency Medical Director position, despite the SMA's advice against the promotion. Federal regulation does not require the AFRH to follow the advice offered by the Deputy Director, DHA, only that this advice be provided.

The AFRH Agency Medical Director job description provided to the medical team included the following duties:

- developing and implementing clinical policies, guidelines, and procedures for comprehensive healthcare programs at both AFRH facilities;
- establishing practice parameters for non-physician healthcare providers and procedures for monitoring the quality of care provided;
- keeping healthcare administrators informed of any problems regarding access to care, quality of care, and risk management issues;
- performing direct patient treatment, both inpatient and outpatient;
- developing a full treatment regimen, including the knowledge of new techniques and advanced procedures;
- chairing the clinical investigation committee;
- monitoring the quality of healthcare delivered; and
- assuring that both facilities meet national accreditation standards.

The AFRH Agency Medical Director spent almost his entire career at the AFRH-W. He had only 2 years of clinical experience (other than training programs and research) prior to coming to AFRH-W. The AFRH Agency Medical Director was involved in formulating agency policies on credentialing, medical staff bylaws, pain management, and suicide awareness. However, he was not tracking any data related to the implementation of these policies. In interviews, the AFRH Agency Medical Director could not articulate, and appeared to not understand, quality management processes such as peer review and clinical quality improvement. With regard to any data used for clinical performance

improvement, the AFRH Agency Medical Director referred the DoD IG Inspection Team to the AFRH-W PI Integrator, who had since been promoted to the agency level. The AFRH Agency Medical Director did not use any of the VA/DoD CPGs. He was only familiar with the American Diabetes Association CPG on diabetes.

The AFRH Agency Medical Director was the agency-level official responsible for planning and supervising direct healthcare services and for establishing practice parameters for non-physician healthcare providers. However, he did not know what action was being taken regarding the social worker who did not meet licensure requirements for her position and privileges at AFRH-G, when questioned by the DoD IG Inspection Team a week after the on-site inspection has identified the deficiency. Immediately following the DoD IG visits, the newly selected AFRH Agency PI Integrator noted that she had been tasked to manage the credentialing process for AFRH, a function that was usually part of the job description of the AFRH Agency Medical Director.

Armed Forces Retirement Home – Washington, D.C. Chief Medical Officer

At the time of inspection, the AFRH-W CMO had been in this position for 8 months. He worked as a contractor at the AFRH from 1986 to 2004 and later returned to AFRH in 2007 as an employee.

The AFRH-W CMO reviewed medical records on the providers he supervised (the nurse practitioners), but was not aware of any peer reviews on these providers.

According to the CMO, podiatrists at the two facilities reviewed each other's records. However, there was no established standard as to what they reviewed. Also, there was no tracking of the findings for re-appraisal and re-privileging of the podiatrists.

In addition, the AFRH-W CMO did not appear to understand the concept of CPGs. Even after the concept was explained and the example of his own professional organization, (which developed CPGs) was provided, the AFRH-W CMO still did not seem to understand. He was unaware of VA/DoD CPGs.

As the DoD IG Inspection Team discussed immunizations with the AFRH-W CMO, they determined that the AFRH-W CMO was unaware that the Zoster vaccine has been recommended by the Centers for Disease Control and Prevention since 2008 for individuals over the age of 60. The residents of the AFRH were all in this age group.

Armed Forces Retirement Home – Gulfport Chief Medical Officer

AFRH-G had a part-time contractor performing some of the duties of a CMO. The incumbent was recently retired from the Air Force, where he last served as Chief of the Medical Staff. He was fully up to date on evidence-based practice, including CPGs. He understood quality management and performance improvement. In addition, the CHS and the DON both had LTC experience and were fully aware of VA/DoD CPGs and other standards of practice.

Recommendations, Management Comments, and Our Response

Recommendation 7.a

Under Secretary of Defense for Personnel and Readiness, require the Armed Forces Retirement Home Chief Operating Officer to open available agency-level and facility-level leadership position hiring actions to external applicants and authorize the Senior Medical Advisor to participate in the selection process.

Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) concurred, stating that the recommendation was complete. The Chief of Healthcare Services and Director of Nursing position for the AFRH-W were posted on USA Jobs and a representative of the SMA was on the selection panel.

Our Response

Management's comments were responsive. No further action is required at this time.

Recommendation 7.b

Armed Forces Retirement Home Chief Operating Officer:

(1) Set hiring criteria and performance objectives which require that the current and future Agency Medical Directors and Armed Forces Retirement Home – Washington, D.C. Chief Medical Officers be, or become, clinically and administratively competent.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that the recommendation was complete, as hiring criteria and performance objectives are determined by the position description and that the current AFRH Medical Director and CMO meet all the criteria in their position descriptions.

Our Response

Management's comments were partially responsive. While hiring criteria may be derived from position descriptions, there is no OPM requirement that performance objectives in the individual's annual performance plan must be exclusively drawn from position descriptions. We ask that the AFRH COO determine how he would modify the appropriate performance objectives to require administrative and clinical competency of the AFRH Medical Director and CMO. He should seek the assistance of the SMA in developing these performance objectives. We will request an update on this process at a later date.

(2) Convert the Armed Forces Retirement Home – Gulfport contract physician position to full-time civil service position.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that the physician position's conversion to a full-time civil service position was underway.

Our Response

Management's comments were responsive. We will request an update on this process at a later date.


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Observation 8

Human Resources Practices and Impact on Medical Issues

The DoD IG Inspection Team observed that:

- AFRH had not opened medical and healthcare leadership job announcements to outside candidates.
- AFRH-W had altered position descriptions, in at least one case, to allow the selection of internal candidates who did not meet prior qualification requirements.
- AFRH was not following the recommendations of BPD to report individuals disciplined/terminated for negligence to state licensing/ certifying boards.
- Supervisors at AFRH had not been trained to serve as supervisors in the Federal system.

This occurred because:

- AFRH leadership failed to follow AFRH regulations or guidance in their human resources (HR) practices.
- AFRH had not been required to, and did not follow DoD regulations in their HR practices.
- AFRH COO failed to ensure that appropriate training was provided to all supervisors.

This has resulted in:

- inability of leadership to set appropriate medical standards for the care of residents, increasing the risk of inadequate, and inappropriate care;
- nursing personnel who were disciplined/terminated for negligence not being reported to state licensing boards; and
- nursing supervisors who felt that they could not improve the quality of medical services at AFRH and had to tolerate incompetent personnel.

Discussion

Significant HR issues were identified throughout the inspection. Specifically:

- nursing supervisors had not received supervisory training;
- policies did not include a process to evaluate quality of care issues in nursing and to report instances of abuse, neglect, mistreatment of residents, or misappropriation of their property to state licensing boards;[28]
- supervisory nursing personnel believed they were unsupported when disciplinary actions concerning their staff needed to be taken at AFRH-W;
- AFRH Agency and AFRH-W lacked adequate medical leadership; and
- AFRH Agency and AFRH-W failed to open jobs for competition to anyone outside the organization.

The only HR training that AFRH had documented for supervisory nursing personnel was the "No Fear Act" training. This was true at both AFRH-W and AFRH-G facilities.

At the time of the inspection, BPD was providing HR support to the AFRH. Interviews were conducted with staff members and the supervisor of the Labor and Employee Relations section at BPD. All allegations of nursing "negligence" were supposed to be reported to BPD for possible investigation. In the past, AFRH conducted its own investigations, but this responsibility was shifted to BPD to ensure consistency in both the investigative process and the disciplinary actions taken as a result of the investigations. However, BPD did not have clinical personnel and had to rely on the expertise of the medical/nursing staff at the AFRH facility where the issue had originated. This raises questions about the independence of their investigation. It was also noted that BPD had recently investigated medical action taken by a physician. This was inappropriate, as BPD had no personnel qualified to investigate the clinical care delivered by a physician. In addition, AFRH Agency policies on medical staff credentialing and privileging required an investigation be done by a physician.

[28] 42 CFR 483.13(c)(2) Retrieved from http://www.law.cornell.edu/cfr/text/42/483.13, 22 October 2013.

Since 2008, BPD had recommended that AFRH report all medical and nursing personnel terminated for negligence to their state licensing boards. However, AFRH had not followed these recommendations. In addition, those allowed to resign (in lieu of termination) should have also been reported to their state licensing boards (board requirements). However, AFRH did not report such cases to the licensing boards.

Excluding simple medication errors and other minor reports, BPD had 21 significant medically-related cases in 2012 (January 1–November 14). Nine of those cases were still under review. Reports to state licensing boards were required by multiple regulations. DoD Regulation 6025.13-R, "Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation," June 11, 2004, requires reporting professional review actions to state licensing boards. AR 40-68, which ARFH was partially following in the past, also requires reporting to state licensure boards.

The issues of inadequate medical leadership and failure to open jobs to individuals outside the agency were very much related. When questioned about why they did not open job announcements externally, the COO and the Chief Human Capital Officer stated that they had qualified candidates at the AFRH, so there was no need to open the vacancies to external candidates. However, they based their principal determination of the qualification of candidates on time in service at AFRH and loyalty to the AFRH, but not necessarily on competence or capability.

As a result of this personnel practice, AFRH-W leadership had an agency Medical Director who did not understand or meet most of the requirements of his job description. Some of his duties were being shifted to the new PI Integrator at the AFRH Agency. Faulty personnel practices had also resulted in a CMO at AFRH-W who did not understand evidence-based practice, did not know what a CPG was, and did not keep up with current immunization recommendations for individuals in the primary age group of residents at AFRH.

In addition, AFRH-W leadership included a CHS who had been promoted from her position as the DON to the CHS with only an associate's degree in nursing. This was very unusual because a Master's degree is the industry standard for a position at the GS-14 level. The CHS's duties included managing AFRH-W's entire healthcare operations. Yet, the current DON, who reported directly to the CHS, had a Master's degree in nursing and was more qualified than the

CHS. The AFRH-W organizational structure diagram also showed that the physicians (including the CMO) reported to the CHS as well. In addition, during staff interviews, the DoD IG Inspection Team found that the CHS was not letting her replacement perform DON duties. The CHS appeared to be most comfortable with managing nursing duties and had no experience in managing other medical services. The DoD IG Inspection Team concluded that an insufficiently qualified person was hired in a leadership position.

Also, based on information the DoD IG Inspection Team obtained from the various sources, the incumbent CHS was neither sufficiently experienced nor was good at managing people and operations. Post inspection confidential communications from senior officials at AFRH-W indicated that, despite having a better qualified candidate and objection from the AFRH-W Administrator, the current CHS was selected by the COO. This was another example of the COO hiring an internal candidate who was not the best qualified candidate. While the DoD IG Inspection Team understands the concept of balancing the financial burden of paying industry standard salaries with the need for the best qualified candidate, the DoD IG Inspection Team believes that by placing too much emphasis on cost reduction, AFRH management ended up with insufficiently qualified personnel unable to properly manage the healthcare services.

Furthermore, when the current CHS was hired as the DON in 2009, the job announcement was apparently tailored to fit the candidate. The announcement of this GS-13/14 position required only a degree,[29] license, and 1 year of experience. The position description (PD) had no specified educational requirements, although the prior GS-13 DON PD required the individual to "possess master degree level of preparation." This appeared to have been deliberately left out of the PD to enable promotion of an employee with only an associate's degree in nursing, thus downgrading the requirements for the position and the capability of the incumbent. Furthermore, the PD for the Associate DON, a position subordinate to the DON, required master's level preparation. This was another example of hiring an internal candidate who did not meet the qualifications normally required for the position. When asked about his reasoning behind hiring the current CHS, the COO stated that his hiring philosophy was to hire personnel and develop them into their respective positions.

[29] Job announcement 10-AFRH-004, Qualifications, Basic Requirements, "A degree or diploma from a professional nursing program approved by the legally designated state agency at the time of the program was completed by the applicant is required."

The DoD IG Inspection Team also found that the AFRH Agency PI Integrator had little experience in QM and PI outside of the PI program at the AFRH. Although the AFRH Agency PI Integrator needed training, she had no one at AFRH to teach her. The AFRH Agency PI Integrator is pursuing all internal and external training in an attempt to fully learn her duties. Again, it would have been a better decision to open the position to outside applicants to ensure that the most qualified individual was hired, rather than hiring an internal candidate who was not qualified for the position. When asked about his rationale behind promoting the current PI Integrator, the COO acknowledged that the current PI Integrator was not qualified for the QM position, but believed that she could learn and grow into it.

Recommendations, Management Comments, and Our Response

Recommendation 8.a

Under Secretary of Defense for Personnel and Readiness, when disciplinary action is taken against nursing personnel, require the Armed Forces Retirement Home to report that disciplinary action to appropriate state licensing/ certifying boards.

Under Secretary of Defense for Personnel and Readiness Comments

Management concurred, stating that they would require the AFRH to establish and implement a disciplinary action policy based on the state/district law for reporting disciplinary action and report to the appropriate state/district licensing/certifying boards.

Our Response

Management's comments were responsive. We will request an update on this process at a later date.

Recommendation 8.b

Armed Forces Retirement Home Chief Operating Officer:

(1) Ensure that supervisors receive appropriate Federal supervisory training.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that all supervisors had received a minimum of 8 hours of Federal supervisory training.

Our Response

Management's comments were responsive. We ask that the AFRH COO provide documentation of this training in response to the final report.

(2) Establish procedures to ensure that medical personnel hired are appropriately qualified for their positions, in accordance with Office of Personnel Management guidelines.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that all applicants provided to AFRH hiring managers are screened according to OPM guidelines at the Bureau of Fiscal Services before they are placed on a certificate of eligibility.

Our Response

Management's comments were responsive. We will look at this area again in our next inspection.

Observation 9

Occupational (Employee) Health

The DoD IG Inspection Team observed that:

- The employee health program was not fully implemented at either facility.
- Although the AFRH Agency Directive 4-9, "Medical Qualification Determinations," September 14, 2007, did provide direction for determining medical qualifications of job applicants and staff, the organization was not following the directive with current employees, including employees receiving injury compensation.
- Although the AFRH Agency Directive 4-14, "AFRH Reasonable Accommodation Policy and Plan," September 15, 2009, did provide guidance on the reasonable accommodation of job applicants and current employees, the organization was not following the directive.

This occurred because agency and facilities management had failed to enforce internal policies.

As a result, AFRH had a number of nursing personnel who were incapable of performing their duties because of medical limitations.

Discussion

At AFRH-W, nursing staff members were often unable to perform the duties required of their positions due to health reasons. Employees with physical limitations would submit notes from their private physicians to exempt them from certain shifts or duties, and, in some cases, permanently. The CHS sent the notes and additional documentation to the AFRH Agency Medical Director for review, but did not receive responses. The lack of responses hindered the evaluation of physical limitations. AFRH Agency guidance on reasonable accommodation failed to address this issue.

Employee records reviewed at AFRH-W indicated that pre-employment physicals had occurred. However, physical requirements were not established for each position. As a result, the employees received only a general physical which was not specific to the duties they would be performing.

Employee health and attendance records at AFRH-G were not available. The responsible staff member was new to this duty and not aware of employee health screening requirements beyond a Tuberculosis (TB) skin test and influenza vaccination. The staff member did state that physicals had been conducted by staff medical providers, but AFRH-G was looking at contracting this function out (still under consideration at time of the inspection). Interviews with some AFRH-G staff members indicated they had not obtained physicals prior to employment. Many of the personnel at AFRH-G were contractors and did not need physicals from the facility.

AFRH Agency Directive 4-9 had not been implemented appropriately at either facility. Only the general health of the individual was evaluated and not the specific physical ability to perform the duties required of the position. Further complicating the issue was the fact that physical requirements had not been established for all positions. There was no delineation of the AFRH Medical Director's role, although documentation on employee limitations was sent to him. In addition, there were no SOPs (facility-level) implementing a medical evaluation program, as required by this 5-year old directive. Thus no program to evaluate employee "fitness for duty" had been implemented.

Recommendations, Management Comments, and Our Response

Recommendation 9

Armed Forces Retirement Home Chief Operating Officer:

a. Update and clarify AFRH Agency medical directives, including processes for determination of fitness for duty of nursing personnel, and clarification of the Medical Director role in that process.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the role of the Medical Director would be added to the directives.

Our Response

Management's comments were partially responsive. We will request a copy of the updated directives that describe the role of the Medical Director, as well as timelines for response in the processes for determination of fitness for duty of nursing personnel at a later date.

b. Develop policies to update and implement AFRH Agency Directive 4-9 concerning qualifications of medical personnel.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that AFRH Agency Directive 4-9 would be fully implemented by the establishment of campus- level SOPs.

Our Response

Management's comments were not responsive. We think that AFRH Agency Directive 4-9 needs to be updated concerning physical requirements of medical personnel before establishment of implementing campus-level SOPs. If AFRH Agency Directive 4-9 has been updated, we ask that the AFRH COO provide a copy in response to the final report. If the directive has yet to be updated, we will request a copy at a later date.

c. Ensure that physical requirements are established for every position.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that physical requirements for every position are clearly identified in the hiring process in the job announcement or the performance work statement.

Our Response

Management's response is only partially responsive. In response to the final report, we ask that management provide a copy of the last three General Services hiring announcements for nurses and a copy of the Statement of Work, if the AFRH has any contract nurses.

d. Assess the capacity of all nursing staff to perform their duties and take appropriate personnel action if they are unable to perform their duties.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the current Fitness for Duty Program is operating as planned and is appropriate for the AFRH.

Our Response

Management's comments were partially responsive. We ask that management send us a copy of the current Fitness for Duty Program and the number of AFRH nurses who are fully capable of performing their duties under the program (X out of XX, excluding temporary disability).


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Observation 10

Quality Management and Performance Improvement

The DoD IG Inspection Team observed that:

- AFRH Agency and AFRH-W lacked personnel with adequate training in medical QM and PI.
- The clinical PI program at AFRH was in its infancy. Metrics, many of which were not clinically meaningful, were developed by the agency and delegated to the facilities for implementation.
- QM was also in its infancy at AFRH (credentialing and privileging were reviewed separately). Peer review was minimal and data was not tracked for re-privileging.
- AFRH Agency guidance on PI was not located in a single policy. The list of members for the PI committee at the agency and facility level included titles, such as *Medical-Pharmacy Component Leader* and *Nursing Component Leader* that were not AFRH functional titles or were not specific enough to identify an individual position. This contributed to confusion at AFRH-W. Also, AFRH Agency guidance describing the membership of the PI committee did not include the CHS.

Based on interviews and analysis by the DoD IG Inspection Team, resistance by the medical leadership to changing outdated clinical PI measures and the poor implementation of QM were major factors impeding necessary progress. Metrics were developed that were not clinically meaningful. Instead of developing priorities through review of high-risk areas, accreditation standards, and/or areas prone to problems, leadership at the AFRH Agency was measuring many things that were not priorities.

This resulted in time wasted on tracking data with no clinical meaning. Additionally, AFRH patients were placed at risk because high-risk areas were not being monitored and critical medical care improvements were not being made.

Discussion

The DoD IG Inspection Team reviewed the agency and facility QM and PI programs related to clinical care. PI is normally a component of a QM program. However, the AFRH had combined clinical PI with their other PI initiatives. In addition, the PI plan was not clearly laid out in a single document at the agency level.

AFRH Agency Directive 1-11A, "AFRH Internal Controls," June 28, 2012, established an agency-level AFRH Internal Control Senior Assessment Team. The directive required PI committees at the facility level, which reported to the Senior Assessment Team. The facility administrators were required to chair the facility PI committee. The membership of the facility PI committees was established in a separate document, AFRH Agency Notice 12-10, "Person-Centered Care Manual," July 20, 2012. The membership list used titles which did not exist at the facilities, including *Medical-Pharmacy Component Leader* and *Nursing Component Leader*. Because the agency guidance describing the membership of the PI committee did not include the CHS in the committee, there was confusion about the role of the CHS in the PI program. This lack of clarity was also reflected in the facility SOPs.

The PI plan identified critical components, including:

- staff development,
- finance,
- clinical services,
- medical and pharmacy,
- psychosocial,
- resident services,
- safety, and
- campus operations.

Use of clinical services, which apparently did not include nursing, added further ambiguity to the guidance. However, the clinical PI metrics were developed at the AFRH-W and had been mandated at the agency level to include *nursing*, *staff development* (education and training), and *healthcare* (medical-pharmacy).

Interviews with the AFRH Agency Medical Director revealed that he did not have familiarity with, or an understanding of, the AFRH PI program, peer review, patient safety, and other components of QM that would be expected based on his job description. The AFRH Agency Medical Director noted that they were expecting to move the AFRH-W PI Integrator to the agency level. The AFRH-W PI responsibility would be for all measures, not just the clinical measures. Interviewswith the AFRH staff members revealed that they knew the AFRH Agency Medical Directordid not understand QM or PI. Moreover, they maintained that the AFRH Agency Medical Director was continuing to obstruct efforts to improve the processes.

At the time of the inspection, a dentist held the position of the PI Integrator for both the AFRH Agency and AFRH-W. She had little previous experience in QM and PI. She was eager to learn and had attended training offered by DHA, including the Patient Safety Course and Team STEPPS.[30] However, the incumbent PI Integrator was doing it on her own as there was no one above her at AFRH with the knowledge to guide/teach her.

The clinical PI program was in its infancy. To date, there had not been any QM metrics reported. They were in the initial stages of data acquisition for the first reporting period. The PI metrics were numerous, totaling 110 for the 3 categories of clinical performance metrics. Some metrics had little to no relevance to the care provided, yet required significant effort to track. Many metrics were solely about compliance and included activities such as checking medical records to see if an exam was done or if a code status was documented. While these were important, they did not get to the quality of the services performed. The development of quality metrics requires specific inclusion and exclusion criteria and meaningful definitions. The lack of these criteria and definitions in AFRH's metric development limited the agency's ability to draw meaningful conclusions and compare data with other facilities or authoritative standards benchmarks.

At the time of the inspection, AFRH was tracking immunization rates for influenza, Pneumovax, and tetanus. The AFRH did not have a captive population. The IL residents were not required to obtain their primary care and other services at the AFRH, so some population health measures may not have applied to them. Some of the metrics used by AFRH-W were good ideas, but the metrics contained the wrong denominators. For example, the medication error metric included the patient count in its denominator. Such a measure had no meaning and no outside

[30] "Team STEPPS" - Team Strategies and Tools to Enhance Performance and Patient Safety

benchmarks to use for comparison. Medication doses given would have been a better choice and were very feasible at AFRH-W, as their system was automated. In addition, AFRH-W tracked urinary tract infections in the general population, rather than focusing the metric to track urinary tract infections in patients with indwelling catheters, which would have been a more useful metric for the AFRH patient population. Peer review was listed as a metric in several specialties. However, without the adoption of clinical standards such as VA/DoD CPGs, there was no basis upon which to perform a peer review. Rather than engaging in a formal peer review process, AFRH-W staff was reviewing records without respect to treatment decisions. Moreover, AFRH-W staff reported that the results were not tracked against providers and were not used to make decisions about privileging.

Metrics appropriate to Coumadin included outcomes of bleeding or thrombosis. Outcomes are generally an effective measurement. However, to ensure early detection in high-risk areas, it would be better to track the number of patients in the desired therapeutic range each month. AFRH-W should consider population health measures and health effectiveness data and information set measures where possible.

At AFRH-G, the DoD IG Inspection Team discussed the PI program with the DON and the PI Integrator, who was just recently moved to the position. The PI Integrator had little experience with PI, but the DON was training her at the time of the DoD IG inspection. All the performance metrics being tracked were provided to them by AFRH Agency before the CARF inspection. AFRH-G staff recognized that many of the metrics did not effectively measure what they felt should have been tracked. The AFRH-G staff members noted they have been frustrated in their attempts to make improvements in metrics. Despite this, they stated that they continued to submit proposed changes to metrics.

During the DoD IG inspection follow-up interview with the COO, he informed the DoD IG Inspection Team that the AFRH-W PI Integrator had been selected for the AFRH Agency PI Integrator position. He stated that the job announcement was restricted to internal AFRH candidates only, because he believed there were “several qualified candidates among the AFRH pool.” However, the selected employee did not have the appropriate experience or education to perform the duties of the PI Integrator position. The AFRH COO did not require the employee to have knowledge, skills, and abilities essential to the performance improvement position. Rather, the AFRH COO appeared to only consider the individual’s length of time at the AFRH and her continued loyalty to the organization as the basis for his selection and hired her despite critical deficiencies.

Recommendations, Management Comments, and Our Response

Recommendation 10

Armed Forces Retirement Home Chief Operating Officer:

a. Ensure the facility personnel and agency Performance Improvement Integrator obtains the necessary training to perform their duties to enable improvements in these programs.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was in progress. Campus Level PI Integrators have taken formal training in the development of performance measures and the performance improvement culture is maturing.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

b. Obtain qualified personnel as medical advisors for the Quality Management and Performance Improvement programs.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the SMA and members of the Advisory Council provide medical expertise, as needed, at the AFRH.

Our Response

Management's comments were responsive. We will request an update on the involvement of the SMA and the Advisory Council in QM and PI Programs at a later date.

c. Revise the policies of the Performance Improvement program, including clarification of the membership of the Performance Improvement committees at the agency and facility level. Include the Medical Director, Chief Medical Officer, Chief of Healthcare Services, and Director of Nursing on the committee.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation is in progress. However, he disputed the DoD IG inspector's observations that some of the SOPs listed positions that did not exist and omitted positions that should have been addressed. He stated that the AFRH performance improvement culture and procedures include an annual evaluation and allows re-alignment of priorities and procedures.

Our Response

Management's comments were responsive. We believe that the annual evaluation described by the COO should address the issue. We will look at this area again during our next inspection.

d. Ensure appropriate metrics, incorporating specific inclusion and exclusion criteria, are adopted to measure the effectiveness of the Quality Management and Performance Improvement programs.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation is in progress. The AFRH is working with the SMA to ensure appropriate healthcare metrics are developed.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

Observation 11

Medical Records and Clinical Care

The DoD IG Inspection Team observed that:

- Medical record documentation at AFRH-W required improvement. Outpatient records needed more than the minimal documentation observed during the team's review.
- AFRH-W LTC/AL nursing notes did not convey the current status of the patient nor what occurred during the day shift.
- Medical record documentation at AFRH-G was acceptable. Noted was an issue with documentation of medications and their purpose in the outpatient records.
- Prescription of medications with opioids, in combination with other drugs, at AFRH-W did not account for the accumulative dose of the second drug. Short acting opioids were being used to manage chronic pain in cases where the patient could have benefited from long acting opioids.
- Coumadin Clinics at both facilities were not set up so that all providers who needed the information on a patient had access to it.
- At AFRH-W, there was no counseling documented for Coumadin patients on drug interactions and dietary restrictions.

This occurred because:

- Oversight and supervision by AFRH Agency and AFRH-W medical leadership was ineffective.
- AFRH Agency and AFRH-W had not established standards for outpatient visits and documentation.
- The situation, background, assessment, and recommendation (SBAR)[31] tools were not intended to be the medical record documentation tool, yet it was being used as such.

[31] SBAR - "Situation, Background, Assessment, and Recommendation"

- AFRH-G did not have a clinical pharmacist to assist with outpatient medications.
- AFRH Agency and AFRH-W had not implemented appropriate clinical practice guidelines for the management of chronic pain.
- An established SOP for the Coumadin Clinic did not exist. Flow sheets (by patient) were not maintained in the medical record.
- AFRH Agency and AFRH-W had not established standards for the counseling of Coumadin patients.

These problems and issues could contribute to inadequate and inappropriate care of residents.

Discussion

Armed Forces Retirement Home – Washington, D.C.

The LTC/AL records were a combination of paper records and a computer-based system used to document nursing notes. Medication administration was also tracked in the computer system. Twelve LTC/AL paper records were reviewed by the DoD IG Inspection Team, who determined that all admission histories and physical exams were thoroughly and extensively documented. Computer notes on 10 LTC/AL patients were also reviewed. The DoD IG Inspection Team observed that nursing personnel were using the SBAR format to document daily notes. This format was intended to be used in handoff communications, not daily progress notes. The notes provided details on diagnoses, but significantly less clinical information pertinent to that day's care.

In addition, the record review in LTC/AL identified an issue with opioid therapy which was discussed under the preceding section on pain management. The issue identified was with an 85-year-old man with chronic pain who was prescribed and taking two Percocet tablets (5mg oxycodone/325 mg acetaminophen per tab) every 4 hours. This medicine was controlling his pain (pain ratings of 0 to 2 out of 10). The concern was that he was receiving 3,900 mg of acetaminophen per day. This was near the maximum dosage (for a younger healthy person) of 4,000 mg per day. In an 85-year-old, the risk of adverse effects was high. The DoD IG Inspection Team discussed the case with the nurse responsible for this resident's care and pointed out that there are long acting opioids that do not contain acetaminophen.

The DoD IG Inspection Team also reviewed six outpatient records. Notes for routine outpatient visits to primary care were generally minimally documented and would not meet primary care industry standards. These notes were also difficult to use in peer reviews as they were not comprehensive, even for the chief complaint. Three progress notes from the contract psychiatrist were also reviewed. These were exceptionally well documented. It was easy to review and follow the clinical decision making in the notes. The documentation included dual mental health and substance abuse diagnoses, along with pertinent physical findings.

Armed Forces Retirement Home – Gulfport

No significant issues were identified with LTC/AL records. No specific review of opioid therapy was performed.

The DoD IG Inspection Team reviewed seven outpatient records. Progress notes were generally sufficient. The initial history and physical required of all new residents was present in all the records. Several individuals were new to the facility and had little information beyond the initial exam in the records. Six out of seven had medication and problem lists. Two of the individuals were on a multitude of medications. One of these did not have documentation in the problem list used to explain use of all medications. Records reviewed included podiatry visits.

Coumadin Clinic

Armed Forces Retirement Home – Washington, D.C.

The anti-coagulation clinic (Coumadin Clinic) was run by a Nurse Practitioner (NP). The clinic followed 43 patients, all of whom were on Coumadin. The patients were tracked in a spreadsheet accessible to the NP and nurses within the Wellness Clinic. The spreadsheet did not clearly list the diagnoses for which the Coumadin was prescribed. It was also difficult to determine the recommended therapeutic range for each patient, based solely on the spreadsheet. Review of the outpatient records on four of the patients found no documentation of patient education with respect to drug-drug or drug-food interactions. One IL patient on Coumadin

left the facility to stay with family for some time. Upon his return to AFRH, his INR[32] was found to be super-therapeutic[33] at 10. Hospitalization was required. This case demonstrated the need for greater education of patients and/or families, as well as documentation of that education in the medical record.

Armed Forces Retirement Home – Gulfport

An NP managed the anti-coagulation clinic (Coumadin Clinic) at AFRH-G. AFRH-G had 54 patients on Coumadin and one on Pradaxa. Generally, four-to-five of the Coumadin patients were in LTC or AL. Two of the IL residents chose to use other clinics outside the facility for management of their anti-coagulation. The NP tracked the patients, as well as the dates and results of the INR in a spreadsheet on her computer. She also included the therapeutic range on the spreadsheet. In addition, the NP notified the IL residents via letters or notes in their mailboxes to advise them on dosage changes or if they were overdue to have labs drawn. If the NP found a resident whose condition was difficult to control or whose labs varied a lot, she referred them to IL Plus, which allowed a resident to remain in his/her IL situation while getting additional support in managing his/her medications. It usually worked well. The AFRH-G Dietitian counseled all Coumadin patients on drug-diet interactions and educated Coumadin patients through the "Share the Care" program: "You & Your Coumadin."

Recommendations, Management Comments, and Our Response

Recommendation 11

Armed Forces Retirement Home Chief Operating Officer:

a. Ensure that appropriate standards for outpatient records documentation and nursing documentation in Long Term Care/Assisted Living are established.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation is in progress. Outpatient records are being transferred to a customized electronic medical record (EMR) system. Documentation required by the Joint Commission standards for Nursing and Ambulatory care are being incorporated into the EMR.

[32] "International Normalized Ratio" (INR) is used to determine the clotting tendency of blood. The normal range is between 2 and 3.

[33] "Super-therapeutic" indicates a state above the desired range for a particular patient.

Our Response

Management's comments were partially responsive. Transferring to an electronic record will not necessarily improve the quality of the documentation without establishment of standards. We will request an update on this issue at a later date.

b. Ensure that peer review is performed based on those standards and peer review results track quality improvement and privileging.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the existing peer review and information and data would be packaged in a manner that demonstrates a direct link to privileging.

Our Response

Management's comments were partially responsive. At the time of our inspection, our medical evaluators were unable to confirm the existence of peer review information/ documentation. We will request an update on the course of action described by the AFRH COO at a later date.

c. Ensure agency-wide adoption of the Department of Veterans Affairs/Department of Defense Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain Working Group.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation is in progress. The AFRH is using The Joint Commission standards to update existing pain management policies. AFRH will also utilize appropriate CPGs for the geriatric population.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

d. Consider the addition of a clinical pharmacist to the staff at Armed Forces Retirement Home – Gulfport. Alternatively, an available physician who is knowledgeable regarding medication use and risks in the elderly should review outpatient medications.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was complete. AFRH-G is coordinating pharmacy medication reconciliation for residents with Keesler AFB, Mississippi.

Our Response

Management's course of action met the intent of the recommendation. No further action is required.

Observation 12

Healthcare Services at Armed Forces Retirement Home – Washington, D.C.

The DoD IG Inspection Team observed that:

- Healthcare services were well structured to meet the needs of the residents in the various levels of care. However, the AFRH-W CHS was not well qualified and continued to perform her previous duties as the DON, rather than the duties required of the CHS. Furthermore, the CHS did not delegate appropriately as a manager.
- AFRH-W CHS did not ensure compliance with all agency policies and facility SOPs, most notably those regarding the role of committees and infection control.
- AFRH-W had significant nursing staff issues which were not being adequately addressed. They ranged from chronic tardiness to medical limitations to providing sub-standard care.
- The behavior of some employees, as described by multiple residents, was not consistent with the "Person-Centered Care" concepts espoused by AFRH Agency Notice 12-10 "Person-Centered Care Manual," July 20, 2012, which was developed to meet CARF standards.

This occurred because:

- Promotion and hiring policies at the agency and AFRH-W facility did not prioritize hiring the best qualified individuals. Qualification status was based on time at the AFRH, rather than education and capabilities (See Recommendation 8.a).
- Agency policies and facility SOPs were outdated or did not describe the actual scope of services at the AFRH. In fact, some SOPs were so far out of the scope of the medical capabilities of the facilities they could not be implemented.

- Management failed to take disciplinary actions recommended by BPD.
- Management failed to implement appropriate occupational health programs.

This resulted in sub-standard care, confused and upset staff, and dissatisfied residents.

Discussion

Outpatient services available to residents in the Wellness Clinic included primary care, psychiatry, optometry, Coumadin Clinic, nutrition, rehabilitation services, podiatry, clinical pharmacy, and dentistry. Pharmacy services were provided through WRNMMC. The AFRH-W providers had access only to the DoD Composite Healthcare System (CHCS) and ordered medications through CHCS. They did not have access to the Armed Forces Health Longitudinal Technology Application (AHLTA).

AFRH-W allowed pharmacy technicians to fill prescriptions at WRNMMC and to distribute those filled prescriptions at the pharmacy window in the clinic. Refills were also picked up at the pharmacy window of the clinic.

The Wellness Clinic had two physicians, two nurse-practitioners, a contract psychiatrist, an optometrist, and a part-time psychiatrist from WRNMMC. The nurse practitioners and physicians also had LTC/AL ward duties. Three social workers covered both ambulatory and in-patient areas. Laboratory services were provided through a contract. Phlebotomists were on-site and the specimens were taken to the contract lab. Radiology services, including on-site X-rays, were provided through a contract which provided prompt service and reports. Dental services were offered to all residents through a contracted mobile dental clinic. Rehabilitation services were primarily contracted, but the Chief of Rehabilitation Services was a Government employee and an occupational therapist who oversaw the contract services for occupational, physical, and speech therapy. Rehabilitation services had a total of 14–16 privileged staff at any time. The contractor was very prompt at supplying privileged staff replacements when needed. AFRH-W had a good working relationship with the VA for prostheses, swallowing studies, and hearing aid support.

The AFRH-W had a support agreement with WRNMMC, which replaced the prior agreement with Walter Reed Army Medical Center. The agreement included healthcare and pharmacy services for the residents, veterinary food inspections, a part-time Clinical Pharmacist (PharmD), and public health services.

The AFRH-W also had multiple other MOUs with outside facilities and providers, including home health and hospice providers who came into the facility to provide services. Medications for AL and LTC were provided through a contractor. The process of administering medications was computerized and included a photo of each resident as part of the identification process. Every dose given was tracked in the system.

Agency documents required the following committees:

- Medical Staff,
- Credentials,
- Infection Control Program,
- Pharmacy and Therapeutics,
- Ethics Consultation Service Functional Team,
- Information Management Functional Team,
- Management of Human Resources Functional Team,
- Clinical Research,
- Pain Management, and
- Performance Improvement.

Of these required committees, only a few existed. The Credentials and PI committees were established and functioning. The Infection Control committee was just getting started at AFRH-W at the time of the inspection. A Professional and Joint Staff Committee was established, although not required by agency documents.

The CHS had been in her position since March 2012. Before that, she served as DON from November 2008 to March 2012. She obtained her associate's degree in nursing in May 2004. Without external competition, the incumbent was selected for the GS-14 Healthcare Administrator position. However, she had not turned over the DON duties to the incumbent DON. The CHS stated that confusion about her role was caused by upper management practices. Not only did the CHS fall under the AFRH-W Administrator, she also received direction and commands from the agency level. The CHS believed that leadership was still expecting her to perform the DON duties, based on what they had asked her to do since taking on the role of Chief. Moreover, the CHS believed that the COO undermined her role as CHS by

bypassing her and bringing in outside consultants, without discussing the issues with her first. She also believed that the COO established performance objectives that were not appropriate for her position.

The organizational charts for Healthcare Services initially provided to the DoD IG Inspection Team did not include the ambulatory care providers. When asked about this, the CHS noted that there had been resistance to her supervision of medical staff. The CHS is not a physician and the medical staff has resisted her supervision. Organizational charts provided later did include the CMO and listed the providers by specialty. It was not clear which chart was being followed, thus contributing to a confusion of medical staff roles and responsibilities.

The DON was very frustrated in her job, mainly because the CHS was still performing the duties of the DON. Nursing staff members often used this situation to their advantage to seek answers which benefited them. They would approach the DON with a question and, if they did not like the answer, they would then seek a different answer from the CHS. At times, the answers conflicted. In addition, the DON had met resistance from the CHS when trying to update the many outdated, irrelevant, and inaccurate nursing SOPs.

The DoD IG Inspection Team conducted a 2-day walk through of the nursing home facility and randomly selected nursing personnel (Certified Nursing Assistants (CNAs), Licensed Practical Nurses (LPNs), and Registered Nurses (RNs)) to speak with regarding processes and procedures. The selected staff stated that they felt overworked, that they were not recognized for their efforts, and that there was no opportunity for advancement. Most of the staff also thought the CHS was still the DON. The DON surveyed clinical supervisors in April 2012 to determine what issues they believed were impacting their ability to provide nursing care. The survey results indicated that several clinical supervisors did not feel supported in their roles or valued by leadership. They often named the role of the CHS as an issue. The DON had tried to engage the staff in initiatives, including getting CNAs involved in chart reviews (peer review), providing opportunities to head projects, and acknowledging staff during staff meetings for good work. However, the DON reported that most staff members were not interested or willing to engage. Staff members often felt overworked because many of them were performing the work others should have been doing. In addition, a significant number of staff members were unable to effectively perform duties

required of them, due to health issues or physical limitations, and there was no occupational health program to handle these issues.

The DON also identified chronic tardiness as an issue. The DON stated that HR told her that the union contract allowed employees to be up to one hour late to work without any consequences. Per the DoD IG Inspection Team's review of the union contract and discussion of the issue with BPD, this was not true. The lack of avenues to fire non-performing employees was very frustrating to the DON. She differentiated between those employees who lacked knowledge and/or training and those who lacked integrity and purposefully engaged in egregious misconduct that was harmful or potentially harmful to patients. Employees in the first category were provided additional support, resources, and training. However, the DON stated that, because they had no way to effectively discipline employees in the second category, these employees got away with egregious and unacceptable activities.

The DoD IG Inspection Team also spoke with a number of residents while touring and evaluating the nursing units. Several residents were not satisfied with many of the employees (CNAs) who provided their care, preferring to be cared for by contract staff. They felt their requests were often ignored, especially at night. For instance, one patient reported that although he had asked to be awakened for dinner if he happened to be asleep at that time, the AFRH civil servant employees routinely failed to wake him. As a result, the patient missed dinner on a few occasions. Another patient complained that his pain medication was routinely given late. He specifically asked the nurse to provide it to him on time, but was told that she "could provide it to him one hour earlier or one hour later [than the time requested]." As a result, he required increased subsequent dosages of pain medications. Staff members did not engage the residents in conversation, but often congregated off to the sides or in corners to converse among themselves. The DoD IG Inspection Team observed the same problem during the inspection.

Moreover, a recent case investigated by BPD showed that nursing personnel were documenting care as being performed when it was not.

Recommendations, Management Comments, and Our Response

Recommendation 12

Armed Forces Retirement Home Chief Operating Officer:

a. Clarify the roles of Chief of Healthcare Services and the Director of Nursing at the Armed Forces Retirement Home – Washington, D.C. to ensure there is no overlap in responsibilities.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was complete. The roles of the Chief of Healthcare services and the Director of Nursing are separate and clearly defined in their position description.

Our Response

Management's comments were responsive. The intent of the recommendation was not that the position descriptions were not clear, but, rather, that the separation of duties was not being enforced in the conduct of daily duties. However, we accept management's assertion that the issue has been resolved. No further action is required.

b. Support the Chief of Healthcare Services in supervising the multiple sections for which she is responsible. Provide education and training to improve her knowledge in management of specialty areas other than nursing.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was complete. The CHS at the time of the DoD OIG inspection is no longer with the AFRH. A new Chief of Healthcare Services has been selected, with the participation of the SMA.

Our Response

Management's comments were responsive. No further action is required.

c. Ensure that agency policies and facility standard operating procedures are revised to reflect the scope and services of the Armed Forces Retirement Home and that staff of the Armed Forces Retirement Home – Washington, D.C., implement those policies.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO non-concurred, stating that the report did not identify where the scope and services were exceeded. Management would respond if DoD OIG further defined the issue.

Our Response

We believe that the scope and services in agency policies and SOPs, in some cases, exceed the capabilities of the AFRH. Specifically:

- AFRH Agency Notice 12-12 "AFRH Medical Staff Bylaws, Rules, and Regulations," July 30, 2012, and its enclosure "Medical Staff Bylaws, Rules and Regulations of the Armed Forces Retirement Home, November 2011." This agency-level document on Medical Staff Bylaws was clearly taken from a much larger inpatient acute care medical center with an organized, self-governing medical staff. There is no CARF, TJC LTC, or TJC Ambulatory Care requirement for an organized, self-governing medical staff. The document also lists services that are not offered at the AFRH; includes mission, vision, and value statements that are not those AFRH lists in other documents and which exceed the scope of the AFRH; lists items to track for ongoing professional practice evaluation that are not within the scope of the AFRH; lists multiple committees (some nonexistent) that report to the medical staff; and includes other structures that do not exist within the AFRH.

- Healthcare Services SOP 4-10. Page 4 Section X appears to be excerpted from the policy of a medical center. It needs to be tailored to the AFRH medical facilities. For example, "device related infections" (A) includes devices not used at AFRH, but does not mention the one device very pertinent to AFRH: urinary catheters. Page 4 section X on performance measures also needs to be modified to fit the AFRH.

- Healthcare Services SOP 4-16. Sentinel Event—Section 2 B includes sentinel events that do not apply to AFRH.

- Nursing Services SOP 4-025 at both facilities requires an emergency medication box. The AFRH-G SOP does not list the contents of this box. The AFRH-W SOP lists contents which include medications used in Advanced Cardiac Life Support (ACLS), such as atropine and epinephrine. AFRH does not have appropriate monitoring equipment available, nor individuals qualified in ACLS available onsite at all times. AFRH needs to define its scope of ACLS services appropriate to the capability of the staff. If that scope is Basic Life Support (CPR and AED use), then the ACLS medications should not be provided.

We ask that the AFRH provide the results of an analysis of those documents in response to the final report.

d. Support and assist supervisory personnel, especially the Director of Nursing, when disciplinary actions are required.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating the recommendation is complete.

Our Response

Management's comments were partially responsive. In response to the final report, we ask that management describe what actions have been taken to meet the intent of the recommendation.

e. Ensure that all staff members are focusing on patient (resident) centered care and provide the staff appropriate training. If staff is unwilling to comply, support termination.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation is in progress. Person Centered Care (PCC) is a strategic goal at the AFRH. AFRH is developing performance measures for PCC. The P&R review and the Defense Equal Opportunity Management Institute (DEOMI) survey conducted since the DoD OIG inspection did not reveal PCC was insufficient at the AFRH. The recent Operational Assessment by the Joint Commission Resources commended the AFRH staff for the level of PCC.

Our Response

While we are uncertain how the DEOMI survey evaluated PCC, we accept management's analysis of progress made in this area. No further action is required.

Observation 13

Healthcare Services at Armed Forces Retirement Home – Gulfport

The DoD IG Inspection Team observed that:

- AFRH-G only had a part-time contract CMO, which was insufficient.
- AFRH-G healthcare services was not in compliance with all agency policies and facility SOPs, which were often not appropriate for the AFRH-G.
- Nursing staff issues at AFRH-G were related to conversion from contract to civil service positions, as well as the inexperience of many of the staff members.
- AFRH Agency had not approved the appropriate civil service level for PDs, most notably for nurse practitioners.

The re-opening of AFRH-G with all contract providers, who were inexperienced in LTC and Federal processes and requirements, resulted in delays in getting appropriate personnel and processes in place. Additionally, the requirement to implement AFRH-W SOPs, without alterations specific to AFRH-G, made it difficult, if not impossible, to implement appropriate AFRH-G policies.

As a result, the work environment at AFRH-G was difficult, but was improving with the new leadership team in healthcare services.

Discussion

AFRH-G re-opened in October 2010 with almost all contract staff, because civil service employees could not be hired quickly enough. In 2011, there were multiple medical care issues and the CHS, DON, and three others were fired. These issues included staff harassment and inadequate medication management. As a result of the negative working environment created by those who were fired, it has been a challenge for the new healthcare leadership to achieve constructive change.

Healthcare Services and Staff

The outpatient services included primary care, optometry, Coumadin clinic, psychology, podiatry, dental care, and rehabilitation services. Many of the contract positions were being converted to GS positions. The staff included two civil service social workers, one civil service dietitian, two nurse practitioners (in the process of conversion from contractor to civil service), one dentist, and one part-time contract internal medicine physician, who performed some of the duties of a CMO.

AFRH-G healthcare services had a dental clinic within the facility. In addition to the dentist, healthcare services staff included a dental hygienist and a dental assistant. Rehabilitation services were provided via a MOU with a civilian healthcare organization. At the time of the DoD IG inspection, the supporting organization was not able to supply a speech therapist or support the total part-time and overtime hours that the AFRH-G needed. In addition, the supporting organization refused to give patient medical records back to the AFRH-G facilities healthcare services. The AFRH-G gave notice to this group and subsequently reached an agreement with a new rehabilitation group contractor. With this new arrangement, the AFRH-G expected to be able to provide speech therapy, 5 days per week and meet its other personnel needs.

AFRH-G healthcare services administration was having issues converting the NP positions to civil service because the agency only authorized a GS-12 pay grade for these positions. The current contract staff members turned down the positions because this would result in a significant pay reduction for them. Thus, AFRH was having difficulty filling these positions because the authorized civil service pay grade was too low to compete in the local healthcare market. At the time of the DoD IG inspection, the Gulfport area market had a shortage of healthcare providers and pay was competitive. The DoD IG Inspection Team provided the CHS a standardized Army Medical Department PD for NPs at a GS-13 pay grade.

AFRH-G had a memorandum of agreement with the 81st Medical Group at Keesler Air Force Base for dental support, environmental health, pharmacy, and some laboratory support for all eligible beneficiaries and secretarial designees. AFRH-G supplied two pharmacy technicians to help fill prescriptions. The facility's administration was also developing relationships with other outside

facilities and providers, and had at least six different MOUs with outside service providers. They were working to include provisions for getting medical information back from both individuals and facilities providing care to the residents.

The outpatient pharmacy services through Keesler Air Force Base were currently available only to retired military beneficiaries. The operation was similar to that at AFRH-W. However, AFRH-G did not have clinical pharmacist support for the IL and ILP. Pharmacy services for the AL and LTC were contracted. A contracted pharmacist reviewed the medications for these areas as part of the contract. The contracted pharmacist also educated the staff and contacted the NPs about issues with medications.

Agency directives required the following committees:

- Medical Staff,
- Credentials,
- Infection Control Program,
- Pharmacy and Therapeutics,
- Ethics Consultation Service Functional Team,
- Information Management Functional Team,
- Management of Human Resources Functional Team,
- Clinical Research,
- Pain Management, and
- Performance Improvement.

The committees implemented at AFRH-G were Infection Control, PI, Professional and Joint Business Staff, and Pharmacy and Therapeutics.

The AFRH-G CHS was an RN with a master's degree in human resources management and development. She had prior experience at the AFRH-G, as well as both acute and LTC experience. Prior to her service at AFRH-G, the incumbent CHS worked in LTC at the VA for about 6 months. The DON had 22 years of active and reserve military service. She worked in LTC before obtaining her master's degree in mental health, with an emphasis on dementia. In addition, the DON worked in education and staff development. Prior to her service at the AFRH-G,

the incumbent DON was an informatics nurse for the VA. She held that position for almost 2 months. Both the AFRH-G CHS and DON were working hard to establish trust with the rest of the staff.

Upon her arrival at the facility, the CHS noted multiple problem areas including:

- lack of nursing credential/license verification,
- failure to track basic life support training, and
- the unsecure storage of medications and medical records.

The CHS corrected these pressing issues and continued to work, along with the DON, to identify and prioritize the implementation of policies and changes to policies where needed. Both the CHS and DON were aware they were not in compliance with all SOPs. They believed that the SOPs written for the AFRH-W may not have been suitable for AFRH-G. However, they had encountered resistance/delays, at the agency level, in getting changes to SOPs that were appropriate to AFRH-G.

The AFRH-G Chaplain led a group that put together the Share the Care activity for residents. Through this program, the Share the Care group scheduled and provided education events twice a month for residents on topics such as Care Giving and Preventing Burnout, Aging and Nutrition, Rehabilitation, Coumadin, Relaxation with Music, and more. Some speakers were staff members at AFRH-G; others were brought in from outside AFRH-G.

The facility put together a manual for its providers. Its primary purpose was to meet the agency requirements on suicide prevention, but also oriented individual providers to many other aspects of the AFRH-G and the care of the elderly.

The DoD IG Inspection Team noted that AFRH-G had an enthusiastic, but inexperienced, nursing staff. The DON was covering the duties of several unfilled functions, including infection control and patient safety. Prudently, AFRH-G contracted a full time Nurse Educator to train staff members and planned to convert the contract positions to civil service. The Nurse Educator was able to improve the orientation of new personnel and the management/documentation of licensures (LPN and RN) and certification (CNAs).

AFRH-G involved current nursing staff members in the interview process for new staff members. Although supervisors had not yet received supervisory training, nursing staff members reported significant improvement in the environment and in staff orientation since the new leadership was in place (CHS and DON).

A CNA was assigned to accompany all LTC/AL residents to their outside medical appointments, and was often allowed in the exam room with the physician and patient. The supervisor believed this greatly improved communication between the facility, the patient, and the outside physician.

In the LTC and AL areas, the DoD IG Inspection Team reviewed medication administration and nursing documentation, and randomly selected staff to interview about nursing procedures. The only area identified as needing attention was the staff response to emergency events, such as a cardiac arrest or an assault. The DoD IG Inspection Team agreed this was value-added practice.

AFRH-G did not have an occupational health program. The Clinical Supervisor of the Health Clinic/Wellness Center was not aware of employee/occupational health processes other than the requirement for TB skin testing and influenza immunization. The DON acknowledged that they were not in compliance with agency directives on employee health, but indicated appropriate action would be taken.

The DoD IG Inspection Team interviewed a number of residents in LTC and AL. All were pleased with the facility and the nursing care. Multiple IL residents also expressed a high level of satisfaction with the facility and staff support. The Inspection Team noted significant differences in resident satisfaction compared to the AFRH-W facility.

Recommendations, Management Comments, and Our Response

Recommendation 13

Armed Forces Retirement Home Chief Operating Officer:

a. Support the Armed Forces Retirement Home – Gulfport Healthcare Services leadership in tailoring standard operating procedures to fit the facility. Utilize the expertise of these leaders to improve policies and procedures at the Armed Forces Retirement Home Agency and Armed Forces Retirement Home – Washington, D.C.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that the recommendation was in progress. SOPs are being reviewed as a part of the preparation for The Joint Commission accreditation. Where there are differences in operations due to the uniqueness of each campus, the SOP will reflect it.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

b. Support the conversion of the contract nursing education position to a General Schedule position and ensure that nursing orientation and education programs are fully implemented.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO reported that the recommendation was complete. The educator position was converted to a GS position with appropriate duties.

Our Response

Management's comments were responsive. No further action is required.

c. Re-evaluate the General Schedule grading decision regarding the Government employee grade level for Nurse Practitioners. Consult the Senior Medical Advisor to assist with such decisions in the future.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the General Schedule grade for Nurse Practitioners was evaluated and determined to be appropriate for the locale. Management provided examples from postings on USA Jobs from Health and Human Services and MEDCOM for comparison with AFRH GS pay scales.

Our Response

Management's comments were responsive. No further action is required.

Observation 14

Accreditation and Prior Inspections

The DoD IG Inspection Team observed that:

- Although AFRH had developed policies to correct prior CARF[34] and DoD IG findings[35] related to critical incidents, data collection, and performance improvement, AFRH failed to fully implement these policies.
- The CARF findings of failing to consider and include the resident in multiple issue areas continued to be an issue at AFRH-W.
- AFRH was not in compliance with section 411(g), title 24 United States Code (24 U.S.C. § 411(g) [2012]), which requires all aspects of the organization to be accredited by a nationally recognized civilian accrediting organization.
- The USD (P&R) and the AFRH did not implement the prior DoD IG inspection recommendation to ensure applicable DoD guidance was implemented at AFRH.

This occurred because of:

- failure to adequately implement AFRH policy due to a lack of sufficiently capable medical and healthcare leadership at the AFRH Agency and AFRH-W;
- failure to implement the PCC approach at AFRH-W;
- failure to hire the best qualified medical personnel (See Observation 7);
- failure of management to take appropriate disciplinary actions;
- failure to ensure that all aspects of AFRH medical operations are accredited, as required by law; and
- inadequate oversight of AFRH by the USD (P&R).

[34] Can be obtained by request from AFRH management.

[35] "Inspection of the Armed Forces Retirement Home" [Report # IE-2010-002], February 25, 2010.

This has led to:

- no correction of processes or individual actions that could lead to critical incidents or other adverse events, resulting in recurrence of these types of events;
- lowered quality of resident care at AFRH-W;
- low staff morale at AFRH-W; and
- failure to meet requirements of United States Code.

Discussion

Accreditation

In accordance with 24 U.S.C. § 411 (2012), the AFRH COO was required to "secure and maintain accreditation by a nationally recognized civilian accrediting organization for each aspect of the Retirement Home, including medical and dental care, pharmacy, IL, AL, and nursing care." The Joint Commission has standards to cover all these areas of the AFRH in their LTC and Ambulatory Accreditation programs, with the exception of IL. In addition, The Joint Commission requires a periodic performance review be performed midway through the accreditation cycle. With assistance from DHA, this requirement would have helped the AFRH meet the expectation for an annual performance review. The AFRH is a unique organization, unlike most civilian organizations that provided these services. There was no single civilian accrediting organization in existence which could cover all of the services, functions, and components of the AFRH. Thus, a single civilian accreditation organization has not been designed to cover all AFRH services.

In 2007, the AFRH switched the accreditation of their LTC services from The Joint Commission to CARF. Prior to this change, The Joint Commission accredited the AFRH LTC and outpatient clinics (Ambulatory Care). A 2007 GAO report—GAO-07-79OR, "Armed Forces Retirement Home: Health Care Oversight Should Be Strengthened," May 30, 2007—identified the IL and AL areas as not covered by The Joint Commission and also noted there was no single standard-setting organization that covered all areas of the AFRH. However, the GAO report incorrectly noted that IL was a *care area*. IL is not a *care area*, but an independent residential living arrangement where residents lived in close proximity to healthcare services, but were not provided any additional healthcare services in their suites or assistance with activities of daily living. IL residents

were able to remain independent and self-sufficient. They had to seek assistance or care, if needed or desired, as they would if they were living outside of an institutional setting. IL residents (as well as all residents) could seek healthcare at the wellness clinic located on the AFRH facility or at an offsite location. Services provided at both AFRH facilities were similar to those found in similar clinics outside of AFRH.

It appeared the GAO report provided AFRH the impetus to switch to CARF accreditation, even though that did not seem to be the intent. AFRH switched from The Joint Commission to CARF which covered the IL and AL functions of the Home and addressed concerns noted in the GAO report. However, the more critical care areas of medical, dental, and pharmacy services were no longer accredited by a nationally recognized accreditation institute as required by law.[36] Therefore, in retrospect, AFRH should have made the decision to add CARF for the areas not covered by The Joint Commission rather than to completely drop The Joint Commission altogether.

CARF accredited multiple types of services in the following categories:

- Aging Services,
- Behavioral Health,
- Business and Services Management Network,
- Child and Youth Services,
- Durable Medical Equipment,
- Prosthetics,
- Orthotics and Supplies,
- Employment and Community Services,
- Medical Rehabilitation,
- One-Stop Career Center,
- Opioid Treatment Program, and
- Vision Rehabilitation Services.

[36] 24 U.S.C. § 411(g) (2012)

AFRH has been previously accredited under the CARF Aging Services programs that included:

- Assisted Living,
- Person-Centered Long-Term Care Community,
- Continuing Care Retirement Community, and
- Dementia Care Specialty Program.

As mentioned previously, *medical and dental care* and *pharmacy* are specific areas that must be accredited by a nationally recognized civilian agency. However, CARF standards were not appropriate for the AFRH's primary care mission. The CARF accreditation program did not include standards for medical, dental, rehabilitation, and pharmacy services provided in both inpatient and outpatient settings, but were focused on organizational structure, with minimal clinical standards. CARF had few specific standards related to the actual care provided at the AFRH, such as those related to medication management. In addition, CARF did not have standards for addressing pain management, waived testing,[37] or rehabilitation services.

Most CARF standards related to arranging for the provision of healthcare, not the quality of care actually provided. The Joint Commission, which heretofore accredited the LTC aspect of the AFRH, had standards for provision of care, medication management, and waived testing. The Joint Commission also had an Ambulatory Care Accreditation program, which covered the outpatient mission of the AFRH.

In September/October 2011, AFRH was accredited by CARF for the following programs:

- Continuing Care Retirement Community,
- Person-Centered Long-Term Care Community, and
- Person-Centered Long-Term Care Community: Dementia Care Specialty Program (AFRH-W).

Neither facility was accredited under the AL program. Review of CARF standards reveals that the programs, under which AFRH-W and AFRH-G were accredited, were all part of the LTC standards. The AFRH-G AL residents were integrated

[37] Waived testing performed at AFRH consisted of finger-stick blood sugar tests performed with a glucometer by the nursing staff.

into the LTC areas. The AFRH-W AL residents were on a separate wing of the LTC area. There was very little difference between AL and LTC in the AFRH facilities. Therefore, accreditation under the LTC program was most appropriate. In addition, at the time of the CARF survey, AFRH-G did not otherwise have a Dementia Care program. Therefore AFRH-G did not receive accreditation for this area.

Both AFRH-W and AFRH-G CARF accreditation reports included the following sections:

- survey summary,
- accreditation decision,
- exemplary conformance,
- consultation recommendations for each area,
- a table of standards with "non-conformance" or "partial conformance," and
- benchmarking (including graphical comparisons to the aggregate of facilities surveyed by CARF.

The DoD IG Inspection Team's review of the AFRH 2011 CARF accreditation reports addressed these sections, as they related to healthcare. The specific standards referenced in the reports were from the 2011 CARF manual.

AFRH-G had no findings related to healthcare in its CARF accreditation report. The staff members present for the CARF visit noted that the surveyors were very impressed with AFRH-G's buildings and structures and did not otherwise look deeply in to its operation.

AFRH-W received a rating of non-conformance[38] from CARF with regard to the a nalysis of the following critical incidents:

- medication errors,
- use of seclusion/restraint,
- incidents involving injury,
- communicable disease,

[38] The organization is expected to demonstrate conformance to applicable CARF-CCAC standards in the areas under accreditation review. CARF rates the organization's level of conformance (nonconformance, partial conformance and conformance) in the areas under review in their accreditation report.

- infection control,
- abuse,
- failure to meet standards of care,
- suicide or suicide attempt,
- sexual assault,
- other sentinel events, and
- some incidents unrelated to healthcare.

AFRH-W also was cited for non-conformance because they failed to address the necessary education and training of personnel and the prevention of recurrence of the critical incident. AFRH-W also had multiple areas of partial conformance or non-conformance related to healthcare. These findings centered on failure to execute two main issue areas:

1. The collection, analysis, and use of appropriate data to improve resident care performance including:
    a. Review of formal complaints to determine trends, areas needing performance improvement, and actions to be taken.
    b. PI data. Written analysis was supposed to be performed at least annually. The information was to be used to review the implementation of the mission and core values of the organization and to improve the quality of programs and services.
    c. Sharing of data from the data collection system with residents, including resident satisfaction, experience with care, and personnel satisfaction.
2. Inclusion of resident preferences in multiple aspects of care planning for the individual including:
    a. Conducting written screenings/assessments in response to changes in preferences of the persons served.
    b. Implementing PCC plans which address the goals of the persons served.

c. Assisting the persons served to set personal goals.

d. Implementing the PCC plan for the person served and modifying the plan as the status of the person served changes.

Additional findings concerned security of records and data collection regarding the learning environment for personnel.

The CARF findings of non-conformance with regard to the analysis of critical events, the partial non-conformance regarding the collection and use of data to improve processes, the IG recommendations regarding the incorporation of all clinical provider services into the medical staff committees, and the need for formal follow-up processes to address issues identified through risk management and other means are all related. They concern shortcomings in identification of key issues, taking appropriate action, implementing changes/education, and following up to ensure improvement or resolution of the issues.

The DoD IG Inspection Team determined that, when unit nursing staff members were asked about handling critical incidents, they were not aware of the related policy, could not define a critical incident, and did not know how to report a critical incident or what to do if they injured themselves. Therefore, the CARF finding with regard to critical incidents remained an issue.

At the time of the inspection, AFRH had recently issued agency-level documents on internal controls and PI. The PI program was in its infancy. If AFRH modifies these programs, as addressed earlier, and continues to progress they could eventually have a working process to address these areas.

AFRH Agency Notice 12-10 "AFRH Person-Centered Care Manual," July 2012, promoted an approach which involved the residents in their care. The DoD IG Inspection Team noted that this manual was not published until July 2012, despite the CARF findings in September 2011. The DoD IG Inspection Team also determined that AFRH-W was not observing the PCC philosophy in their practice. In contrast, DoD IG Inspectors observed that the staff members at AFRH-G were very focused on providing PCC.

Prior Inspections

The 2010 DoD IG Inspection of AFRH-W healthcare recommendations included issues related to:

a. I-1: The CHS position vacancy.

b. I-2: Accreditation for all aspects of the home's functions and supplementing CARF accreditation. The recommendation directed the Deputy Director DHA to perform reviews to determine an appropriate supplement to CARF.

c. I-3: Establishment of formal dental referral coordination affiliations.

d. I-4: Incorporation of all clinical care provider services, assessments and activities into the Medical Executive Committee meetings and minutes.

e. I-5: Formal follow-up processes for addressing issues identified through risk management and other means.

The DoD IG recommendation I-1 in the 2010 DoD IG Inspection report regarding the healthcare services position vacancy was resolved as the position had been filled internally. HR issues regarding the emphasis on, and problems related to, internal personnel fills have already been discussed.

The DoD IG recommendation I-2 in the 2010 DoD IG Inspection report to supplement the CARF accreditation had not been accomplished. According to DoD IG recommendation I-2, "The USD (P&R) should direct the SMA (Deputy Director DHA) to determine, in consultation with the Armed Forces Retirement Home Chief Operating Officer and Medical Director, an appropriate practice for supplementing CARF accreditation through a focused, ongoing clinical review and oversight element." The AFRH COO and DHA engaged in a clinical review, but did not determine an appropriate supplement to the CARF accreditation, as recommended. The act of engaging in a "focused, ongoing clinical review and oversight element" does not meet the requirements of 24 U.S.C. § 411(g) (2012) for "accreditation by a nationally recognized civilian accrediting organization for each aspect of the each facility of the Retirement Home, including medical and dental care, pharmacy, IL, and AL and nursing care." The review was not intended to, nor did it, meet the requirement for additional accreditation. To meet the intent of 24 U.S.C. § 411(g) (2012), the AFRH must seek and obtain an appropriate supplement to CARF accreditation.

DoD IG recommendation I-3 in the 2010 DoD IG Inspection report to set up a dental memorandum of agreement due to inadequate dental services was no longer necessary. At the time of the 2010 DoD IG inspection, AFRH-W had twice as many residents as they did during the 2012 DoD IG inspection, due to closure of the AFRH-G after Hurricane Katrina. At the time of the 2012 inspection, the DoD IG Inspection Team determined that the dental resources available through the contract mobile dental service were sufficient to meet the needs at AFRH-W.

In addition to the healthcare-related DoD IG recommendations, several other recommendations from the 2010 DoD IG Inspection report were identified as still pertinent in the 2012 DoD IG inspection.

Recommendation A-7 in the 2010 DoD IG Inspection report stated that the USD (P&R) "should promulgate all desired DoD guidance deemed applicable to the AFRH." This had not been accomplished. USD (P&R) cited language in paragraph 4.b. of DoDI 1000.28, "Armed Forces Retirement Home," February 1, 2010, as justification for not implementing this recommendation, missing the intent of the recommendation. The recommendation still applies.

Other Issues

At the time of the inspection, the AFRH was using the BPD to investigate all nursing issues. However, it was not appropriate to use BPD to document all quality assurance actions because BPD did not have the medical expertise to appropriately assess certain situations. For instance, investigation of privileged providers should not be done through BPD and investigation of other issues, such as sentinel events, may or may not be appropriate for reporting to BPD. BPD should follow DoD and AFRH policies on privileged providers.

Recommendations, Management Comments, and Our Response

Recommendation 14.a

Under Secretary of Defense for Personnel and Readiness, require the Chief Operating Officer to meet the requirements of section 411(g), title 24 United States Code to have all services of the Armed Forces Retirement Home accredited by a nationally recognized civilian accrediting organization.

Under Secretary of Defense for Personnel and Readiness Comments

USD (P&R) concurred, stating that the process is underway to get accreditation for those AFRH services not currently accredited.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

Recommendation 14.b

Armed Forces Retirement Home Chief Operating Officer:

(1) Improve policies addressing data collection, analysis, performance improvement, and staff education. Implement the improved policies and evaluate the implementation.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was in progress. The AFRH Agency provides oversight in PI and risk management in a continuous improvement manner. Staff education regarding performance improvement will continue to be promoted to enhance efficiency and effectiveness in services rendered, as well as to control operational costs.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

(2) Establish metrics to determine and measure progress made on implementation of person-centered care.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was in progress. Metrics were being developed as part of the preparation for The Joint Commission accreditation process.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

(3) Add accreditation from The Joint Commission for Long Term Care and Ambulatory Care.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the accreditation process for Ambulatory and Nursing Care by The Joint Commission is underway. This is expected to occur in September 2014.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

(4) Continue Commission on Accreditation of Rehabilitation Facilities Accreditation as a Continuing Care Retirement Community.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the AFRH will maintain necessary accreditations to meet legislative accreditation requirements.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Results – Part B

Human Resources Management

Human Resources Management

Introduction

The AFRH contracted out its staffing functions to the BPD in Parkersburg, West Virginia. The DoD IG Inspection Team traveled there to review staffing case files and the corresponding electronic official personnel files to ensure compliance with various requirements of title 5, United States Code of Federal Regulations (1999) [5 CFR (1999)]. Instances of non-compliance are discussed below. The DoD IG Inspection Team used the OPM checklist forms, titled "Delegated Examining Action Review"[39] and "Merit Promotion Audit,"[40] to document the inspection. These OPM checklists referenced 5 CFR (1999) criteria related to the HR function. Additionally, the DoD IG Inspection Team interviewed AFRH and BPD HR personnel and reviewed 5 CFR (1999) and AFRH HR directives to understand AFRH HR strategies and to ensure that they were in compliance with merit system principles. The DoD IG Inspection Team also reviewed OPM's "Armed Forces Retirement Home Human Capital Management Evaluation Report, Q1 FY 2010," March 2010, regarding AFRH HR operations.

[39] "Delegated Examining Authority" is the hiring authority used to fill competitive service jobs with competitive and noncompetitive status Federal applicants and non-Federal employees. An audit of the process, facilitated by a Delegated Examining Action Review checklist, determines whether the process meets provisions of 5 U.S.C. § 2301. OPM Delegated Examining Operations Handbook, dated May 2007.

[40] "Merit Promotion Audit" facilitated by the Merit Promotion Audit Checklist, is a review of the process for hiring under the merit promotion category, opened solely to current, permanent, competitive service employees of any Federal agency. Retrieved from the Department of Homeland Security website: http://www.dhs.gov/common-terms-job-opportunity-announcements, April 9, 2013.

Observation 15

Inadequate Documentation of the Outcome of Career Transition Assistance Plan Clearance

BPD did not adequately document the outcomes of Career Transition Assistance Plan (CTAP)[41] clearance. There was not a clear audit trail to see who was cleared.

The AFRH CTAP SOP lacked guidance on documenting the clearing of CTAP outcomes.

AFRH could not verify that CTAP was cleared during the application process or that well-qualified CTAP candidates received priority over non-CTAP candidates in the selection process, as directed by 5 CFR (1999).

Discussion

CTAP provided intra-agency selection priority for the agency's displaced employees. Thus, CTAP required agencies to give selection priority to their own well-qualified, surplus employees who applied for vacancies. With a few exceptions, the agency must have selected surplus employee applicants who applied and were well qualified before any other candidate from within or outside the agency. At the time of the inspection, the BPD had a checklist where they could mark off if CTAP was cleared. However, there was no other evidence that CTAP was cleared (control number from the computer system, documentation of qualification determinations, etc.). Providing additional evidence that CTAP was conducted and cleared would have helped ensure an audit trail for a third party to accurately assess the soundness of AFRH hiring practices and AFRH's compliance with Federal regulations.

[41] CTAP is a career transition program that provides priority for the agency's eligible and displaced employees when filling vacancies. U.S. Office of Personnel Management, *The Employee's Guide to Career Transition,"* July 2003.

Recommendations, Management Comments, and Our Response

Recommendation 15

Armed Forces Retirement Home Chief Operating Officer, coordinate with the Bureau of Public Debt to develop a process for documenting the requisition number and the dates that the Career Transition Assistance Plan was cleared.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was complete. The Administrative Resource Center has re-engineered operations, developing multiple training tools, work logs and check sheets; SOPS were examined and updated; a formalized training program developed and implemented; and a Quality Control Plan was implemented in FY 2013. Management provided a copy of the Staffing Quality Control Program and Staffing Peer Review Procedures.

Our Response

Management comments were responsive. We will look at this area again during our next inspection.

Observation 16

Lack of Transparency in Armed Forces Retirement Home Hiring Practices

AFRH Agency's hiring practices were not sufficiently transparent.

The AFRH Agency administration was not accurately following required HR procedures or OPM guidelines, or effectively communicating its hiring practices to employees. During on-site sensing sessions with AFRH Agency personnel, many of the AFRH personnel in attendance were not fully aware of, or clear about, AFRH staffing and HR policies.

As a result, some AFRH employees believed hiring practices at AFRH were unfair and this lowered employee morale.

Discussion

BPD used a veterans preference checklist, which provided a useful reference for HR Specialists to adjudicate and ensure the integrity and use of veterans preference. However, during the inspection, the DoD IG Inspection Team found the following areas of concern:

- The CHS position was announced and cancelled several times (the position was opened three times in AFRH-W and twice in AFRH-G). On two occasions, the position was cancelled because the PD needed to be re-written. On another occasion, the position was cancelled with no reason given. Industry best practices require that PDs are finalized before the position is announced. If a hiring manager wanted to cancel the position announcement, a written justification should have been given. Additionally, more rigor needed to have been applied when non-selecting someone for a position. For instance, requiring the hiring manager to document reasons for non-selecting.
- The PD for the Medical Director was still in draft format at the time of the inspection. PDs should have been finalized before a person was placed into a position.

- Additionally, there was no documentation saved in the electronic Official Personnel file regarding the adjudication of the foreign education or board certifications for the Medical Director and the CMO. OPM guidelines required the applicant to show that: (1) their medical education credentials had been evaluated by a private organization that specialized in the interpretation of foreign education programs, and (2) that such education had been deemed equivalent to education gained in an accredited U.S. education program.

Recommendations, Management Comments, and Our Response

Recommendation 16

Armed Forces Retirement Home Chief Operating Officer:

a. Ensure that hiring managers provide documentation with justification for cancelling position announcements and document reasons for non-selection.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that selecting officials retain the documentation and justification for cancelling positions and non-selection.

Our Response

We accept management's comments as responsive, although the intent of the recommendation was to ensure that the HR office collect and retain documentation and justification (for cancelling position announcements) from the selecting officials. We will check this area again on our next inspection.

b. Ensure that position descriptions are finalized before a job is announced and employees come on duty. Review all position descriptions when positions are vacant before they are announced.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that all position descriptions are reviewed prior to beginning the recruiting process.

Our Response

We accept management comments were responsive. We will check this area again on our next inspection.

c. Ensure that the Human Resource Office sends e-mails out to employees informing them of all Armed Forces Retirement Home open positions. Additionally, ensure all positions are posted in the Armed Forces Retirement Home intranet.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with the recommendation, stating that all job announcements are provided to employees via email and copies are posted on bulletin boards in employee common areas.

Our Response

Management comments are responsive. No further action needed at this time.

d. Coordinate with the Bureau of Public Debt to ensure staffing case files and electronic Official Personnel Files contain all necessary information (for example resume, transcripts, veteran's preference documents, and clearance of Career Transition Assistance Plan).

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was complete. The Administrative Resource Center has re-engineered operations, developing multiple training tools, work logs and check sheets; SOPS were examined and updated; a formalized training program developed and implemented; and a Quality Control Plan was implemented in FY 2013.

Our Response

We accept management comments as responsive. We will check this area again on our next inspection.

e. Ensure that all vacancies are posted on external locations such as USAJobs and that the vacancies' area of consideration is sufficiently broad to ensure availability of highly qualified candidates.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with recommendation, noting that all vacancy announcements are posted on USAJobs, Monster.com, and Indeed.com, as well as on trade websites.

Our Response

Management comments were responsive. No further action needed at this time.

Results – Part C

Financial Management

Financial Management

Overall Assessment

Since 2009, the AFRH had improved its overall financial management of deficient areas noted in the 2010 DoD IG Inspection report. AFRH's financial statements for fiscal years 2009–2011 demonstrated compliance with the Chief Financial Officer's Act of 1990. Supporting this assessment, the independent auditor (Brown & Company Certified Public Accountants) concluded that the AFRH's financial statements fairly presented AFRH's financial position. In addition, the financial statements, accompanying notes, and opening narrative of the annual Performance and Accountability Report (PAR) described an organization that had maintained a solvent financial state during periods of economic hardship.

Review of AFRH's financial statements, footnotes, and other financial information found in AFRH's PAR supported AFRH's claims of solvency. Comparison of the 2 years presented in each reporting period focused on fluctuations of certain accounts. Specifically, major fluctuations were observed in the fund balance with treasury. The account's 2008 starting balance of $175,561,312 dropped to $76,282,883 in 2009, then to $13,824,429 in 2010, and finally ended with a balance of $4,814,306 in 2011. This dramatic decline in the account's balance during the period 2008-2011 raised the DoD IG Inspection Team's concern about the viability of AFRH's trust fund. AFRH's financial statement footnotes, interviews with the AFRH financial staff, and additional financial-related discussions located in the PAR supported the conclusion that the fund balance drawdown was strongly related to the reconstruction of the AFRH-G facility and other AFRH property, plant, and equipment investments.

Review of the 2010 DoD IG Inspection report verified that AFRH's commitment to doing auditable financial statements continued into the current 3-year scope of the inspection. All three financial statements reviewed received clean opinions from Brown and Company Certified Public Accountants. Each year, AFRH also received internal control reports stating that the internal control and its operation contained no significant deficiencies or material weaknesses. Additionally, the three reports noted AFRH's compliance with laws and regulations which could have a direct and material effect on the determination of financial statement amounts.

Review of the budget and the process of creating the budget indicated satisfactory results. During the inspection, the Financial Management Officer demonstrated AFRH's process for developing its 2013 budget, using multiple examples. The execution of the current budget was also demonstrated from the individual purchase, down through reconciliation, and finally to the actual budget element. However, review of the Financial Management Officer's process for developing the 2012 budget raised concern. Without constant assistance, monitoring, and advice from the Financial Management Officer, the budget process would not have succeeded. Efforts at the agency level depended on input from the AFRH-W and AFRH-G financial staff. The DoD IG Inspection Team determined that more experience was needed at the individual facility locations. The facility financial staff needs more experience and training to make the overall budget process more effective and efficient. Without the knowledge and management efforts of the Financial Management Officer, the yearly budget proposal would not have been of acceptable quality.

The annual PAR served as a depository for most of the elements needed to review the financial management of AFRH. The PARs for 2009–2011 were reviewed. The PAR included the annual financial statements, the opinion on those financial statements by an independent auditor, the statement of assurance, and a wide ranging discussion of the overall operations of AFRH. The annual statement of assurance was management's assertion that the organization was reasonably assured of having functioning internal controls and that any material weaknesses had been reported. The annual statement of assurance also asserted that AFRH was in compliance with all applicable laws and regulations. The DoD IG Inspection Team determined that all statements of assurance reviewed were positive.

The financial statements published in the annual PARs were also reviewed. The opinion of the independent auditor was part of the financial statements. All three opinions stated that the financial statements presented the financial position of the AFRH fairly. Additionally, the financial statements were compared and significant variations between years of any accounts were researched. No unexplained issues were identified.

Financial transaction processing was integral to the review of the PARs and the budget process. BPD and AFRH had a reconciliation process that had served as a control over financial transaction processing. The 2010 DoD IG Inspection report

on financial transaction processing observations was reviewed and no concerns were identified. The additional controls put in place since the 2010 DoD IG Inspection report were determined to be adequate and functioning properly.

However, the DoD IG Inspection Team's analysis of AFRH's management of purchase card use and internal controls identified some areas where improvement was needed.

Observation 17

Inadequate Oversight of Convenience Checks Used by Armed Forces Retirement Home Purchase Cardholders

Oversight of convenience checks was inadequate.

Approving officials were not effectively monitoring convenience check usage of assigned purchase cardholders.

As a result, a purchase cardholder had utilized convenience checks for transactions prohibited by the U.S. Department of Treasury and in violation of AFRH Agency Directive 3-1, "Financial Management," July 18, 2012.

Discussion

The use of convenience checks was strongly discouraged by AFRH Agency Directive 3-1. AFRH Agency Directive 3-1 stated that convenience checks were only to be used when vendors did not accept purchase cards. At the time of the inspection, both AFRH-G and AFRH-W facilities utilized convenience checks in lieu of purchase cards for this reason. Examples included paying for services provided by small companies or individuals, such as piano tuning, or to reimburse residents who voluntarily made purchases for AFRH. Convenience checks were issued to the administrative officers at each facility. They were the only AFRH personnel authorized to make purchases with convenience checks. Administrative officers were prohibited from purchasing items for personal use, items that were not authorized by AFRH, or items on the *do not buy list*. However, after reviewing the purchase card and convenience check transaction logs, the DoD IG Inspection Team observed that a convenience check holder was using convenience checks inappropriately for purchases that should have been disallowed by the convenience check holder's approving official.

Purchases were made with convenience checks to fund:

- Unbudgeted medical reimbursements that were funded from already obligated funds. The accounting strings, merchant names, and merchant category classification codes for some of these transactions were found to be incorrect and this was still reflected in the BPD purchase card transaction report, but not captured in BPDs audit.

- Travel expenses of job applicants who traveled to Gulfport for interviews. Although authorized by management, this was a clear violation of the AFRH Agency Directive 3-1 and BPD purchase card procedures.

Recommendations, Management Comments, and Our Response

Recommendation 17

Armed Forces Retirement Home Chief Operating Officer:

a. Develop policies that ensure that the Armed Forces Retirement Home Agency Chief Financial Officer directs the Purchase Card Program Coordinator to require all approving officials and cardholders that use or approve convenience checks to attend refresher training on convenience checks that stresses the restrictions on their use.

AFRH COO's Comments

AFRH COO concurred with this recommendation.

Our Response

Management's comments were responsive. We ask that the AFRH COO provide a copy of training documentation in response to the final report.

b. Develop policies that ensure the Armed Forces Retirement Home Agency Chief Financial Officer direct the Purchase Card Program Coordinator to require approving officials to closely monitor use of all convenience checks to confirm compliance with guidance by preapproving all convenience check purchases.

AFRH COO's Comments

AFRH COO concurred, commenting that AFRH Agency Directive 3-1 will be updated to require pre-approval by the Campus Administrator and/or Corporate Resource Approver only.

Our Response

Management's comments were responsive. We will request an update on this recommendation at a later date.

Observation 18

A Number of Funds are Not Being Audited

Although required by AFRH-W SOPs, AFRH-W Business Center personnel were not conducting required audits/cash counts of AFRH funds, including the Chaplain's Fund (Catholic and Protestant Funds), Security's petty cash, the Golf Shack's cash drawers, and two safes on the premises (one in the LaGarde Building and one in Security).

The DoD IG Inspection Team determined that AFRH-W Business Center personnel were unaware of these requirements, as defined in SOPs.

Consequently, theft or misuse of the funds could occur without detection, although there was no indication that this had occurred.

Discussion

AFRH-W SOPs, No. W-OA-ADM-1-06, "Fund and Gift Accountability," July 6, 2012, and No. W-OA-BUS-2-04, "Miscellaneous," July 6, 2012, required the AFRH-W Business Center to conduct audits of various AFRH funds and provided the requirements for the cash count and audit of these funds. The "Fund and Gift Accountability" SOP required an audit of the non-appropriated petty cash and change funds. The "Miscellaneous" SOP required monthly audits of Security's petty cash, the Golf Shack's cash drawers, and the safes located in the LaGarde Building and in the Security Office of the Sheridan Building. In addition, both the "Miscellaneous" and the "Fund and Gift Accountability" SOPs required the Business Center staff to conduct quarterly audits of the Religious Service's Catholic and Protestant Funds and to ". . . facilitate an annual outside audit . . ." of the Chaplain's Fund of each individual faith group, respectively. Moreover, the "Miscellaneous" SOP stated that the Business Center's audits of all Religious Service's Catholic and Protestant Funds, including the Chaplain's Funds, must ensure that balances were correct, charges were appropriate, and proper documentation was provided. However, the DoD IG Inspection Team noted that these audits were not being conducted because the Business Center of AFRH-W was unaware of the requirements.

Recommendations, Management Comments, and Our Response

Recommendation 18

The Armed Forces Retirement Home Chief Operating Officer:

a. Develop policies to require the Armed Forces Retirement Home Agency Chief Financial Officer to ensure that the Armed Forces Retirement Home – Washington, D.C., Support Services personnel initiate cash counts of all cash funds at the Armed Forces Retirement Home – Washington, D.C., facility, as required by standard operating procedures W-OA-ADM-1-06, Fund and Gift Accountability," July 6, 2012, and W-OA-BUS-2-04, "Miscellaneous," June 21, 2012.

AFRH COO's Comments

AFRH concurred, commenting that AFRH will update AFRH Agency Directive 3-4 to require Campus Business Centers to provide results and certify cash audits have been completed annually.

Our Response

Management's comments were responsive. We will request a copy of the updated AFRH Agency Directive 3-4 at a later date.

b. Develop policies to ensure that the Armed Forces Retirement Home – Washington, D.C., Financial Management Officer facilitate an annual outside audit of the Chaplain's Funds, as required by standard operating procedure, W-OA-ADM-1-06.

AFRH COO's Comments

AFRH COO concurred, commenting that AFRH IG will perform an annual audit of the Chaplain's fund. In addition, when AFRH Agency Directive 3-4 is updated, the IG audit responsibility will be included.

Our Response

Management comments were partially responsive. The current SOP, W-OA-ADM-1-06, requires an annual outside audit. AFRH IG is an internal entity and may not be the best entity to conduct this task. We will request an update on this issue at a later date.

c. Ensure the education and training of all Armed Forces Retirement Home – Washington, D.C., Business Center staff on the requirements of W-OA-ADM-1-06, "Fund and Gift Accountability," July 6, 2012, and W-OA-BUS-2-04, "Miscellaneous," June 21, 2012, and the procedures for conducting audit/cash counts.

AFRH COO's Comments

The AFRH COO concurred with this recommendation.

Our Response

Management's comments were responsive. We ask that management provide documentation confirming any training or education of noted staff, if complete, in response to the final report.


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Results – Part D

Armed Forces Retirement Home Inspector General Program

Armed Forces Retirement Home Inspector General Program

The COO of the AFRH issued AFRH Agency Directive 1-9, AFRH Inspector General Program, June 2, 2009, establishing the AFRH IG program and providing policy, assigning responsibilities, and establishing procedures for the operation of the AFRH IG Program.

As per AFRH Agency Directive 1-9, the AFRH IG:

a. serves as the COO's principal advisor on the detection and prevention of waste, fraud, abuse, and mismanagement;

b. manages the AFRH Hotline program and issues implementing guidance that specifies:

    - quality standards for the AFRH Hotline Program,
    - procedures to ensure appropriate evaluation and action on all allegations of fraud, waste, abuse, and mismanagement, and
    - methods to ensure appropriate protection of the identity of sources requesting anonymity or confidentiality;

c. conducts audits and investigations and recommends policies to promote economy, efficiency, and effectiveness in the administration of AFRH programs and operations; and

d. serves as the AFRH POC to coordinate IG matters with external entities, such as the Federal Offices of Inspectors General (*e.g.*, DoD OIG), Military Service IGs, the Office of Special Counsel, and members of Congress and their staffs.

Observation 19

Conflict of Interest in Dual Hatted Armed Forces Retirement Home Inspector General Position

The AFRH IG position is a dual-hatted position with other primary responsibilities.

This happened because the COO assigned the AFRH Public Affairs Officer the additional duties of the AFRH IG.

As a result, there is a possibility of conflict of interest between the duties of the IG and the duties of the Public Affairs Officer when an investigation involves issues pertaining to the Public Affairs Office. Additionally, the duties of the IG may get a lower priority than the duties of the Public Affairs Officer.

Recommendations, Management Comments, and Our Response

Recommendation 19

Armed Forces Retirement Home Chief Operating Officer, convert the Armed Forces Retirement Home Inspector General position to a full-time position, without any additional responsibilities that could cause a conflict of interest in the performance of Inspector General duties.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the AFRH Inspector General Position had been advertised and the first round of interviews had been completed.

Our Response

Management's comments were responsive. No further action needed at this time.


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Observation 20

Lack of Quality Standards for the Armed Forces Retirement Home Inspector General Investigations and Audits

The AFRH IG program does not have quality standards defined for AFRH IG audits and investigations.

As an independent establishment within the Executive branch, the AFRH IG is not subject to Federal or DoD IG quality standards.

- The AFRH is not an *independent establishment*[42] or *designated Federal entity*,[43] as defined in the IG Act of 1978, as amended. Therefore, the AFRH IG program is not subject to the Council of Inspectors General for Integrity and Efficiency (CIGIE) quality standards that apply to the Federal Offices of Inspectors General.
- Although the AFRH COO is subject to the authority, direction, and control of the Secretary of Defense, the AFRH is not part of the DoD and is not subject to DoD policy and issuances, except when expressly made applicable. As a result, the AFRH IG program is not subject to DoD Hotline policy, responsibilities, and procedures established by the DoD IG.

Due to lack of quality standards for AFRH IG investigations and audits, the program may lack credibility. They may also prove less than responsive to DoD Hotline referrals.

[42] An independent establishment is an establishment in the executive branch (other than the United States Postal Service or the Postal Regulatory Commission) which is not an Executive department, military department, Government corporation, or part thereof, or part of an independent establishment; and Government Accountability Office, 5 U.S.C. § 104.

[43] Designated Federal entities are the entities listed in the Inspector General Act of 1978 (IG Act), as amended (5 U.S.C. App.), which requires the head of each entity to establish an Office of Inspector General (IG) and appoint an Inspector General. GAO report GAO-09-270, "Designated Federal Entities: Survey of Governance Practices and the Inspector General Role," April 2009.

Recommendations, Management Comments, and Our Response

Recommendation 20.a

Under Secretary of Defense for Personnel and Readiness update Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010, to make the following Department of Defense Instruction applicable to the Armed Forces Retirement Home: Department of Defense Instruction 7050.01, "Defense Hotline Program."

USD (P&R) Comments

USD (P&R) non-concurred. As an independent agency, and in accordance with (IAW) 24 U.S.C § 411(a) (2012), AFRH has legislative authority to set policy/guidance to meet credible standards for audits and investigations and will also develop policy in the area of Hotline activities.

Our Response

Although USD (P&R) non-concurred, we found their comments to be responsive with the intent of the recommendation. Accordingly, we find it unnecessary, at the present time, to address the extent, if any, of their legislative authority. We will request an update at a later date on the development of AFRH policy compatible with DoD IG Hotline procedures/requirements.

Recommendation 20.b

Armed Forces Retirement Home Chief Operating Officer, revise Armed Forces Retirement Home Agency Directive 1-9, "AFRH Inspector General Program," June 2, 2009, to include quality standards for Armed Forces Retirement Home Inspector General audits and investigations. Audits should comply with the Generally Accepted Government Auditing Standards published by the Government Accountability Office. Investigative standards should be modeled after the Council of Inspectors General for Integrity and Efficiency Quality Standards for Investigations, November 15, 2011.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the AFRH would establish standards within the AFRH Agency Directive 1-9 that meet Federal government standards.

Our Response

Management's comments were responsive. We will request an update on the development of standards in this area at a later date.


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Results – Part E

Admissions/Eligibility

Admissions/Eligibility

Overall Assessment

The DoD IG Inspection Team examined whether AFRH's pre-admissions process sufficiently complied with resident eligibility standards defined by section 412, title 24, United States Code (24 U.S.C. § 412 [2012]), AFRH directives, and AFRH SOPs. The DoD IG Inspection Team also examined whether AFRH had established and implemented a priority system for the acceptance of residents once the retirement home reached maximum capacity, as required by section 412(d), title 24, United States Code (24 U.S.C. § 412(d) [2012]). Upon review, the DoD IG Inspection Team determined that AFRH Agency directives[44] and SOPs[45] were sufficiently written in accordance with 24 U.S.C. § 412 (2012). In addition, the DoD IG Inspection Team determined that AFRH personnel involved in the pre-admissions process at the agency level and at both the AFRH-W and AFRH-G facilities possessed general knowledge about program requirements and executed their responsibilities in an acceptable manner with a few exceptions.

AFRH's pre-admissions process failed to comply with AFRH's Agency directives and facility SOPs in ensuring that: (1) the correct personnel conducted activities in the pre-admissions process, and (2) that admissions eligibility approval determinations met screening specifications directed by 24 U.S.C. § 412 (2012). AFRH was not accurately following its directives to determine the eligibility for applicants applying under the *incapable of earning a livelihood* designation and lacked an adequate process for assessing and excluding applicants who may abuse drugs. Inadequacies and contradictions in AFRH Agency directives and facility SOPs contributed to AFRH's noncompliance with established procedures.

The DoD IG Inspection Team evaluated the execution of AFRH's prioritization plan for the re-occupancy of AFRH-G facility, and determined that the prioritization plan successfully managed the return of AFRH-G residents to the new facility in Gulfport, Mississippi.

[44] AFRH Agency Directive 8-5C (draft), "AFRH Admissions Program," dated July 2012.

[45] W-OA-ADM-1-14, "Transitions," dated July 9, 2012, and G-OA-ADM-1-15, "Transitions," dated July 18, 2012.

The Pre-Admissions Process

The pre-admissions process was solely an agency-level function. The AFRH Public Affairs Office managed the marketing and pre-admissions program at the agency level and was the entry point for all applications, regardless of the facility for which prospective residents wished to apply. The Public Affairs Office coordinated with the prospective residents by obtaining forms and documentation required to complete an application package. Applicants were required to obtain and provide AFRH with evidence of their satisfactory compliance with eligibility requirements in 24 U.S.C. § 412 (2012), as well as the eligibility requirements established by AFRH. Once received, the AFRH Agency Public Affairs Officer and Public Affairs Specialist of the Public Affairs Office processed all applications and supporting documentation for both facilities.

Applications were reviewed by the pre-admissions team, which included the Public Affairs Officer, the Public Affairs Specialist, and the AFRH Agency Medical Director.

The Public Affairs Specialist and the Public Affairs Officer determined whether the applicants met the military eligibility requirements and eligibility requirements for applicants specifying they were ". . . incapable of earning a livelihood" under rules prescribed by the COO, as stipulated in 24 U.S.C. § 412 (2012). Applicants were required to provide documentation that they had satisfactorily met at least one of the eligibility categories specified in 24 U.S.C. § 412 (2012).

The Medical Director's assessment was conducted independently of the Public Affairs Office.

The AFRH Medical Director:

(1) provided clearance on an applicant's ability to meet the eligibility requirement of section 412(b), title 24, United States Code (24 U.S.C. § 412(b) [2012]), to be without drug, alcohol, and psychiatric problems;

(2) determined an applicant's medical suitability for living at the retirement home; and

(3) assessed whether or not applicants could meet Activities of Daily Living (ADL) to live independently.

In response to deficiencies reported in the 2010 DoD IG Inspection report, AFRH had satisfactorily adopted measures to improve these areas of the pre-admissions process. AFRH had implemented policies and procedures to screen applicants for felony convictions and excluded these applicants from admission into the retirement home. For each applicant, the AFRH Public Affairs Office completed two background checks through a Web-based contractor, L.P. Police.com, to determine if the resident had a prior felony conviction which could render him/her ineligible for admission into the retirement home. The first background check was conducted upon receipt of application. A second background check was conducted during the 60-day probationary period after an applicant had moved into the retirement home.

In addition, the AFRH COO had also taken measures to prescribe rules (guidance) beyond the statutory resident eligibility categories to supplement eligibility standards for the acceptance of residents into the retirement home. This included AFRH Agency Directive 8-13, "Incapable of Earning a Livelihood Designation," July 3, 2012, which serves to guide eligibility decisions in determining whether a person was incapable of earning a livelihood.

At the time of the inspection, AFRH was at full capacity and there was a waiting list for acceptance. The waiting period was up to 2 years. AFRH was following its prioritization plan in accepting new residents, as directed by 24 U.S.C. § 412(d) (2012) and AFRH Agency Directive 8-9A, "AFRH Resident Eligibility Prioritization Plan," October 2013.

Observation 21

Noncompliance with Armed Forces Retirement Home Directive 8-13 in Determining Applicant Eligibility

The AFRH Pre-admission Team was not using financial factors to determine whether an applicant was eligible under the "Incapable of Earning a Livelihood" category, as directed by AFRH Agency Directive 8-13.

This occurred because provisions of AFRH Agency Directive 8-13 materially contradicted the AFRH Legal Team opinion.

Consequently, AFRH failed to comply with the established rules set forth in AFRH Agency Directive 8-13 when determining whether an individual was incapable of earning a livelihood and therefore eligible for admission into the retirement home.

Discussion

AFRH was not following the prescribed rules, as established in AFRH Directive 8-13, with respect to implementing criteria used to qualify applicants for admissions under the statutory category listing resident as ". . . incapable of earning a livelihood."

According to 24 U.S.C. § 412 (2012), paragraphs (a)(2), (a)(3)(C) and (a)(4)(B), the COO had the authority to admit applicants who he determined were:

a. ". . . incapable of earning livelihood because of a service connected disability incurred in the line of duty in the Armed Forces,[46]

b. ". . . incapable of earning a livelihood because of injuries, disease or disability,[47] or

c. eligible for admissions because of ". . . compelling circumstances as a person who served in a women's component of the Armed Forces before June 12, 1948."[48]

[46] 24 U.S.C. § 412 paragraph (a)(2).
[47] 24 U.S.C. § 412 paragraph (a)(3)(C).
[48] 24 U.S.C. § 412 paragraph (a)(4)(B).

The meaning of the phrase ". . . incapable of earning a livelihood" was evaluated and clarified by the AFRH Legal Team review in 2009 and 2010.

The AFRH Legal Team concluded that AFRH should "…interpret the phrase unable to earn a livelihood as [being] unable to earn means of support or subsistence," and advised AFRH to ". . . [consider the fact] that courts have recognized individuals as 'unable to earn a livelihood' even though they had an income."[49]

During an interview, AFRH COO stated that the basis for his determination rested solely on the guidance provided by the AFRH Legal Team.

However, AFRH Agency Directive 8-13 included several financial factors which served as the basis for the AFRH Pre-admission Team in their determination of whether or not an individual was incapable of earning a livelihood. In addition, AFRH Agency Directive 8-5C (draft), "AFRH Admissions Program," July 2012; AFRH Agency Directive 8-13; and AFRH-W facility SOP W-OA-ADM-1-14, "Transitions," July 9, 2012; and AFRH-G SOPG-OA-ADM-1-15, "Transitions," July 18, 2012, required that applicants be able to pay an established monthly resident fee. The directives and SOPs' use of means testing as a mechanism for assessment not only contradicted both the legal opinion given by the AFRH Legal Team and the actual eligibility assessment process used by the AFRH Pre-admissions Team, but also increased the risk of rendering the admissions process unfair and inequitable. However, the AFRH Public Affairs Officer reiterated several times that an applicant's financial position was not considered in the application process. Therefore, AFRH reportedly does not deny admission based on wealth or an applicant's inability to pay resident fees.

In practice, the AFRH Pre-admission Team requested that the applicant provide AFRH legal documentation stating they were incapable of earning a livelihood and relied mostly on VA to make the determination as to whether or not an individual was actually incapable of earning a livelihood. The Pre-admission Team only considered the applicant's: (1) ability to meet requirements of 24 U.S.C. § 412 (2012), (2) ability to meet medical clearance requirements, and (3) the applicant's ability to live independently in their decision making process.

[49] Memorandum sent from 11WG/JA to AFRH COO, 3 December 2009, Subject: *Legal Review of the phrase 'unable to Earn a Livelihood"* paragraph 5.

The contradictions between AFRH Agency Directive 8-13 and the AFRH Legal Team opinion had rendered AFRH noncompliant with its own prescribed guidance on the process for admitting individuals who claimed eligibility because of their ability to meet the "incapable of earning a livelihood" requirements.

Recommendations, Management Comments, and Our Response

Recommendation 21

Armed Forces Retirement Home Chief Operating Officer, modify Armed Forces Retirement Home Agency Directive 8-13, "Incapable of Earning a Livelihood Designation," July 3, 2012, to reflect the established Armed Forces Retirement Home practice and the Armed Forces Retirement Home Legal Team opinion, with respect to determining eligibility of those deemed incapable of earning a livelihood.

AFRH COO's Comments

AFRH COO concurred, reporting that the recommendation was complete. AFRH COO also noted that the AFRH Agency Directive 8-13 does not require modification. AFRH Agency Directive 8-9D, dated September 26, 2013, covers the legal reviews for each applicant applying under the incapable of earning a livelihood category.

Our Response

Management comments were partially responsive, but did not fully meet the intent of this recommendation. Financial criteria noted in AFRH Agency Directive 8-13 were not being used to determine if an applicant was eligible for admission under the "incapable of earning a livelihood" category. The issue goes beyond a legal review. The recommendation asked that AFRH COO revise AFRH Agency Directive 8-13 to provide both staff and applicants an accurate picture of the methodology and criteria used in this assessment. We will request an update on this issue at a later date.


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Observation 22

Inadequate Eligibility Verification Process to Exclude Applicants Who Have Drug Abuse Problems

Current methods used to verify eligibility may fail to identify and eliminate applicants who have a drug abuse problem.

There was no evidence that drug testing was a requirement of the admissions process or the basis for medical evaluations used by pre-admissions personnel to assess eligibility.

Applicants who abuse drugs may have been given admissions into the AFRH, violating 24 U.S.C. § 412(b) (2012).

Discussion

Section 412(b), title 24, United States Code stated that a person was ineligible to become a resident if they had been convicted of a felony or were not free from illegal drugs, alcohol, and psychiatric problems.

Sufficient screening existed in the application process to determine whether an applicant had a felony conviction and was free of psychiatric and alcohol problems. However, AFRH did not have an effective means of determining whether an applicant was free of illegal drugs. At the time of the inspection, AFRH did not include drug testing as part of the pre-admissions process to determine the existence of current drug use by applicants. Instead, AFRH primarily relied on the "honest" self-reporting of applicants to their personal physician, who then reported this information on the medical and psychological evaluation forms.

Because AFRH applicants were able to self-report their history of drug use and there was no requirement for them to be drug tested at any time during the pre-admissions process, there was an increased risk that some might falsify or omit pertinent information related to illegal drug usage or prescription abuse to attain admission to the retirement home.

According to the AFRH Medical Director, he reviewed the medical history and psychological evaluation of applicants whose medical form did not report a history of drug/alcohol abuse for possible indicators of alcoholism or drug abuse. If the Medical Director suspected drug abuse/alcoholism from his assessment of an applicant's medical documentation, he requested that the applicant obtain a psychiatric consultation with another psychiatrist, of the applicant's choosing, to assess suitability of the applicant for living at the retirement home.

AFRH's only other means of verifying that an applicant was free from illegal drugs was to require that all AFRH personnel observe and monitor new residents and report on unusual behaviors occurring during the 60 day probationary period after a resident had moved into the retirement home. If evidence of drugs, alcohol, or felony convictions arose within the probationary period, residents were discharged from the Home. There was no drug testing done on-site. According to AFRH Medical Director, if evidence of drugs, alcohol, or psychological issues arose beyond the probationary period, AFRH was responsible for providing treatment for the resident, resulting in a cost exceeding that of the upfront drug testing.

In addition, the AFRH policies and procedures brochure stated that AFRH staff and facility were not equipped to treat such conditions or perform continual evaluation, observation, or treatment for individuals found to have had problems associated with alcohol, drugs, or mental health. Therefore, AFRH had to contract out mental and behavioral health services to local providers in the communities at each location when residents exhibited problems with drugs, alcohol, and/or mental health.

Recommendations, Management Comments, and Our Response

Recommendation 22

Armed Forces Retirement Home Chief Operating Officer, establish drug testing as a requirement of the admissions process and random drug testing during the probationary period.

AFRH COO's Comments

AFRH COO concurred and stated that if the prospective applicant's medical provider makes the determination the applicant has a drug problem, then additional drug testing will be required by AFRH.

Our Response

Management's comments were not responsive to the intent of the recommendation. There is no assurance that a medical provider makes a determination of drug abuse, beyond being told by the applicant that a drug or alcohol abuse existed. This requires the AFRH to assume that the applicant has or will divulge complete and accurate information about drug or alcohol abuse to his/her provider. While the medical form requires that the applicant's medical provider provide indications or history of alcohol and/or drug misuse or addictions, there is no indication that the medical provider includes drug testing as a part of his/her assessment. The law is clear that residents must be "...free from drug... problems." Drug testing completed within 24–72 hours (or within a short window of time identified by the AFRH) of notice prior to admission will add assurance that the home and applicant are compliant with the law and eligibility standards for admission. We note that prospective Federal employees are required to take a pre-employment drug test. We ask that the AFRH COO consider drug testing as requisite for admittance to the AFRH to ensure the applicant is free from drug problems and advise us in response to the final report.


INSPECTOR GENERAL
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Observation 23

Noncompliance with Agency Directive and Standard Operating Procedure Requirements for the Pre-admissions Process

AFRH personnel were not accurately following agency directives or facility SOPs in conducting the pre-admissions function.

In addition, AFRH Agency Directive 8-5C (draft), "AFRH Admissions Program," July 2012, contradicted AFRH-W SOP W-OA-ADM-1-14, "Transitions," July 9, 2012, and AFRH-G SOP G-OA-ADM-1-15, "Transitions," July 18, 2012.

Consequently, AFRH personnel did not have clearly defined policies and the standards applied by AFRH personnel to pre-admissions activities were inconsistent and contradictory.

Discussion

AFRH Agency Directive 8-5C AFRH facility SOPs W-OA-ADM-1-14 and G-OA-ADM-1-15 provided guidance on the pre-admissions process. The AFRH Pre-admissions Team was generally following many aspects of all guiding documents. Other AFRH personnel involved in the admissions process at both AFRH facilities were primarily following prescribed rules of facility SOPs W-OA-ADM-1-14 and G-OA-ADM-1-15. However, at the time of the inspection, AFRH Agency Directive 8-5C was still in draft phase, had not been finalized, and contradicted AFRH facility SOPs on a few important points.

First, the AFRH Agency Directive 8-5C (draft) differed from the facility SOPs W-OA-ADM-1-14 and G-OA-ADM-1-15 in the use of terminology to define the office designated with the responsibility for pre-admissions functions. The directive used the term *Marketing Office*, while the SOPs used the term *Public Affairs Office* when referring to the entity that was responsible for the pre-admissions function. During an interview, the title Public Affairs Office was validated by the Public Affairs Officer as synonymous with Marketing Office.

Secondly, the AFRH Agency Directive 8-5C (draft) and the facility SOP W-OA-ADM-1-14 differed with regard to who was responsible for reviewing and approving or denying admissions applications. The AFRH facility SOP

stated that the AFRH Agency Medical Director, Facility Administrator, Chief of Resident Services, Ombudsman, and CMO were supposed to review these applications. However, AFRH Agency Directive 8-5C (draft) stated that the review and approval of admissions applications were solely the responsibility of the AFRH Agency Medical Director and AFRH Agency (authority). AFRH Agency Directive 8-5C (draft) did not explicitly define this *authority* as the Public Affairs Officer. However, the directive's description of the Admissions Team stated that the AFRH Marketing Office (or Public Affairs Office, as noted by the AFRH Public Affairs Officer), was assigned the responsibility over all pre-admissions functions, up to and including the assignment of the resident's report date.

Interviews with the AFRH Agency Public Affairs Officer, the AFRH Agency Medical Director, and other staff confirmed that the Public Affairs Officer and the Medical Director were following AFRH Agency Directive 8-5C (draft) and not the AFRH facility SOPs in this respect. However, other AFRH personnel were primarily following the SOPs in conducting the majority of pre-admissions and admissions functions. The Public Affairs Specialist's participation in the process complied with AFRH Agency Directive 8-5C (draft), but contradicted the provisions of the facility's SOPs, which omits him/her from the process and included several other entities who did not participate in the process at the time of the DoD IG inspection.

Thirdly, both AFRH facility SOPs stated that each facilitys' Admissions Board was supposed to provide the Public Affairs Officer with a rationale for the disapproval of an applicant's admissions into the Home. However, in their account of the pre-admission's process, the Medical Director, the Public Affairs Officer, and both the AFRH-G and the AFRH-W facility Admissions Officers stated that the pre-admissions activities were limited to the Public Affairs Officer and the Medical Director. During the inspection, it was determined that there was not an Admissions Board established at the facility level.

Recommendations, Management Comments, and Our Response

Recommendation 23

Armed Forces Retirement Home Chief Operating Officer, in coordination with Armed Forces Retirement Home – Gulfport and Armed Forces Retirement Home – Washington, D.C. facility Administrators, review and revise the standard operating procedures and directives to resolve any contradictions.

AFRH COO's Comments

AFRH COO concurred, commenting that the Admissions Program Directive update is in progress. The directive will provide the correct guidance for the Administrators to update the Standard Operating Procedures for the Transition Program at the facility level.

Our Response

Management's comments were responsive. We will request a status on the update of agency directive at a later date.


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Results – Part F

Facilities Engineering and Safety

Facilities Engineering and Safety

Overall Assessment

The DoD IG facilities engineering assessment addressed facility operations and safety operations at the agency and facility level. The AFRH used a two-tier policy issuance system. Agency-level guidance was issued as an AFRH Agency directive or notice. Each facility was responsible for implementing agency-level policy and for developing and issuing facility-level SOPs at its facility. The agency-level, facility-related issues were being handled separately by the corporate facilities manager. At the facility level, the AFRH-W and AFRH-G facilities each managed their own facilities and safety operations.

In August 2011, the Washington, D.C., metro area was hit by a 5.8 magnitude earthquake, causing structural damage to the Sherman Building. In light of the historic nature of this structure, Congress awarded AFRH-W $14.6 million to repair the damage. Because the contract was just awarded and the repairs were underway, the Sherman Building was excluded from the AFRH 2012 Assessment.

At the AFRH-W, the Acting Chief of Campus Operations was also the supervisory Contracting Officer's Technical Representative (COTR) and was responsible for the operation of all buildings on the AFRH-W facility. AFRH-W Safety Officers managed the safety issues for all buildings and properties on the AFRH-W facility. The majority of AFRH-W facilities were maintained using contractors. Service contracts included:

- facilities maintenance,
- grounds maintenance,
- pest and wildlife control,
- transportation (on-campus/off-campus),
- golf course,
- utilities,
- heating plant,
- waste disposal, etc.

These contracts were handled by respective COTRs who reported to a supervisory COTR. Each COTR provided monthly quality assurance surveillance plans that were reviewed by the supervisory COTR.

As part of the overall master planning of AFRH-W, the leadership of the AFRH determined that the Scott Building, a major residential dormitory, was at risk due to its aging infrastructure and massive repair requirements which would cost approximately $81 million. The AFRH Long-Range Financial Plan recommended demolishing the existing Scott Building and replacing it with a multi-function healthcare facility. Demolition of the Scott Building began in August 2011 and was completed by February 2013. The new Scott Building was opened for residents to move in March 2013.

In FY 2011, just over 5 years after the devastation of Hurricane Katrina, the AFRH reopened the newly renovated AFRH-G facility. The AFRH-G facility was included in this inspection. (AFRH-G was excluded from the 2009 AFRH inspection as the facility was closed due to the hurricane damage.) Also in FY 2011, AFRH-G admitted their 500th resident to the Gulfport facility.

Overall, the DoD IG Inspection Team found that the AFRH personnel worked cooperatively between both facilities. In addition, the DoD IG Inspection Team found that AFRH personnel generally gave adequate due diligence and care to the facilities engineering and safety assets.

The DoD IG Inspection Team completed the AFRH-G and AFRH-W facilities engineering assessment that resulted in the observations described below.

Figure 2. Armed Forces Retirement Home—Gulfport Mississippi
Source: AFGH-G


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Observation 24

Armed Forces Retirement Home Occupational Health and Safety Manual and Emergency Operations Plan Not Issued

The AFRH Occupational Health and Safety Manual (Directive 7-1) and the AFRH Emergency Operations Plan (Directive 7-2) had not been issued. Furthermore, AFRH did not have an official agency-level notice or directive issued for the Occupational Health and Safety program and Emergency Operations, even though AFRH had operating procedures in place for Occupational Safety and Health Standards at each facility.

The agency had not made production of the AFRH Occupational Health and Safety Manual and the AFRH Emergency Operations Plan a priority.

This may result in confusion about the requirements for administering the Occupational Health and Safety program across the agency and its facilities and a lack of guidance on effective response planning for emergency situations.

Discussion

AFRH Agency Notices 09-10, "AFRH Occupational Health and Safety Manual," and 09-11, "AFRH Emergency Operation Plan," had been under AFRH Legal Team review. They were issued on September 9, 2009, with a review date of October 31, 2010. These notices had not been reissued as AFRH Agency Directive 7-1 and 7-2, respectively, as noted in the updated "AFRH Agency Policy Statements, Notices and Directives Index," July 25, 2012. In addition, AFRH displayed a lack of internal document control by allowing a significant period of time to elapse between re-issuances of its directives and notices.

Recommendations, Management Comments, and Our Response

Recommendation 24

Armed Forces Retirement Home Chief Operating Officer, issue the pending directives related to the Armed Forces Retirement Home Occupational Health and Safety Manual, and the Armed Forces Retirement Home Emergency Operations program, as required by Armed Forces Retirement Home Agency policy.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with the recommendation and is planning to review the pending draft AFRH Agency Directives 7.1 & 7.2 to determine if a single directive will suffice.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

Observation 25

Defective "HomeFree Emergency Call and Wander Alert System" ("HomeFree" System)

In a system test conducted by the DoD IG Inspection Team, a HomeFree Emergency Call and Wander Alert System ("HomeFree") door alarm in the LaGarde Building did not alert the AFRH security, upon breech.

AFRH-W was not performing adequate testing/monitoring of the "HomeFree" devices to identify any defects or issues with the system.

Consequently, a monitored resident of the LaGarde Building, at risk of wandering, could leave a monitored area without AFRH-W personnel knowledge.

Discussion

As per AFRH Directive 8-11, AFRH-W used the "HomeFree" system as a wireless alert system designed specifically for the safety and security of all residents. The "HomeFree" system allowed AFRH to extend real-time assistance and attentive care to its residents and it provided the means to monitor potential wandering occurrences.

In accordance with AFRH Agency Directive 8-11, "AFRH HomeFree Emergency Call and Wander Alert System," June 2, 2008, residents at LaGarde Building (AL, LTC, and Memory Support) who were at risk for wandering, were required to wear a "HomeFree" personal watch, which caused mounted door alarms to generate an alert on the "HomeFree" computer monitor if a resident left the building. The "HomeFree" vendor provided support for all performance issues with the system.

Figure 3. HomeFree Personal Watch Used at AFRH-W
Source: DoD IG–SPO

The "HomeFree" computer monitor was kept at the information desk at the LaGarde Building and monitored by security personnel. The DoD IG Inspection Team tested the "HomeFree" personal watch in the mess hall corridors of the basement floor in the LaGarde Building. The door alarm was installed on a double-door exit to a service/utility area in the southeast corner of the LaGarde Building. It was noted that the doorway was not a monitored exit even though the "HomeFree" door alarm had been installed. Furthermore, upon inspection the DoD IG Inspection team observed that the door alarm had been blocked off by metal lockers and had been either deactivated or rendered inoperable. Upon exiting through the door while wearing the "HomeFree" device, the computer monitor did not create an alert.

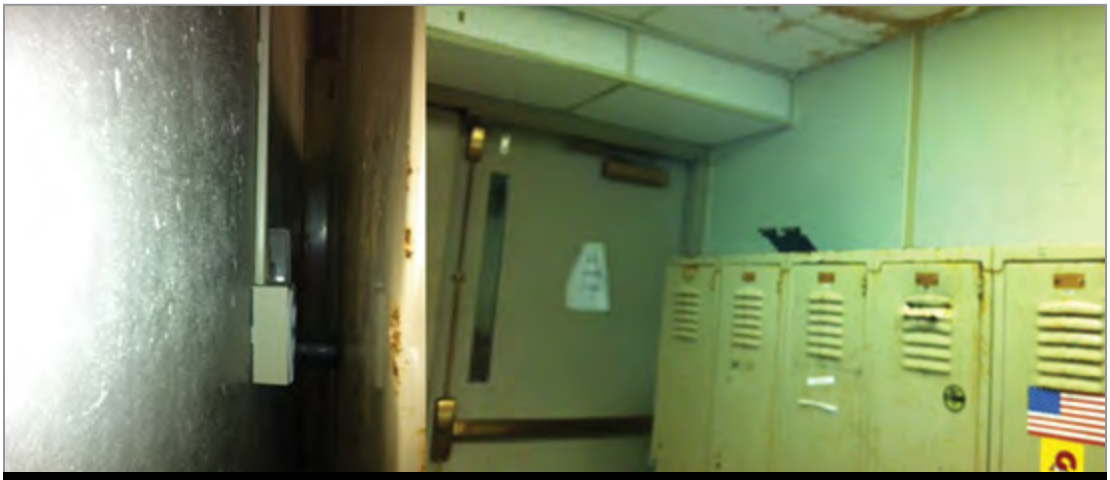
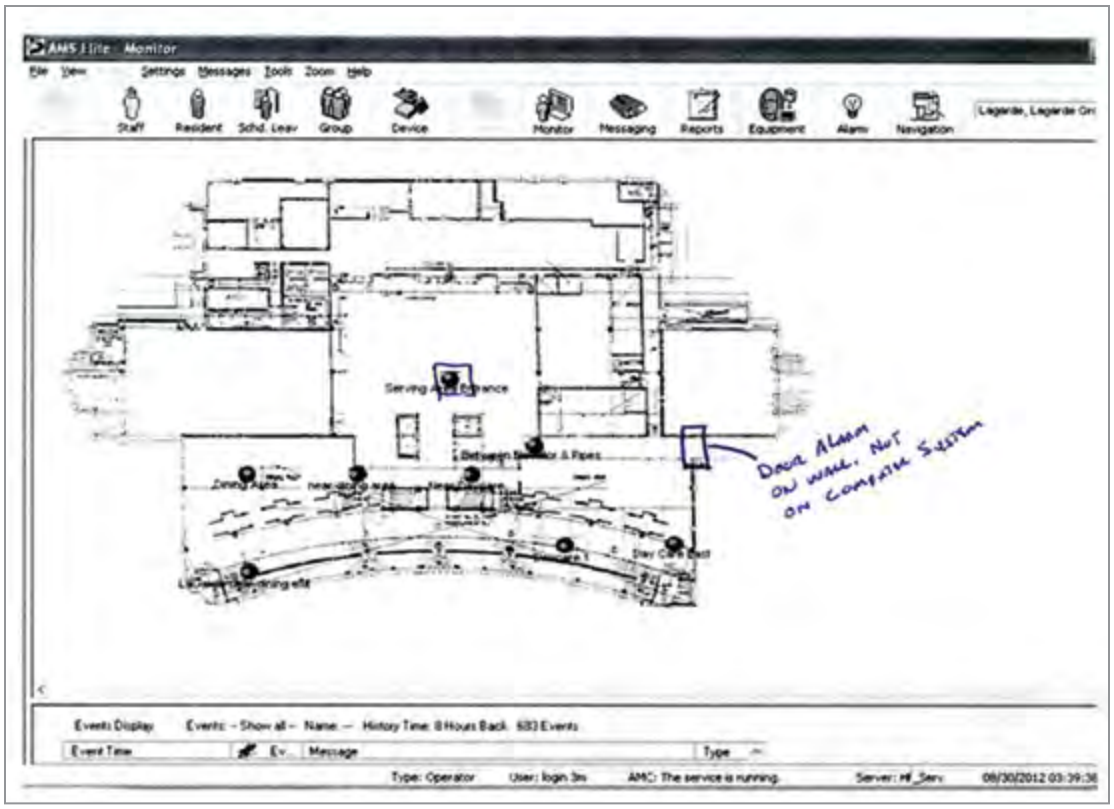


Figure 4. HomeFree Door Alarm System Blocked Off and Rendered Non-functional at AFRH-W
Source: DoD IG–SPO

Figure 5. Location of Faulty Door Alarm at AFRH-W



Source: Security Monitor printout provided to DoD IG–SPO by AFRH Administration

Recommendations, Management Comments, and Our Response

Recommendation 25

Armed Forces Retirement Home Chief Operating Officer ensure that security personnel:

a. Calibrate the failed device in the "HomeFree" system.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that the HomeFree system is being phased out and is being replaced by the new Tektone System.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

b. Follow operating procedure to test the monitoring devices periodically.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that a new directive had been developed for testing the new Tektone system.

Our Response

Management's comments were responsive. We request a copy of the new directive in response to the final report.

c. Notify the "HomeFree" system vendor about identified defects and failures, and ensure that routine tests cover all system checkups.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with the recommendation, stating that AFRH personnel would follow the Tektone manufacturer guidelines/recommendations for maintenance work and inspections of the system.

Our Response

Management's comments were responsive. No further action required at this time.

Observation 26

Fallen Pole-Mounted Wireless Device Did Not Notify the "HomeFree" System

The "HomeFree" system did not generate an alert from a wireless device mounted on a pole that had fallen over.

AFRH and the "HomeFree" vendor were not performing adequate monitoring of the "HomeFree" devices to identify any defects or issues with the system. There was no specific procedure in the "HomeFree" system to check for failed field devices.

If the "HomeFree" system does not generate an alert, a non-functional unit remains unnoticed. Thus, if a weak spot existed in the "HomeFree" system on the AFRH-W grounds, security personnel may not be alerted in the event of a wandering LaGarde resident who could be susceptible to confusion or harm.

Discussion

A utility pole with a mounted "HomeFree" monitoring device still attached to it was found on the ground in the ponds area by the DoD IG Inspection Team. At the time of the inspection, the fallen pole had not been reported. The pole had a wireless monitoring unit mounted to it, but the "HomeFree" system did not raise an alert regarding the non-functional device. If an alert is not generated, then the security personnel will not readily identify the failure, putting monitored residents at risk. Without such monitoring and/or daily checks in place, the purpose of providing a system to monitor wandering residents is impeded.

Figure 6. Fallen Pole in the AFRH-W Ponds
Source: DoD IG–SPO

Figure 7. Fallen Pole in the AFRH-W Ponds
Source: DoD IG–SPO

Recommendations, Management Comments, and Our Response

Recommendation 26

Armed Forces Retirement Home Chief Operating Officer, ensure that the fallen utility pole is fixed, and work with the "HomeFree" contractor to ensure that notifications are generated when a wireless monitoring unit is non-functional.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with the recommendation, stating that the new Tektone system incorporated an automatic notification process when an issue arises with monitoring device.

Our Response

Management's comments were responsive. No further action required at this time.

Observation 27

Inadequate Safety Inspections in the LaGarde Building

The DoD IG Inspection Team determined that safety inspections in LaGarde Building were not being conducted as routinely as they were at other AFRH-W facilities. In addition, AFRH-W was not ensuring that all rooms in the LaGarde Building were included in routine safety inspections.

AFRH-W was not adequately prioritizing safety inspections in the LaGarde Building. In addition, there were no records to verify the occurrence of periodic inspections.

Inadequate safety inspections increased the threat to the safety of residents, staff, and visitors in the LaGarde Building.

Discussion

The National Fire Protection Association (NFPA) 10 standard required that each fire extinguisher in the workplace be inspected monthly for damage, correct pressure, condition of the hose and nozzle, broken seals, and proper documentation of inspections.

Figure 8. Missing Cabinet Door Handle AFRH-G
Source: DoD IG–SPO

However, during a tour of the LaGarde Building, the DoD IG Inspection Team found a fire extinguisher cabinet in the basement, just outside the memory support patients' dining hall, that was missing a door handle. In addition, the DoD IG Inspection Team found a fire extinguisher on the third floor with expired inspection tags.

The DoD IG Inspection Team also observed that AFRH-W was not ensuring that all Assisted Living patient rooms in the LaGarde Building were included in routine safety inspections, nor were they performing routine safety inspections adequately in rooms that were reportedly inspected in the LaGarde Building as per AFRH guidelines.

During an inspection of the AL rooms, the DoD IG Inspection Team observed the following:

- A resident room in the LaGarde Building was missing a contaminated sharps-disposal receptacle. AFRH safety personnel had not detected the absence of a contaminated sharps-disposal receptacle from the room. If regulated waste is not disposed of in accordance with industry and community standards, it can create a safety hazard for the residents.
- A room had two electrical outlet plates that were not securely mounted to the base of the wall.

The 2011 CARF recommendations highlighted the need for AFRH to conduct comprehensive health and safety self-inspections on each shift at least semi-annually.

The DoD IG Inspection Team was provided evidence that some random safety checks were being conducted, but determined that safety inspections were not being conducted routinely at the LaGarde Building.

Figure 9. Electrical Plate Not Securely Mounted at AFRH-W
Source: DoD IG–SPO

Recommendations, Management Comments, and Our Response

Recommendation 27

Armed Forces Retirement Home Chief Operating Officer:

a. Ensure that safety inspections at the Armed Forces Retirement Home – Washington, D.C., LaGarde Building are performed and documented periodically, as required by the Armed Forces Retirement Home standard operating procedures.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with the intent of the recommendation. However, the LaGarde Building was shuttered in March 2013 and is no longer in use.

Our Response

Management's comments were responsive. No further action needed at this time.

b. Ensure that the Armed Forces Retirement Home – Washington, D.C., supervisors conduct daily inspections of conditions in the Assisted Living rooms, and that the Safety Officer(s) conducts/coordinates follow-up inspections to verify that corrections have been made to identified deficiencies.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with the recommendation and provided additional information about the safety inspections for the AL rooms, which are now located in Sheridan Building.

Our Response

Management's comments were responsive. No further action needed at this time.

Observation 28

Open Gaps in the Chain-Link Security Fence

The perimeter fencing at AFRH-G had two gaps which resulted in incomplete enclosure of the grounds.

The gaps occurred at two points where a storm water drain entered and exited the facility.

These two gaps created security and safety concerns because there was a probability of unmonitored entry/exit by nonresidents, as well as the occasional use by residents as shortcuts. In addition, the gaps weakened AFRH-G's security posture, increasing the possibility of property theft and/or damage to the facility's buildings.

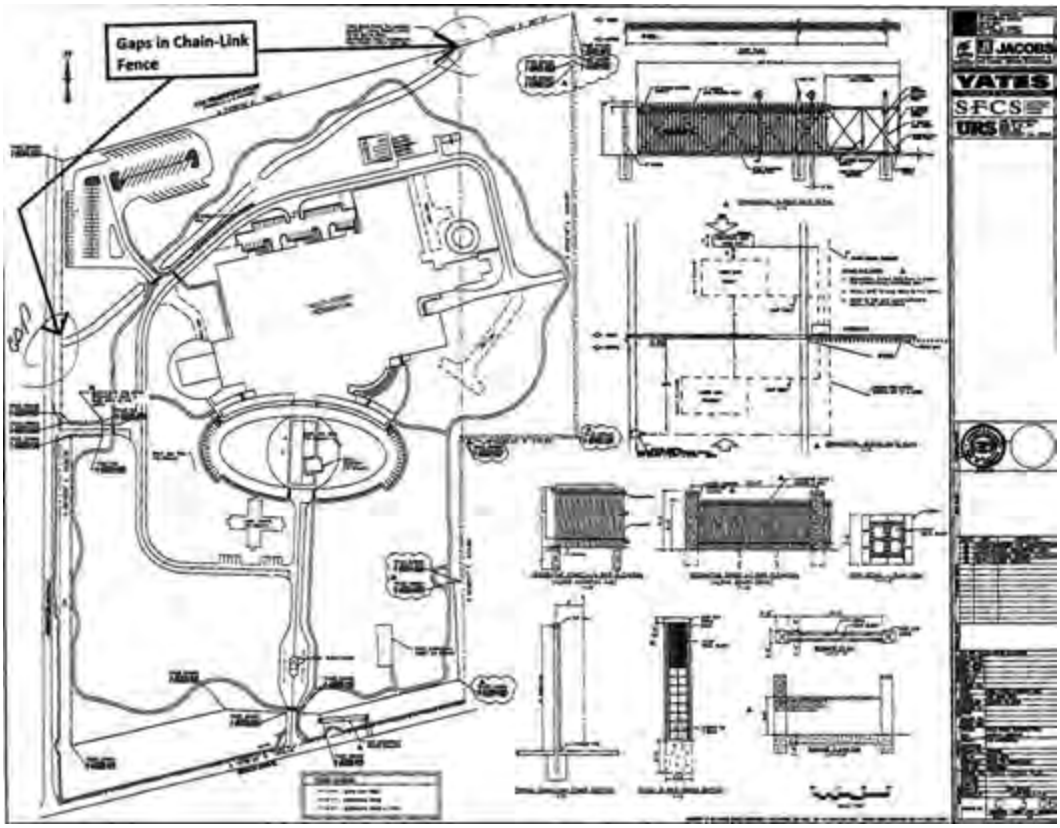
Discussion

The DoD IG Inspection Team observed two wide gaps on the northeast corner of the property where the drainage ditch entered the property and on the west side of the property along Anniston Avenue where the drainage ditch left the property. At the time of the inspection, AFRH-G personnel were aware of the breaches in the perimeter fence but had not taken action to fix them.

AFRH-G fence layout plan, (Figure 10 on next page) depicts the location of the two fence gaps which are located at the points of the two arrows at the top and left side of the plot plan. Perimeter fencing was absent at these two gaps, as observed during the AFRH-G site visit. A storm water drain entered and exited the facility at the two points where fencing was absent. The two gaps created security concerns, because there was a probability that unmonitored entry/exit by nonresidents might occur. Also, there was a safety concern, because on occasion the residents would reportedly use the two gaps as shortcuts. The current perimeter fencing provides incomplete enclosure of the AFRH-G grounds; therefore, the facility was not completely secured.

If left unaddressed, disoriented or distraught residents might wander away from the facility through those openings without the knowledge of AFRH-G management. This could result in harm to the individual and lack of timely proper medical care and attention. Also, non-residents could enter the property without proper authority/clearance and with malicious intent.

Figure 10. AFRH-G, Mississippi—Drawing No. C 306—Fence Layout Plan



Source: Copy provided to DoD IG–SPO by AFRH Administration

Recommendations, Management Comments, and Our Response

Recommendation 28

Armed Forces Retirement Home Chief Operating Officer, ensure that the two security fence gaps are securely closed at the Armed Forces Retirement Home – Gulfport.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO non-concurred. He stated that the Department of Homeland Security conducted a threat assessment at the Gulfport facility and determined that the cameras used to monitor the openings in the fence at the entrance/exit of the drainage canal passing through the facility provided adequate security.

Our Response

We note management's evaluation and acceptance of the risk associated with their reported course of action. No further action needed at this time.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Observation 29

Outages in the Resident Monitoring System at Armed Forces Retirement Home – Gulfport

The CISCOR Resident Monitoring System (RMS) at AFRH-G, used to track the location of residents, experienced at least 39 outages from June 5, 2012, to September 12, 2012. Because the RMS system produced such a high number of outages in just a 3-month period, the system has proven to be unreliable.

The high number of outages may have been caused by unknown technical issue(s), possibly including a lack of appropriate operation and maintenance procedure(s).

Consequently, AFRH has been unable to consistently monitor residents' presence at the facility. This has impeded the ability of AFRH personnel to provide real-time assistance and attentive care to AFRH residents in the case of injury or other medical needs.

Discussion

AFRH-G used the CISCOR DEVI 9000 RMS as a wireless emergency call and security system, designed specifically for the safety and security of all residents. The resident monitoring system allowed AFRH-G to extend real-time assistance and attentive care to its residents. The system also provided the means to monitor residents' presence and enabled the seamless integration of other security functions, such as door access control, intrusion alarm systems, the intercom, and fire alarm systems.

At the time of the inspection, the AFRH-G RMS had experienced a high number of outages within a short period of time. During the DoD IG on-site visit to the AFRH-G facility, the DoD IG Inspection Team observed that these failures were continuing and varied in nature. The frequency of these outages made the system unreliable and hindered the ability of AFRH-G personnel to provide real-time assistance and attentive care to its residents.

In addition, the record of system failures from June 5, 2012, to September 12, 2012, described the nature of the outages, but did not provide the duration of each outage nor the cumulative total down time for the period. To resolve the issue with such a high number of outages, a root cause analysis must be performed.

Recommendations, Management Comments, and Our Response

Recommendation 29

Armed Forces Retirement Home Chief Operating Officer, ensure that the Armed Forces Retirement Home – Gulfport Resident Monitoring System is fully functioning and maintained, and provides the sustained and reliable service intended.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred with the recommendation and provided additional information about the maintenance and functionality of the Gulfport RMS. The system is currently running as designed, with no outages.

Our Response

Management's comments were responsive. We will inspect the functionality of the system in our inspection.

Results – Part G

Information Assurance

Information Assurance

Overall Assessment

The AFRH's general support system (GSS) was certified and accredited for security assessment and received interim Authorization to Operate (ATO) in July 2011. However, during the Certification and Accreditation (C&A) process, the information technology (IT) assessor identified many information assurance (IA) weaknesses and documented these weaknesses in the System Security Plan (SSP). In order to receive full ATO certification, AFRH systems needed to fully meet all the requirements, and correct all the weaknesses as identified and documented in the SSP.

The Department of the Interior National Business Center (DOI NBC) and AFRH generated a Plan of Actions and Milestones (POA&M) to correct weaknesses or deficiencies noted during the assessment of the security controls, and to reduce or eliminate known vulnerabilities in the system. Nonetheless, in reviewing the POA&M documents, the DoD IG Inspection Team discovered weaknesses in all security control[50] areas. The AFRH did not implement or execute security controls as planned in the POA&M, nor did the AFRH consistently update the status records of the security control weaknesses in the POA&M.

Moreover, whenever the DoD IG Inspection Team requested records to verify information, AFRH personnel referred the team to the contractor, the DOI NBC, which hosted and operated all AFRH systems and networks. However, according to the National Institute of Standards and Technology (NIST) standard, the use of contract vendors did not diminish AFRH responsibility for the management and security processes associated with their information assurance systems.

Background

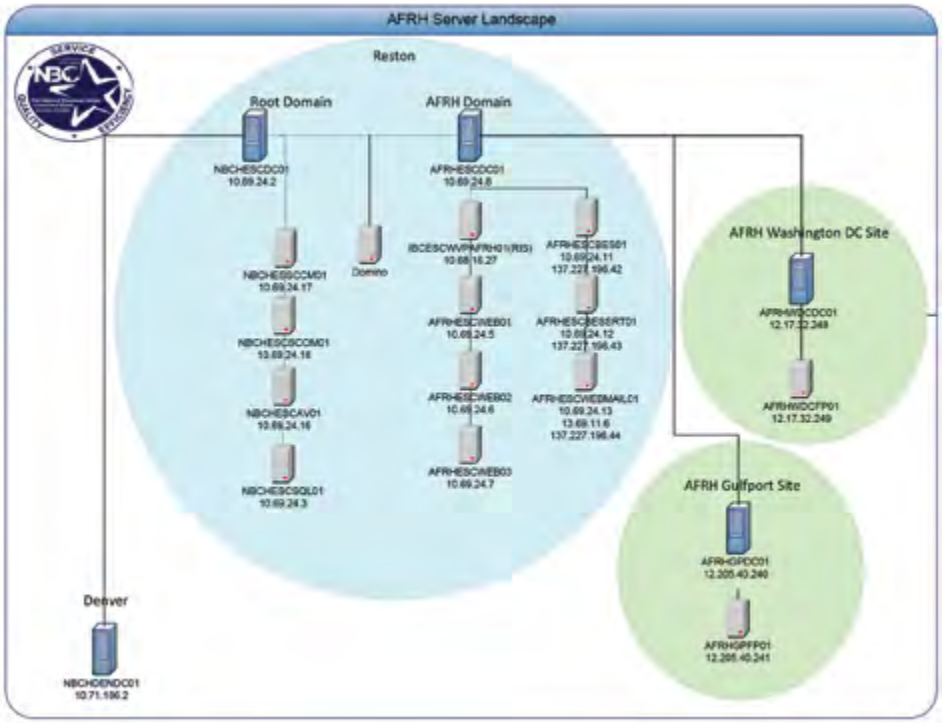
The "Federal Information Security Management Act of 2002" (FISMA) (section 3541, title 44, United States Code (44 U.S.C. § 3541 [2002])) was enacted as Title III of the " E-Government Act of 2002" (Public Law 107-347). FISMA recognized the importance of information security to the economic and national security interests of the United States. Prudently, FISMA required each Federal

[50] Security Controls are the management, operational, and technical safeguards or countermeasures employed within an organizational information system to protect the confidentiality, integrity, and availability of the system and its information. NIST Special Publication 800-53, "Information Security" revision 3, August 2009.

agency to develop, document, and implement an agency-wide program to provide security for information and information systems that support the operations and assets of the agency, including those provided or managed by other agencies, contracts, or sources.

FISMA also required agency program officials, chief information officers, and inspectors general to conduct annual reviews of the agency's information security program and to report the results to the Office of Management and Budget (OMB). OMB used this data to assist in its oversight responsibilities and to prepare an annual report to Congress detailing the status of each Federal agency's compliance with Public Law 107-347.

Figure 11. AFRHS GSS Network Diagram



Source: AFRH GSS System Security Plan

OMB Circular A-130, Appendix III, November 28, 2000, and Public Law 107-347, required Federal agencies to have "a minimum set of controls" for their information technology systems and networks.

In accordance with FISMA, NIST was responsible for developing standards, guidelines, and associated methods and techniques for providing adequate information security for all agency operations and assets, excluding national security systems.

The DoD IG Inspection Team used NIST Special Publication (SP) 800-53, Revision 3, "Recommended Security Controls for Federal Information Systems," dated May 2010, as the basis for the development of criteria for the IT inspection. The DoD IG Inspection Team also compared NIST-recommended IA security controls with those established in the AFRH SSP, updated August 23, 2012, to determine whether the AFRH policies are in compliance with the NIST standard.

Figure 11 describes the AFRH's GSS network. The diagram has four network sections:

- the AFRH-W network,
- the AFRH-G network,
- the DOI NBC Reston network, and
- DOI NBC Denver network.

The AFRH had contracted with the DOI NBC to operate and maintain its information technology systems and networks. The DOI NBC was a fee-for-service organization that had several facilities throughout the United States. It provided financial and payroll computing services for over 59 Federal agencies, with more than 300,000 clients.

The AFRH GSS network contained all the servers, workstations, and applications providing automation to the AFRH Agency and facilities. The AFRH utilized desktop computers and internal office servers to support its office staff members. End-user accounts were configured and managed using Windows' services. There were approximately 175 desktop systems in use at the AFRH-W, and approximately 75 desktop systems at the AFRH-G. Applications, network, and Internet services were provided by the AFRH GSS. The AFRH GSS supported the Resident Information System (RIS) that provided AFRH with the software and tools to manage retirement home issues related to admission, resident care information, etc.

Observation 30

Armed Forces Retirement Home Has Not Provided Adequate Contractor Oversight

The AFRH's GSS continued to possess more than 50 high and moderate security control weaknesses that were identified in the AFRH SSP and POA&M. In addition, the GSS did not comply with NIST SP 800-53, Revision 3, "Recommended Security Controls for Federal Information Systems," May 1, 2010.

AFRH did not provide adequate contractor oversight in the execution of IA services. The AFRH also failed to consistently update records of opened or closed information security controls and failed to compel the DOI NBC to implement appropriate corrective actions, as required by NIST standards.

Without the appropriate corrective actions to fix these security weaknesses and the related documentation, the AFRH information systems and network were vulnerable to a cyber-attack. As a result, sensitive resident information and data were at risk of being lost or stolen.

Discussion

Per FISMA, all Federal information systems must have met certain minimum security requirements included in the second mandatory security standard of the Federal Information Processing Standards (FIPS)-200, "Minimum Security Requirements for Federal Information and Information Systems," March 2006. In order to meet this standard, organizations must select appropriate security controls and assurance requirements, as described in NIST SP 800-53. The standard also required organizations to document all security controls selected or planned for selection in the agency system security plan.

The AFRH established an information manual providing guidance requirements for security in 2006. The DoD IG Inspection Team determined that the information manual was not in compliance with the updated revisions of the NIST SP 800-53 standard, causing several NIST security control weaknesses in the following areas:

- awareness and training,
- configuration management,
- incident response,
- maintenance,
- media protection,
- physical and environmental protection,
- security planning,
- personnel security,
- risk assessment, and
- system and services acquisition.

In addition, the DoD IG Inspection Team assessed the AFRH SSP, updated August 23, 2012, and compared it with the NIST SP 800-53 Revision 3, May 2010. In reviewing the SSP and the results of certification and accreditation process, the DoD IG Inspection Team discovered weaknesses in the resolution of SSP issues. Moreover, the POA&M was not updated to eliminate weaknesses that were already corrected. The following is a summary of NIST security control weaknesses.

Access Control

This control was intended to protect the systems and network from unauthorized access. This control also required the information system to enforce approved authorization for controlling the flow of information within the system and between interconnected systems, in accordance with the applicable policy. The DoD IG Inspection Team reviewed the DOI NBC-AFRH POA&M and found two weaknesses in this security control family area that were not corrected. AFRH did not have a remote access area procedure that included AT&T remote support. AFRH also lacked tools to monitor unauthorized connections and/or to interrogate the information system prior to establishing a connection to the system.

Audit and Accountability

This control required the AFRH to identify events which needed to be auditable as significant and relevant to the security of the information system. The DoD IG Inspection Team reviewed the DOI NBC-AFRH POA&M and found that the security violations and auditable events were logged; however, there was no formal process established for an audit to facilitate the review or evidence that the review was consistently completed.

Security Assessment and Authorization

This control required AFRH to assess all security controls in the information system to determine the extent to which the controls were implemented correctly, operating as intended, and producing the desired outcome with respect to meeting the security requirements for the system. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed that a process between NBC and AFRH to track and remediate deficiencies through a POA&M process had not been implemented. The DoD IG Inspection Team also observed other control weaknesses listed in the DOI NBC-AFRH POA&M that were not implemented nor executed, most notably:

- The Continuity of Operations Plan (COOP), Federal Information Processing Standards-199 (FIPS-199), and Incident Response Plan were not approved.
- The flow of information within the system and between interconnected systems was not controlled according to NIST policy.
- The AFRH policies and procedures referenced in the SSP were outdated.

Configuration Management

This control was intended for controlling modifications to hardware, firmware, software, and documentation to protect the information system against improper modifications before, during, and after system implementation. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed the following controls still had not been implemented as required:

- Information on how AT&T monitors internal network baselines was not documented.
- A formal configuration management process had not been developed or implemented.

- The standards and hardening principles for configuration settings had not been identified.
- The AFRH had not identified the information deemed necessary for effective IT property accountability.
- The AFRH had not developed or implemented a configuration management plan.
- The AFRH Windows systems were missing security patches.
- AFRH had not implemented permission controls that limited the ability to install or run application software to authorized users. With the ability to run arbitrarily, the AFRH system may be used maliciously to introduce additional risks into the system network. The permission controls to install or run application software must be limited to authorized personnel only.
- The access to undo network shares may have presented unauthorized information to unauthorized users.
- Domain Name Servers (DNS) were provided with the remote access protocols. Remote access protocols were not supposed to include DNS.
- The Adobe software was not updated to mitigate vulnerability. The security patches were not updated for Adobe software, exposing the system and network to undue risks.
- The Socket Security Layer certificate was expired and needed to be updated.
- The system revealed too much data during information gathering activities, relaying system functions, ports, programs, etc.
- The AFRH information system was not configured in accordance with baseline configuration documents.
- The AFRH changes to the information system were not tested and approved prior to implementation, nor were these changes documented.
- The standards and network hardening principles for baseline configuration had not been established.

Contingency Planning

This control required the AFRH to establish an alternate storage site, including necessary agreements to permit the storage and recovery of AFRH backup information. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed the following weaknesses still remained:

- The AFRH did not elect to have an alternate processing site. Thus, an alternate processing site service had not been established. AFRH reportedly had no plan to search for an alternate site, because they planned to move their enterprises to the cloud.[51] The organization will not be able to recover the system in a reasonable time when alternate sites have not been established.
- The AFRH did not utilize NBC disaster recovery services, nor did the AFRH have a process in place to recover the system after a disaster. In the event of a system/hardware failure, the AFRH system could not have been recovered and reconstituted by backup tapes.
- The backup processes had not been developed to periodically backup the systems, and AFRH may not have been able to recover the system from backup.
- The AFRH contingency activities were not tested annually.

Identification and Authentication

This control required the AFRH system to have the capabilities to uniquely identify and authenticate information before establishing a connection. It also required AFRH to comply with the Homeland Security Presidential Directive 12 (HSPD-12), "Policy for a Common Identification Standard for Federal Employees and Contractors," August 27, 2004, which required the AFRH system to use multifactor authentication for both network-access and local-access to privileged and non-privileged accounts. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed the multifactor authentication was not in use at the AFRH-W local area network (LAN).

[51] Cloud computing is the use of computing resources (hardware and software) that are delivered as a service over a network (typically the Internet). While the business software and end user's data are stored on servers at a remote location, end users can access cloud-based applications through a Web browser or a light-weight desktop or mobile application. This eliminates the need for the alternate process site.

Maintenance

This control required AFRH to audit and document non-local maintenance and diagnostic sessions. The AFRH also required designated personnel to review the maintenance records. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed that:

- The AFRH did not handle the maintenance of the servers, desktops, and laptops as part of the AFRH system. The DOI NBC was responsible for providing security patch management. However, external maintenance was not conducted on the Windows operating environment.
- The maintenance and repairs made to the information system at AFRH were not consistently documented.

Physical and Environmental Protection

This control required AFRH to have formal, documented procedures to facilitate the implementation of the associated physical and environmental protection controls, such as the fire protection system, the temperature and humidity controls, water damage protection, emergency lighting, emergency power shutoff system, etc. A review of the AFRH SSP and NBC-AFRH POA&M revealed that:

- Neither server room at the AFRH-W and AFRH-G facilities had an emergency power off switch to cut off the power to the information systems in an emergency situation.
- The fire suppression system was not installed in AFRH-W.

Program Management

This control required AFRH to develop and disseminate an organization-wide information security program plan. The information security program plan could have been represented in a single document or compilation of documents at the discretion of the organization. The plan documented the organization-wide program management controls and organization-defined common controls. A review of the AFRH SSP revealed:

- The AFRH had not implemented the project management controls.
- The AFRH had not documented the risk management strategy.

Risk Assessment

This control required AFRH to conduct risk assessment. This control also required AFRH to employ vulnerability scanning tools and techniques, to scan for vulnerabilities in the information system, and to analyze vulnerability scan reports and results from security control assessments. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed that the AFRH did not periodically scan the systems for vulnerability.

System and Services Acquisition

This control required AFRH to determine, document, and allocate the resources required to protect the information system. It also required the AFRH to manage the information system using system development life cycle methodology. A review of the AFRH SSP revealed that the AFRH did not have the IT life cycle in place.

System and Communications Protection

This control required AFRH system to monitor and control communications at the external boundary of the system and at key internal boundaries within the system. This control also required the AFRH system to implement required cryptographic protections using cryptographic modules that complied with applicable Federal policies and standards. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed that:

- A Voice over Internet Protocol (VoIP) was not implemented in the AFRH's LAN GSS.
- The AFRH servers, workstations, and laptops were not encrypted.
- An agreement between AFRH and AT&T to provide adequate system and communication control had not been established.

System and Information Integrity

This control required AFRH to develop, review, and update formal, documented procedures to facilitate the implementation of the system and information integrity policy and associated system information controls. A review of the AFRH SSP revealed that information system weaknesses were not identified, documented, and corrected. Failure to assess, document, and correct information

system weaknesses could allow a cyber-attacker to access and exploit the weakness. Vulnerabilities and deficiencies may still negatively impact the system if proper identification and tracking through remediation does not occur.

Recommendations, Management Comments, and Our Response

Recommendation 30.a

Under Secretary of Defense for Personnel and Readiness, ensure that the Armed Forces Retirement Home takes aggressive Information Technology security actions specified in Observation 30.b.

Under Secretary of Defense for Personnel and Readiness Comments

The USD (P&R) concurred, stating that the AFRH has taken, and will continue to take, aggressive Information Technology security actions as specified in Observation 30.b.

Our Response

Management's comments were responsive. We will inspect the status of the system during our next inspection.

Recommendation 30.b

Armed Forces Retirement Home Chief Operating Officer, improve contractor oversight and take immediate steps to correct security control weaknesses as described in the Plan of Actions and Milestones including:

(1) Applying updates to security control documentation as required by National Institute of Standards and Technology standards.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating the recommendation was complete. The corrective actions for weakness identified in the AFRH 2012 POA&M was well underway during the DoD OIG Inspection and has been completed since the conclusion of the DoD IG Inspection of the AFRH in 2012. AFRH Security Control documentation has been updated to reflect the remedies and corrective actions from the POA&M. Additionally, the AFRH is establishing a support contract, on or before

July 2014, with an IT vendor to provide continued support for its FipMA, Web Development & Hosting, and to provide periodic updates to its security control documentation and POA&M to ensure compliance with NIST standards.

Our Response

Management's comments were responsive. We will inspect the status of the system during our next inspection.

(2) Developing a formal physical access authorization and review process.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating the recommendation was complete. The AFRH has an established formal physical access authorization form and review process. This process was outlined in the AFRH Information Security Manual that was available during the DoD IG Inspection. The AFRH provided a copy of the Physical Authorization Form and Plan of Action and Milestones.

Our Response

Management's comments were responsive. We will inspect the status of the system during our next inspection.

(3) Developing and implementing a process between the Department of the Interior National Business Center and the Armed Forces Retirement Home to track and remediate deficiencies through a plan of actions and milestones.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating through the 2012 C&A Process conducted by the Interior Business Center (IBC), a POA&M was developed and closed. This POA&M will be used on a continuous basis by the AFRH to monitor deficiencies. The COO disagreed with the inspector's conclusion that a formal configuration management process had not been developed or implemented. He reported that this plan does exist and is available from DOI-NBC. Reportedly, the DoD IG did not ask for the plan.

Our Response

Management's comments were responsive. We request a copy of the DOI-NBC plan in response to the final report. We will inspect the status of the system during our next inspection.

(4) Implementing security patches for Armed Forces Retirement Home Windows® systems.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was complete. Security patching is done routinely by the IBC for AFRH-W desktops. There was an issue with the AFRH-G desktops. Manual updates were applied. Automated updates commenced for AFRH-G desktops beginning February 1, 2014.

Our Response

Management's comments were responsive. We will inspect the status of the system during our next inspection.

(5) Developing a process to recover systems after a disaster.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO Concurred, stating that AFRH will develop a disaster recovery plan for its IT systems.

Our Response

Management's comments were responsive. We will request an update on this issue at a later date.

(6) Developing a process to backup systems periodically.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. AFRH systems are backed up by the vendor, IBC. Desktop and laptop computers are not backed up; however, staff have been instructed to save their files to the AFRH network drives to ensure that data is securely backed-up at both campuses (AFRH-G & AFRH-W). Backup policies for the AFRH staff are outlined in the AFRH Information Security Manual.

Our Response

Management's comments were responsive. We will inspect this area during our next inspection.

(7) developing a procedure to periodically scan the systems for vulnerabilities.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that periodic scans have been conducted by the IBC since 2010 for all systems used by the AFRH. Any discrepancies found are reported to the AFRH for a corrective plan of action.

Our Response

While management's comments are not fully supported by the observations of our inspectors, we will accept management's analysis as responsive. We will inspect this area during our next inspection.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Results – Part H

Resident Recreation Services

Resident Recreation Services

Overall Assessment

Overall, AFRH Resident Recreation Services provided a variety of planned activities, with input from the residents. The facilities for these activities were well maintained. The observations noted below are made from a management perspective and should be addressed by the AFRH COO, Administrators, and Chief of Resident Services.

Introduction

To assess the status of recreational services provided at each AFRH facility, the DoD IG Inspection Team used the 2012 Resident Services Inspection Checklist,[50] conducting on-site interviews with the Chief of Resident Services, Activities Managers, and Resident volunteers, covering 26 resident recreational service areas.

The DoD IG Inspection Team also assessed AFRH's compliance with section 421, title 24, United States Code (24 U.S.C. § 421 [2012]), section 422, title 24, United States Code (24 U.S.C. § 422 [2012]), and section 5533, title 5, United States Code (5 U.S.C. § 5533 [1966]) with regard to the AFRH Resident Stipend Volunteer Program (RSVP), Hard to Fill RSVP, and Uncompensated Volunteer Services provided to the retirement home.

The RSVP and Hard-to-Fill RSVP programs were found to be effective and compliant with established statutes, directives, and SOPs in providing productive activities for residents, with the additional benefit of producing labor cost savings for work that would have otherwise occupied an AFRH employee.

General Overview of Armed Forces Retirement Home—Washington, D.C., Services

The Volunteer and Recreational Activities Managers were all professional and knowledgeable about their respective programs. The Acting Chief of Resident Services conducted surveys, used suggestion boxes, accommodated in-office discussions with residents, and hosted monthly and quarterly general

[50] This checklist was developed from AFRH Recreation Services SOPs 5-02 through 5-09, 5-11, 5-12, 5-14, 5-15, 5-17, 5-19 through 5-23, 5-25 through 5-28, and 5-30 through 5-33.

recreation meetings to identify and meet the needs of the residents. Early participation in recreational services was encouraged and fostered as part of the newcomer's orientation, where new residents were interviewed and asked to identify their hobbies and interests.

The Acting Chief of Resident Services provided the DoD IG Inspection Team with a synopsis of their marketing strategy for increasing resident participation. This strategy included the use of a monthly calendar of events, flyers, and the extension of personally delivered invitations to those who were observed to always stay in their rooms. Regardless of the level of participation in an event, the Acting Chief of Resident Services stated that she was committed to keeping all activities available to meet the needs of all residents. Upholding the principles of PCC, the AFRH Resident Services sought to deliver meaningful recreational activities that met the needs of residents by enriching and fostering an active lifestyle.

Overall, AFRH-W Resident Services recreational activities were being managed well. Although some of the recreational services were temporarily relocated because of ongoing construction, the residents were still able to participate. The observations noted below are from a safety perspective and should be addressed by the Administrator and Chief of Resident Services.

Figure 12. Recreation Services
Source: DoD IG–SPO

Figure 13. List of Volunteers
Source: DoD IG–SPO

Figure 14. Bingo Activity
Source: DoD IG–SPO

The success of the AFRH-W Resident Services recreational activities was derived from the AFRH-W volunteer program which was comprised of a total of 96 resident volunteers: 21 stipend[51] and 75 non-stipend.[52] The volunteer program also used volunteer support received from individual, non-affiliated community volunteers, military services, and local/national community organizations.

General Overview of Armed Forces Retirement Home—Gulfport Services

The collective team of activity managers and volunteers appeared to be focused on soliciting inputs from the residents and trying to meet their needs. The result of these efforts was well documented in the various events and trips captured in the monthly AFRH-G Recreational Activities calendar, as well as the "Plan of the Week" bulletins.

[51] The designation of resident volunteer as "stipend" means that the resident receives payment for services delivered to AFRH under the RSVP or Hard to Fill RSVP programs. Non-stipend resident volunteers who did not receive any compensation for the services they provided at AFRH.

[52] Non-stipend resident volunteers did not receive any compensation for their services they provided at AFRH.

Observation 31

Lack of Adherence to Standard Operating Procedures at the Armed Forces Retirement Home – Washington, D.C.

AFRH-W personnel could not provide evidence that they were following all SOPs in a manner sufficient to meet the criteria addressed in the 2012 Inspection Checklist. (See footnote 53.)

This occurred because the SOPs were put together just prior to the DoD IG Inspection (all Washington, D.C., SOPs were dated July 2, 2012) and were probably not reviewed thoroughly.

Consequently, AFRH-W personnel may not have been following the SOPs and thus could have been in violation of established procedures.

Discussion

The recent date on many SOPs raised concerns that the provisions within SOPs may not have existed for AFRH-W personnel to follow prior to the date of SOP issuance. Additionally, the recent date on SOPs raised concerns that the SOPs and current operations were not thoroughly reviewed and discussed with the Activity Managers before the SOPs were issued. As a result, some Activity Managers were not aware of or knowledgeable about the current SOP for their designated activity and did not complete records to document their compliance with the provisions of their respective SOP. Additionally, some SOPs may not be providing adequate guidance or internal controls to execute the recreational activity as intended.

Recommendations, Management Comments, and Our Response

Recommendation 31

Armed Forces Retirement Home Chief Operating Officer, develop internal controls to ensure the current Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services review standard operating procedures, monitor implementation, and make corrective actions, where warranted.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but did not describe actions taken or planned to implement the recommendation.

Our Response

Management's comments were partially responsive. In response to the final report, we ask that management provide a description of actions taken to implement the recommendation.

Observation 32

Armed Forces Retirement Home – Washington, D.C., Walk-through Inspections Lack Consistency in Occurrence and Documentation

Although AFRH-W personnel were conducting some walk-through inspections, they were not conducting walk-through inspections[53] daily, as required by established SOPs. Additionally, inspection documentation lacked consistency.

AFRH-W Recreational Supervisors were not providing adequate oversight over this duty and ensuring that Resident Volunteers and Managers were meeting the intent of AFRH Agency Directive 8-7, "AFRH Recreation Services," September 18, 2006, by conducting and documenting walk-through inspections adequately and consistently, as required by the 2012 Inspection Checklist. (See footnote 53.)

The lack of consistent and adequate daily walk-through inspections decreases the AFRH personnel's overall awareness to safety hazards and presents safety concerns.

Figure 15. AFRH-W Auto Body Shop
Source: DoD IG–SPO

Figure 16. AFRH-W Auto Body Shop Equipment and Facility
Source: DoD IG–SPO

[53] "…To monitor usage, resident safety and maintenance, to ensure that regulations and procedures are followed." (Based on Analyst analysis of Directive 8-7, "AFRH Recreation Services," September 18, 2006, and AFRH SOPs).

Recommendations, Management Comments, and Our Response

Recommendation 32

Armed Forces Retirement Home Chief Operating Officer, develop procedures to ensure the Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services implements a quality control plan to guarantee daily walk-through inspections are conducted, documented, and confirmed.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but did not describe actions to implement the recommendation.

Our Response

Management's comments were partially responsive. In response to the final report, we ask that management provide a description of actions taken to implement the recommendation.

Observation 33

Easy Access to Potentially Dangerous Heavy Equipment within the Armed Forces Retirement Home—Washington, D.C., Wood Shop

Access to the Wood Shop's heavy equipment was not sufficiently restricted.

Access to the heavy equipment in the Wood Shop was only restricted by yellow stationary cones.

Consequently, there was an increased risk of harm to residents, visitors, or AFRH personnel who were unaware of the potential dangers.

Recommendations, Management Comments, and Our Response

Recommendation 33

Armed Forces Retirement Home Chief Operating Officer, develop procedures to ensure the Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services and Safety Officers conduct a safety assessment of the Auto Hobby Shop, Wood Shop, and Arts and Crafts Shop and take corrective actions to comply with Armed Forces Retirement Home Resident Services Standard Operating Procedures. (See footnote 53.)

Armed Forces Retirement Home Chief Operating Officer Comments

Management concurred, describing corrective action taken, to include posting signs indicating the only area where cleaning greenware and spraying is authorized.

Our Response

Management's comments were responsive. No further action required.


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Observation 34

No Ventilation System in the Armed Forces Retirement Home—Washington, D.C., Arts and Crafts Shop

Besides the single entry doorway, there was no other means by which air could flow in and out of the Arts and Crafts Shop to reduce potentially harmful airborne particulates.

The Arts and Crafts Shop was designed as an enclosed room with a door being its single point of entry and exit.

Consequently, anyone working in the Arts and Crafts Shop was at an increased risk of exposure to toxic pollutants.

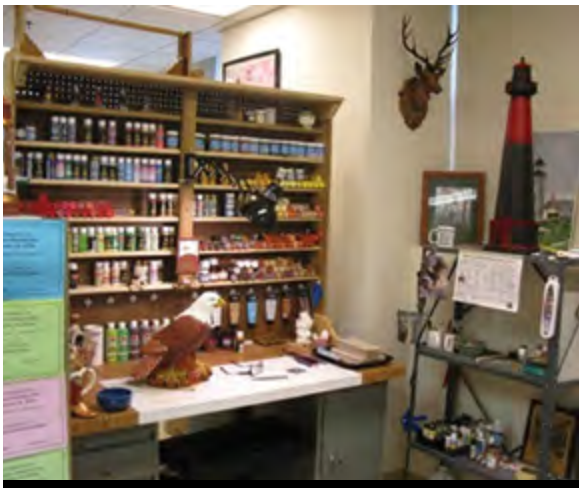

Figure 17. AFRH-W Wood Shop
Source: DoD IG–SPO

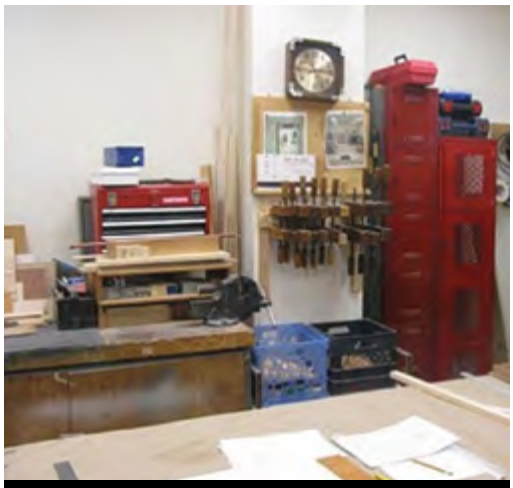

Figure 18. AFRH-W Arts and Crafts
Source: DoD IG–SPO

Recommendations, Management Comments, and Our Response

Recommendation 34

Armed Forces Retirement Home Chief Operating Officer, develop procedures to ensure the Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services and Safety Officers conduct a safety assessment of the Auto Hobby Shop, Wood Shop, and Arts and Crafts Shop and take corrective actions to comply with Armed Forces Retirement Home Resident Services Standard Operating Procedures. (See footnote 53.)

Armed Forces Retirement Home Chief Operating Officer Comments

Management concurred, describing corrective action taken, to include posting signs indicating the only area where cleaning greenware and spraying is authorized.

Our Response

Management's comments were responsive. No further action required.

Observation 35

Possible Lack of Adherence to Standard Operating Procedures at the Armed Forces Retirement Home – Gulfport

The AFRH-G personnel could not produce evidence that they were following all SOPs in a manner sufficient to meet the criteria addressed in the DoD IG's 2012 Inspection Checklist. (See footnote 53.)

Some activity managers were not aware of or knowledgeable about the current SOP for their designated activity. In addition, SOPs were recently signed, all with the same date, and only recently issued.

Consequently, AFRH-G personnel may not have been knowledgeable about or accurately following SOPs and thus may be in violation of established SOPs. Furthermore, SOPs may not have been providing adequate guidance or internal controls to execute the recreational activity as intended.

Discussion

Most of the activities observed had corresponding SOPs. However, upon review, the DoD IG Inspection Team observed that the SOPs were dated within 2 to 3 months prior to the inspection, and looked very similar in content to the SOPs designated for the AFRH-W facility. There was a lack of documentation supporting the activity managers' compliance with the provisions of their respective SOP. The recent date on all SOPs raised concerns that the provisions contained within the SOPs did not exist for AFRH-G personnel to follow prior to the date observed on each SOP. Furthermore, it appeared that SOPs and current operations were not thoroughly reviewed before the SOPs were issued. In addition, some SOPs did not adequately address all characteristics or aspects of related activities. Specifically, SOP G-RS-REC-5-16, "Gift Shop," July 9, 2012, did not reflect the fact that the gift shop was, at the time the SOP was issued, under private ownership.

Recommendations, Management Comments, and Our Response

Recommendation 35

Armed Forces Retirement Home Chief Operating Officer, develop internal control policies to ensure the current Armed Forces Retirement Home – Gulfport Chief of Resident Services:

a. Reviews and revises standard operating procedures so that they capture the appropriate characteristics of activities that take place at the Armed Forces Retirement Home – Gulfport.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but did not describe actions to implement the recommendation.

Our Response

Management's comments were partially responsive. In response to the final report, we ask that management provide a description of actions taken to implement the recommendation.

b. Implements the procedures developed in response to recommendation 35.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but did not describe actions to implement the recommendation.

Our Response

Management's comments were partially responsive. In response to the final report, we ask that management provide a description of actions taken to implement the recommendation.

Observation 36

Armed Forces Retirement Home – Gulfport Walk-through Inspections Lack Consistency in Occurrence and Documentation

Although AFRH-G personnel were conducting some walk-through inspections, they were not conducting walk-through inspections daily, as established by the 2012 Inspection Checklist. (See footnote 53.) Additionally, inspection documentation lacked consistency.

AFRH-G recreational supervisors were not providing adequate oversight over this duty and ensuring that resident volunteers and managers were conducting and documenting walk-through inspections adequately and consistently, as intended by AFRH Directive 8-7, "AFRH Recreation Services," September 18, 2006.

The lack of consistent and adequate daily walk-through inspections decreased the AFRH personnel's overall awareness of safety hazards and presented safety concerns.

Discussion

The DoD IG Inspection Team determined that AFRH-G personnel were conducting some daily walk-through inspections. However, documentation of the inspections was inconsistent. Generally, inspections were documented approximately once a week, and in instances when a violation was detected. The DoD IG Inspection Team gathered documentation of conducted inspections from the fitness center and the swimming pool. These inspections were documented separately, on different forms. However, inspections of the wrapping room, craft room, art room, sewing room, wood shop, radio room, and paint room were documented on a single form. Resident volunteers and managers were not consistently or adequately carrying out these their inspection and documentation duties.

Recommendations, Management Comments, and Our Response

Recommendation 36

Armed Forces Retirement Home Chief Operating Officer, develop procedures to ensure the Armed Forces Retirement Home – Gulfport Chief of Resident Services implements a quality control plan to guarantee daily walk-through inspections are conducted and documented.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that all walk through inspections are conducted daily (Monday-Friday with exceptions of holidays) and documentation of walk through inspections are completed daily. Daily walk through forms have been revised for all areas to be consistent with the SOP. The Recreation Supervisor will sign inspections log weekly to verify compliance. All associated files are maintained in one location

Our Response

Management's comments were responsive. We will request a copy of the most recent monthly inspection logs at a later date.

Results – Part I

Contract Management

Contract Management

Overall Assesment

Since 2004, AFRH and the Treasury Franchise Fund's BPD Administrative Resource Center have been partnered by an interagency agreement and memorandum of understanding (MOU), which details the services rendered in-kind in exchange for an obligated net total order amount of $3.03 million. Procurement services were one of several key services provided by BPD to AFRH. Overall, the BPD provided AFRH adequate service, in accordance with the Federal Acquisition Regulation (FAR) and Department of Treasury Acquisition Regulation (DTAR). This assessment was further supported by BPD's 2011 customer satisfaction survey, in which ARFH stated that the agency was satisfied with the quality of BPD's personnel and the overall level of service received from its Administrative Resource Center.

In spite of these reviews, the DoD IG Inspection Team noted seven deficient areas where increased AFRH emphasis and action was needed, including:

1. documenting greater detail for Independent Cost Government Estimates (IGCE),
2. increasing focus on collective market research executed in accordance with FAR 10 and DTAR Subpart 1019.502,
3. developing consistent with developing recommendation for award memoranda,
4. documenting the impetus behind modification transactions,
5. overseeing consistent interagency agreements,
6. managing COTR contracting workload and experience within the organizational structure, and
7. focusing on developing Quality Assurance Surveillance Plan/Service Delivery Summary/Performance Requirement Summary and documenting oversight conducted.

Outsourced Procurement

Through Interagency Agreement No: ARC-1213-0026, BPD provided AFRH with procurement services, to include simplified acquisitions, formal contracts (over $150,000), and contract administration. BPD conducted procurement services in accordance with the FAR and DTAR. The FY 2012 cost for performing these services was approximately $1.1 million, using seven dedicated contracting personnel (one Lead Contracting Officer, two Contracting Officers, and four Contracting Specialists).

Since the last DoD IG inspection in 2010, BPD has awarded over 439 contract actions valued at $224.5 million over 4 fiscal years (FY 2009: 127 transactions, $49.1 million; FY 2010: 134 transactions, $98.3 million; FY 2011: 111 transactions, $29.5 million; and FY 2012: 67 transactions, $47.6 million). Given this universe, the DoD IG Inspection Team reviewed 47 active contracts and interviewed multiple COTRs and Functional Managers at AFRH-W and AFRH-G. The AFRH Management and COTRs from both sites were in continual contact via phone, e-mail, in-person visits, and written correspondence with the Contracting Specialists and Contracting Officers at BPD. To ensure everyone was mutually supported, the two agencies designated weekly status meetings as primary conduits to address issues and resolve areas of concern.

The DoD IG Inspection Team concluded that BPD was satisfactorily maintaining their respective contract files. BPD's contracting personnel efforts continually ensured that contracting fundaments for funding, acquisition planning, advertising, competition, and objective-based evaluations and negotiations were carried out in accordance with the FAR. However, the COTR portion of the contract files was missing documentation required to support contract transactions and to manage contractor performance. Although AFRH and BPD shared a collective effort for awarding and administering procurement services, the Contracting Officer was ultimately responsible for addressing the gaps and shortfalls on behalf of the Government.


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Observation 37

Failure to Maintain Independent Government Cost Estimates and Other Supporting Documentation for Contract Estimates

Thirty-two of the 47 contracts inspected did not have IGCEs on file or supporting documentation with enough clarity to articulate how the estimate was ascertained.

Detailed IGCE were not being documented and provided to the Contract Specialist at the BPD.

Without the IGCEs, it was difficult for the Contracting Officer's Representative (COR) to assist the Contracting Officer with assessing a contract cost proposal or make determinations that offered prices were fair and reasonable.

Discussion

COTRs and Contracting Officers must ensure that there is a consistent methodology being used to create IGCEs, in accordance with Interagency Agreement #1213-0026 between AFRH and Treasury Agency Fund, "AFRH COR Handbook," July 2012; Federal Acquisition Regulation (FAR) 36.203, "Government Estimate of Construction Costs," February 2, 2012; and FAR 15.406, "Documentation," September 13, 2012. As per FAR 4.803(a) (7), "Contents of Contract Files," December 2012, the Contract Officer's contract file should have contained the Government's estimate of contract price.

However, the DoD IG Inspection Team determined that COTRs were not documenting or providing IGCEs (lump sum or detailed) to Contracting Officers at the BPD on a consistent basis. Without the IGCE, it was difficult for the COR to assist the Contracting Officer with assessing the offeror's cost proposals in order to ensure that offered prices reflected an understanding of the Government's requirements. It was also difficult for the COR to assist the Contracting Officer in making determinations for price fairness and reasonableness.

Recommendations, Management Comments, and Our Response

Recommendation 37

Armed Forces Retirement Home Chief Operating Officer, ensure that the Bureau of Public Debt's Contracting Officers enforce standards within the Interagency Agreement #1213-0026, the Armed Forces Retirement Home Contracting Officer Technical Representative Handbook, and the Federal Acquisition Regulation for developing Independent Government Cost Estimates and that this documentation is consistently provided by Armed Forces Retirement Home Contracting Officer Technical Representatives as part of the acquisition packages.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. He noted that, since the IG did not provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if IGCEs were complete and appropriate for the award size and scope. The BPD review determined IGCEs were included for each contract, were appropriate for the size and scope of the contracts and were within the standards set by the AFRH COR Manual and the FAR.

Our Response

Management's comments were responsive. The contracts reviewed by the IG were:

Facilities/Campus Operations:

- TPD-AFRW-12-000017 (Amar Group): Construction Inspection Services
- TPD-AFRW-12-K-00006 (CMI Management): Facility Maintenance Services
- TPD-AFRW-12-00008 (LVI Environmental Services): Shoring Equipment/ Dehumidifiers
- TPD-AFRW-09-K-00011 (Simplexgrinnell): Fire Protection Sys Maintenance
- TPD-AFRW-09-K-00019 (CMI Management): Facility Maintenance Services – modification documentation P00007, P00008)

- TPD-AFRW-10-K-00019 (CMI Management): Fire Hydrant Replacement/ Repair
- TPD-AFRW-11-C-0013 (Hensel Phelps Construction): Earthquake Safety
- TPD-AFRW-12-C-0008 (Baistar Mechanical Inc): Eagle Gate Construction Project

Resident (Recreational) Services:

- TPD-AFRW-12-C-0006 (Lakeview Center): Custodial Services
- TPD-AFRW-12-00004 (Chamber Funeral Home): Mortuary Services
- TPD-AFRW-10-C-0013 (Lakeview Center): Food Services
- TPD-AFRW-12-00005 (Fitness Workshop): Preventive Maintenance Fitness Equipment

Medical Services

- TPD-AFRW-09-C-0016 (ASCO Health Care): Pharmacy Services
- TPD-AFRW-09-C-0011 (Millennium): Pharmacy/Ancillary Services
- TPD-AFRW-09-C-0008 (Professional Services of America): Exec Coach/ Consulting Services
- TPD-AFRW-BPA-10003 (Sensa Solutions Inc)
- TPD-AFRW-10-C-0016 (Mantoni Dr. Robert Inc): Mobile Dentistry Services
- TPD-AFRW-08-C-0001 (Professional Services of America): Medical Services Professionals

We will review this area again during our next inspection.


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Observation 38

Inconsistencies in Market Research and Documentation

The market research was not consistently documented in a manner appropriate to the size and complexity of the acquisition.

This occurred because COTRs were not conducting market research to standards delineated in:

- Interagency Agreement #1213-0026 between AFRH and Treasury Agency Fund,
- "AFRH COR Handbook," July 2012,
- Federal Acquisition Certification for COR,
- CLC 004 – Market Research,
- FAR 10, and
- DTAR Subpart 1019.502.

This could inhibit the development of the most suitable acquisition strategy, as well as the acquisition timeline for procuring the capability or service.

Discussion

The COR's ability to collect and analyze relevant market information and identify possible sources for the acquisition is a required part of acquisition planning. There are a variety of methods for conducting market research. Regardless of the method chosen, the outcome of the market analysis is a critical ingredient to the subsequent acquisition strategy. During a review of the Contracting Officers and COTR files, the DoD IG Inspection Team determined that the outcome of the collective market research was not being concluded and signed off by the Contracting Officer, in accordance with the standards listed above.

AFRH and BPD were not consistently meeting the standard for conducting and documenting market research. When the results of the market research are not consistently documented in a manner appropriate to the size and complexity

of the acquisition and provided to the Contracting Officer, there could be a direct bearing on the development of the most suitable acquisition strategy, as well as the acquisition timeline to procuring the capability or service.

Rarely did the DoD IG Inspection Team see the outcomes of the collective market research summed up and finalized, in accordance with FAR 10 and DTAR Subpart 1019.502, to show how the COTR derived his/her most suitable approach to acquire, distribute, and support supplies and services.

Recommendations, Management Comments, and Our Response

Recommendation 38

Armed Forces Retirement Home Chief Operating Officer, ensure that Bureau of Public Debt's Contracting Officers enforce standards within Interagency Agreement 1213-0026, the "Armed Forces Retirement Home Contracting Officer Technical Representative Handbook," and the Federal Acquisition Regulation and Department of Treasury Acquisition Regulation for conducting market research to ascertain a suitable approach to acquire, distribute, and support supplies and services.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. He noted that, since the IG did not provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of current contracts to determine if market research was completed and appropriate for the size and scope of the award.

Our Response

Management's comments were responsive. See the listing of contracts sampled in "Our Response" in Recommendation 37. We will review this area again during our next inspection.

Observation 39

Failure to Maintain Recommendation for Award Memoranda for Contracts

At least 6 of the 47 contracts inspected did not have a recommendation for award memorandum or a similar document describing how the Contracting Officer determined the award outcome on file.

The BPD procedures for preparing award recommendations and the supporting documentation for Contracting Officers were not being consistently followed by all Contract Specialists and Contracting Officers.

As a result, the integrity and validity of the contract could have been negatively impacted.

Discussions

At least 6 of the 47 contracts inspected did not have a recommendation for award memorandum in the file or a similar document describing how the Contracting Officer determined the award outcome. BPD procedures for preparing award recommendations and the requirement for supporting documentation for Contracting Officers were included in:

- Interagency Agreement #1213-0026 between AFRH and Treasury Agency Fund,
- FAR: 9.103 subparagraphs (a-c), "Responsible Prospective Contractors – Policy," May 12, 2012,
- FAR 9.104-1, subparagraphs (a-g), "General Standards," May 12, 2012,
- FAR 15.404-1(a)(1), and (a)(2), "Proposal Analysis Techniques – General," September 13, 2012,
- FAR 15.404-1(b), "Proposal Analysis Techniques – Price Analysis for Commercial and Non-Commercial Items," September 13, 2012, and
- DTAP: 1019.502 (b) and (c), "Setting Aside Acquisitions," March 1, 2012.

The procedures and requirements were not being consistently followed by all Contract Specialists and Contracting Officers.

Without the recommendation for award memorandum, there was no summarized documentation capturing:

- the technical evaluation outcome,
- a determination for price fairness and reasonableness, or
- a determination that the potential contractor was deemed responsible to perform the work.

Recommendations, Management Comments, and Our Response

Recommendation 39

Armed Forces Retirement Home Chief Operating Officer, ensure that the Bureau of Public Debt Contracting Officers place increased emphasis on making the determination and recommendation for award using procedures and requirements, as prescribed by the Federal Acquisition Regulation and Department of Treasury Acquisition Regulation.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. He noted that the IG did not provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if award memoranda for contracts was completed and appropriately prepared for the award size and scope. The BPD review determined award recommendations were appropriately completed for the size and scope of the contract, were signed by both the Contracting Specialist and Contracting Officer, and were available in the contract file as required by FAR and DTAR.

Our Response

Management's comments were responsive. See the listing of contracts sampled in "Our Response" in Recommendation 37. We will review this area again during our next inspection.

Observation 40

Failure to Consistently Support Modifications Transactions

AFRH CORs consistently lacked documentation to support contract modification transactions.

AFRH CORs were not consistently documenting requirements that were being conveyed to BPD's Contract Specialists/Contracting Officers in support of modifications and post-award administration.

Lack of documentation for post-award requirements (administrative/constructive changes) had the potential to adversely impact the desired outcome.

Discussion

During the inspection, the DoD IG Inspection Team found that AFRH consistently lacked documentation to support contract modification transactions. The DoD IG Inspection Team noted multiple instances where AFRH CORs authorized modifications to add or deobligate funding without explanation, or where AFRH CORs received verbal direction to conduct modifications, but failed to document actions in a memorandum. AFRH CORs were not consistently documenting the requirements that were being conveyed to BPD's Contract Specialists/Contracting Officers in support of modifications and post-award administration. Often, this information was missing from the Contract Specialist's files. The DoD IG Inspection Team determined that CORS were not consistently adhering to the following guidelines:

- Interagency Agreement #1213-0026 between AFRH and Treasury Agency Fund,
- AFRH Notice 12-04, "Records Management Program" March 7, 2012,
- "AFRH COR Handbook," revised July 2012, and
- FAR 4.803, "Contents of Contract Files".

The approval of a purchase request was insufficient by itself; it must have been documented with rationale for what was being procured. A continual lack of documentation for post-award requirements (administrative/constructive changes) has the potential to create problems during future audits and can create the perception of a lack of contract oversight.

Recommendations, Management Comments, and Our Response

Recommendation 40

Armed Forces Retirement Home Chief Operating Officer, ensure that Contracting Officers focus on obtaining all appropriate documentation from Contracting Officer Technical Representatives, as prescribed by Armed Forces Retirement Home and Bureau of Public Debt policies, to support contract transactions and the contract file.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. He noted that the IG did not provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if contract modifications were sufficiently documented for the complexity of the individual contract action. BPD determined the files contained sufficient documentation for the complexity of the contract action being undertaken as prescribed by AFRH and Bureau of Public Debt policies. The specific observation "approval of a purchase request was insufficient by itself and has the potential to create problems during future audits and can create the perception of a lack of contract oversight" does not recognize the various types of administrative modifications.

Our Response

Management's comments were responsive. See the listing of contracts sampled in "Our Response" in Recommendation 37. We will review this area again during our next inspection.

Observation 41

Inadequate Oversight and Management of Interagency Agreements

Neither AFRH facility was consistently managing or providing oversight of interagency agreements between AFRH and other Federal agencies.

The interagency agreements did not clearly define whether BPD or AFRH was required to provide surveillance over the interagency agreements.

Lack of oversight over interagency agreements may produce adverse outcomes and poor service.

Discussion

Oversight and management of interagency agreements were carried out at the AFRH Agency level and not at BPD. The functionality of BPD's role, beyond setting up the original interagency agreements framework, was unclear. The surveillance of interagency agreements was not consistently managed at either AFRH-W or AFRH-G. Although AFRH Agency provided limited surveillance, the surveillance was inconsistent. Monitoring surveillance oversight and performance was difficult when there was not clear guidance for the respective roles and responsibilities between BPD, AFRH, and the other intra-government agencies.

Recommendations, Management Comments, and Our Response

Recommendation 41

Armed Forces Retirement Home Chief Operating Officer, work with Bureau of Public Debt's Administrative Resource Center to clarify their respective roles and responsibilities, as well as to define consistent methodology for surveillance and monitoring of interagency agreements performance.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, noting that the AFRH Agency was responsible to provide oversight of the interagency agreements. He stated that AFRH would review AFRH Agency Directive 3-1 and provide additional clarity on their roles.

Our Response

Management's comments were responsive. We will request an update on the review of AFRH Agency Directive 3-1 at a later date.

Observation 42

Inequitable Distribution of Contracts Among Contracting Officer Technical Representatives

AFRH COTR background/experience was not adequate to support all the contracts they were managing and COTR responsibility was not evenly distributed.

The workload distribution of contract oversight to COTRs was unbalanced and some COTRs were more experienced than others.

Inadequate oversight by COTRs of heavily labor-driven contracts could lead to excessive labor-related expenditures, causing periods of performance to shorten.

Discussion

The unbalanced workload distribution of contracts to COTRs and the great differences in the levels of experience among COTRs made it difficult to meet the requirements stipulated in:

- the Interagency Agreement #1213-0026 between AFRH and Treasury Agency Fund,
- the "AFRH COR Handbook," July 2012,
- the Federal Acquisition Certification for COR,
- CLC 004, "Market Research" August 8, 2012 and
- DTAR policies.

Additionally, there was inadequate oversight by COTRs to monitor contractor performance that was labor-intensive, as prescribed by AFRH and DTAR polices. This deficiency could result in excessive labor-driven expenditures and shortened periods of performance due to fixed price over burning the contract value.[54]

[54] "Over burning the contract value" – spending at a faster rate than planned by the contract due to an increased need for resources. AFRH may for instance require additional staff to carry out a service on a contract with a fixed price over a fixed amount of time. The additional staff will use up a greater percentage of the obligated funds at a faster rate than if they were not hired, therefore speeding up the time when total cost of contract is expended or becomes due.

Recommendations, Management Comments, and Our Response

Recommendation 42

Armed Forces Retirement Home Chief Operating Officer, ensure that the Armed Forces Retirement Home Contracting Office analyzes Contracting Officer Technical Representative's workload and seeks to align Contracting Officer Technical Representative experience with contracts to improve surveillance and monitoring of contractor performance.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. Per AFRH COR Handbook (July 2012), each AFRH COR has met the mandatory training requirements, been nominated by their management team based on their technical experience, and been designated in writing. In addition, BPD completes annual AFRH contract file reviews to identify file and responsibility improvements needed to assist AFRH CORs in performing their responsibilities. Although CORs may temporarily be requested to assume additional duties due to separations/retirements, COR responsibilities are reviewed and adjusted appropriately.

Our Response

Management's comments were responsive. We will review this area again during our next inspection.

Observation 43

Failure to Document and Maintain the Quality Assurance Surveillance Plan, Service Delivery Summary, or Performance Requirement Summary

The contract files reviewed lacked documented Quality Assurance Surveillance Plans (QASPs), as directed by corresponding contracts. In several cases, contract files lacked documentation of evidence that COTRs were providing oversight over the contractor performance.

Some COTRs were not aware of the importance of documenting QASPs and the methods for conducting surveillance over the contractor performance, as well as the requirement to maintain these documents as part of the contract file.

The lack of a QASP and measureable inspection/acceptance criteria made it difficult for the Government to reliably measure contractor performance and ensure the contractor was carrying out his or her quality control obligations.

Discussions

After reviewing several contract files, the DoD IG Inspection Team observed that there were no documented QASPs as directed by the corresponding contract. In several cases, the DoD IG Inspection Team observed a lack of documentation to support the fact that oversight was being conducted in accordance with:

- "AFRH COR Handbook," July 2012,
- AFRH Agency Directive 3-1, "AFRH Financial Management Program," July 18, 2012,
- COR SOP #W-CO-COR-3-02, Contract Monitoring, and
- FAR policies.

Some AFRH COTRs were not aware of the requirement to document their respective method for conducting surveillance of the contractor performance and keeping the documentation as part of the contract file. The lack of a QASP and measureable inspection/acceptance criteria made it difficult for the AFRH to measure contractor performance and the effectiveness of quality control obligations.

Recommendations, Management Comments, and Our Response

Recommendation 43

Armed Forces Retirement Home Chief Operating Officer ensure that:

a. Contracting Officer Technical Representatives develop Quality Assurance Surveillance Plans for surveillance in accordance with the prescribed Armed Forces Retirement Home and Federal Acquisition Regulation policies.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. He noted that the IG did not provide a list of contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if QASP or Performance Requirement Summary (PRS) were adequate to evaluate contract performance based on contract type. BPD determined QASP and PRS were included for all awards and were prepared appropriately.

Our Response

Management's comments were responsive. See the listing of contracts sampled in "Our Response" in Recommendation 37. We will review this area again during our next inspection.

b. Bureau of Public Debt Contracting Officers document and implement surveillance methodologies to effectively manage contractor performance.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred. He noted that the IG did not provide a list of contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if surveillance technologies were adequate to assess contractor performance. BPD determined QASP or PRS were adequate to measure contractor performance.

Our Response

Management's comments were responsive. See the listing of contracts sampled in "Our Response" in 37. We will review this area again during our next inspection.

Results – Part J

Security

Security

Overall Assessment

The DoD IG Inspection Team's AFRH security assessment addressed security management, physical security safeguards, training programs, electronic security systems, and security SOPs. The DoD IG Inspection Team observed major improvements in the AFRH-W's security operations from the DoD IG's AFRH 2009 assessment. AFRH Security Management incorporated the DoD IG's recommendations from the 2009 assessment.

Perimeter security was a significant concern at the AFRH-W and the AFRH-G facilities. Both facilities were vulnerable to unauthorized access as a result of inadequate security measures. Physical security measures did not adequately meet the requirements established by AFRH policies.

Significant concerns about AFRH's security training programs and SOPs emerged during the inspection, primarily due to a lack of standardized security processes observed at each facility. AFRH security guards did not possess the requisite training or authorization to conduct traditional Federal security guard operations or to respond in the event of an emergency.

Observation 44

Poor Security at the Scale Gate Entrance

Security of the AFRH-W Scale Gate facility entrance, controlled by VA police, did not meet the security standards established in SOP No. W-OA-SEC-5-27, "Perimeter Security," July 6, 2012.

An enforceable written agreement did not exist between the AFRH-W and the VA police that required the VA police to apply appropriate access control measures to the Scale Gate facility entrance.

As a result, the AFRH-W facility grounds were vulnerable to unauthorized access.

Discussion

AFRH-W's "Perimeter Security" SOP outlined procedures to prevent unauthorized access to the AFRH-W grounds. Security officers assigned to gate duty were required to be alert for individuals who did not have a legitimate purpose for entry. Perimeter gate security procedures stated that security officers were required stop every motor vehicle at the entrance that did not visibly display a valid AFRH decal or a temporary vehicle pass. Visitors were supposed to be asked to present a valid AFRH pass or queried as to their business on the AFRH-W grounds. These procedures were also applicable to every pedestrian and bicyclist who was not a resident or employee of the AFRH. AFRH-W security officers applied these procedures to ensure that facility entrances were secure, with the exception of the Scale Gate entrance, which was monitored by the VA police. Based on anecdotal accounts and a direct observation of the unsatisfactory performance of the VA police, the Scale Gate entrance to the AFRH-W was determined to require additional access control measures.

VA personnel utilized parking spaces on the AFRH-W property through an agreement between the AFRH-W and VA, under the condition that VA assign police officers to monitor the Scale Gate facility entrance. During an interview, the AFRH-W Security Chief stated that VA police officers were failing to properly monitor the Scale Gate facility entrance. The AFRH-W Security Chief also stated that VA police officers were absent from security gate duty at times. During a site visit, the DoD IG Inspectors

observed that VA police officers were not adequately checking the identification of individuals entering the facility through the Scale Gate. This resulted in an insufficiently secured Scale Gate, and thus a facility vulnerable to unauthorized access.

The AFRH-W Security Chief had addressed the concerns with the VA police officers on duty and referenced the AFRH-W's "Perimeter Security" SOP. However, the issue continued to exist because there was no enforceable written agreement outlining proper security procedures between the AFRH-W and VA that required the VA police officers to apply access control measures that met the standards in AFRH-W's "Perimeter Security" SOP.

Recommendations, Management Comments, and Our Response

Recommendation 44

Armed Forces Retirement Home Chief Operating Officer:

a. Complete a written agreement with the Department of Veterans Affairs to ensure that Veterans Affairs Police Officers on Scale Gate facility entrance security duty are in full compliance with Armed Forces Retirement Home security policies and standards for access control.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the recommendation was in progress.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

b. Assign Armed Forces Retirement Home – Washington, D.C. security guards to attend to the Scale Gate facility entrance until Department of Veterans Affairs Police Officers begin providing security in full compliance with required policies.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that the VA Police Force assumed responsibility for the Scale Gate on or about November 2013. Barricades prohibit Scale Gate traffic from entering the AFRH Main Grounds.

Our Response

Management's comments were responsive. No further action required at this time.


INSPECTOR GENERAL
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DEPARTMENT OF DEFENSE

Observation 45

Inadequate Security Guard Minimum Qualifications, Training, and Authority

Although a baseline security training program with SOPs and a master training task list existed, the AFRH-W and AFRH-G guards were not adequately trained nor empowered to provide traditional Federal security services according to recognized Federal standards.

The security guards lacked Federal professional standards, training, and authority.

Consequently, security guards were unprepared to properly address security threats, especially in an emergency.

Discussion

After reviewing Federal, DoD, and General Services Administration (GSA) security standards and AFRH-W and AFRH-G SOPs, the DoD IG Inspection Team determined that the security guards at both facilities lacked adequate security response training. Additionally, upon further review of the SOP's "Orientation and Training" and 'Perimeter Security," and discussions with security personnel, the team determined that AFRH guards at both facilities were not trained or necessarily authorized to respond to emergencies involving threats to personnel and property.

Security guards were unarmed and lacked the requisite safety training needed to protect themselves and the AFRH residents and staff members. Adoption of a security guard program, such as those described in DoD Instruction 5525.15, "Law Enforcement (LE) Standards and Training in the DoD," April 27, 2012, would prove beneficial to improving the state of AFRH security.

Recommendations, Management Comments, and Our Response

Recommendation 45

Armed Forces Retirement Home Chief Operating Officer, establish a security guard program that meets the minimum qualification and training requirements of Department of Defense or Department of Homeland Security Federal Protective Service guards, including a plan to respond to an active shooter incident.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, stating that the AFRH would explore various Federal training programs for security officers and secure a training program that meets minimum training requirements of the Department of Homeland Security Protective Service guards. AFRH security has implemented an active shooter program and provided training to staff and residents.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

Results – Part K

Estate Matters and Disposition of Effects

Estate Matters and Disposition of Effects

Overall Assessment

This inspection examined the AFRH's compliance with section 420, title 24, United States Code (24 U.S.C. § 420 [2012]) regarding activities related to the disposition of AFRH's deceased residents' (decedent) effects and estates. Specifically, the DoD IG Inspection Team:

- reviewed AFRH's directives and SOPs,
- checked AFRH personnel's knowledge of their roles and responsibilities,
- assessed the process for the disposition of decedents' last will and testament (will), and the inventory process for the administration of decedents' effects and estates, and
- evaluated the conduct of AFRH personnel during probate proceedings in which AFRH may have legal interest as a nominated fiduciary,[55] testamentary legatee,[56] escheat legatee,[57] or other capacity.

While many personnel accounts and records reviewed indicated compliance with AFRH SOPs, the DoD IG Inspection Team discovered deviations from directives and SOPs and determined that key AFRH personnel were not accurately and consistently following AFRH directives and policies regarding the disposition of effects[58] and estates.[59] AFRH staff actions and procedures related to the disposition of effects lacked: (1) internal controls in key risk areas, (2) accountability of AFRH personnel for conduct related to the disposition of effects and estates, and (3) adequate oversight by AFRH Administration, particularly during the inventory process.

[55] An individual who is given the power to act on behalf of an individual in the administration of the individual's estate in accordance with the directions in the will.

[56] A person who receives personal property as directed by a will after the owner/author of the will has died. Retrieved 28 October 2013, from http://legal-dictionary.thefreedictionary.com/Legatee & http://thelawdictionary.org/testamentary/.

[57] The transfer of the property of a deceased person to the AFRH when no will has been written or no legal heirs exist or can be found.

[58] Disposition of Effects - All activities related to the distribution and disposal of a decedent's personal belongings as specified in a will or as directed by a fiduciary or court. Usually includes small personal items.

[59] Disposition of an Estate - All activities related to settling of the decedent's estate including, but not limited, to the settling of all finances/debt and the dissolution and/or transfer of large properties (that is, home, businesses, land etc.) and/or proceeds to individuals specified in a will or directed by a fiduciary or court.

The DoD IG Inspection Team observed that many AFRH personnel were generally knowledgeable about their roles, as they were specified in AFRH Agency Directive 8-8, "Estate Matters," September 2, 2008, and facility SOPs. However, some AFRH personnel were not. SOPs for the AFRH were only updated or written within the 3 months preceding the 2012 inspection. Staff accounts of conduct conflicted with SOPs in some areas and records failed to support statements of staff about activities related to the disposition of effects. Additionally, AFRH Agency Directive 8-8 was outdated, and did not include changes to titles, noted in Public Law 112-81. AFRH Agency Directive 8-8 and SOPs conflicted, inadequately addressing many aspects of processes related to the disposition of effects and estates, and contributed to the lack of compliance of AFRH staff with established policies.


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Observation 46

Inadequate Disposition of Wills

AFRH could not assure the delivery of decedent's wills to the appropriate court of record, as specified by 24 U.S.C. § 420(a)(1) (2012).

AFRH did not have an explicit policy which prohibited the maintenance of residents' wills on file at either facility or policies which dictated AFRH personnel actions related to the disposition of wills that came into the possession of an AFRH staff member.

AFRH may have violated 24 U.S.C. § 420(a)(1) (2012), if, upon death, a resident's will, in the possession of an AFRH staff member, was not delivered to the appropriate court of record.

Discussion

Section 420 (a)(1), title 24, United States Code. required ". . . the Administrator of. . . [each] facility. . . [to] ensure that a will or other instrument of a testamentary nature involving property rights executed by a resident. . . [was] promptly delivered, upon the death of the resident, to the proper court of record." At both facilities, residents were encouraged to create a will. If a resident did not possess a will at the AFRH-W facility, they were referred to the AFRH Legal Team to obtain assistance with the creation of a will. If a resident did not possess a will at the AFRH-G facility, this fact was notated in their file. Each facility noted whether each resident possessed a will and recorded the executor's name, as noted in the decedent's will, on the *face sheet* in each resident's file. However, when the DoD IG Inspection Team reviewed files, many face sheets had not been updated to indicate current status and contact information for emergency contacts, executor, or personal representative. In addition, AFRH-W files did not accurately reflect the current possession of wills by residents.

The DoD IG Inspection Team spoke with many AFRH staff members involved in the disposition of decedent's effects and estates at both the AFRH-W and AFRH-G facilities, and was informed several times that "the AFRH did not keep residents' wills on file." However, at both locations wills were found in

files. At AFRH-W, a will was found in a Memory Support resident's file. At AFRH-G wills were found in decedents files. At AFRH-G, a list of the files containing wills was provided to the AFRH-G Administrator at the conclusion of the on-site inspection out-brief. AFRH had no guiding policy on what AFRH should do about wills that are given to or found by an AFRH staff member, with the exception of AFRH-G SOP, G-OA-ADM-1-15, "Transitions," July 18, 2012, which allows AFRH staff to receive a copy of the executor's page of the will from the executor as verification of his or her designation as the executor over the decedent's effects.

In the Air Force Inspection Agency (AFIA) Office of the Inspector General's 2005 Triennial Inspection Report, AFRH-W was cited for violation of 24 U.S.C. § 420 (2012) because AFRH-W's Chief of Resident Affairs was ". . . relinquishing residents' wills to the executor or legal representative at the time of the resident's death and not delivering them to the appropriate court as required by law." At AFRH-G, when a resident's will was found in the resident's room, their practice was to provide the document to the resident's family or executor listed on the will, which was the same practice noted by AFIA's assessment in their report.

The AFIA 2005 report concluded that ". . . by providing the executor or legal representative with the decedent's will, AFRH-W believed that they absolved themselves of any further legal involvement with the probate proceedings, thus avoiding any expense or manpower expenditures."

Recommendations, Management Comments, and Our Response

Recommendation 46

Armed Forces Retirement Home Chief Operating Officer:

a. Update Armed Forces Retirement Home Directive 8-8, "Estate Matters," September 2, 2008, to include amendments from the Public Law 112-81 and to reflect current practices of the Armed Forces Retirement Home.

AFRH COO's Comments

AFRH COO concurred, reporting that AFRH Agency Directive 8-8 is currently under revision. AFRH COO noted that AFRH is not in the practice of keeping original wills. Original wills found among Residents' personal effects are disposed of IAW 24 U.S.C. § 420.

Our Response

Management's comments were responsive. We will request a status on the update of the revised agency directive at a later date.

b. Establish a written policy covering the handling, tracking, and recording of all actions related to the disposition of last will and testaments that are given to or found by Armed Forces Retirement Home staff, before or after the death of a resident, with special emphasis on whether the will was provided to the court or given to the next of kin, executor, or other entity.

AFRH COO's Comments

AFRH COO concurred, commenting that requirements related to the handling of wills are also covered in 24 U.S.C. § 420. AFRH is not in the practice of keeping original wills. Original wills found among Residents' personal effects are disposed of IAW 24 U.S.C. § 420.

Our Response

Management's comments did not address the intent of the recommendation. We think the AFRH COO should promulgate the requirements of the law in policy, so that his staff is aware of the process for proper handling/disposal if they come across a resident's original will while on duty at the Home. They are unlikely to know that they should follow, or even look at, 24 U.S.C. § 420. We ask that the AFRH COO again consider establishing written policy on this issue and advise us, in response to the final report.

c. Ensure that Armed Forces Retirement Home Administrators adequately account for all wills executed by residents in their possession.

AFRH COO's Comments

AFRH COO concurred, reporting that the recommendation was complete. AFRH is nonetheless not in the practice of keeping original wills. Copies of wills serve only as references for AFRH Administrators in identifying next of kin or nominated fiduciaries. Original wills found among residents' personal effects after they have died are accounted for, the AFRH/General Counsel is notified, and the wills are disposed of IAW 24 U.S.C. § 420. Residents are also under no requirement to make a will and may revoke or alter a will at any time, without providing notice to any interested party. The task of creating, updating, and securing a will is the resident's responsibility.

Our Response

Management's comments were responsive. We accept management's analysis that AFRH employees know procedures for handling resident's wills. We will look at this area again on our next inspection.

Observation 47

Noncompliance with Established Policies and Procedures

AFRH employees involved in the disposition of effects and estates were not accurately following AFRH Agency Directive 8-8, "Estate Matters," dated September 2, 2008, or AFRH facility SOPs.

This was attributable to the fact that:

- AFRH activities involving the disposition of decedent's effects and estates lacked adequate oversight or review to check for employee adherence with policies.
- AFRH Agency Directive 8-8 and AFRH facility SOPs were outdated, contradictory, and did not adequately cover all important aspects of processes related to the disposition of decedent's effects and estates.
- New employees assigned estate matters were not formally trained on their roles.

As a result, there was potential for lawsuits against AFRH for failing to properly handle the decedents' belongings and for failure to show compliance with written procedures.

Discussion

At both facilities, the duties of the Administrator, as specified in AFRH Agency Directive 8-8 (2008), were delegated to the Administrative Officers and the Admissions Officers. The Administrative Officer was only tasked with cases where residents died intestate (without a will) or cases where an heir, next of kin, executor, or emergency contact could not be readily identified by the Admissions Officer. The Admissions Officer had primary responsibility for activities related to the disposition of effects of residents whose deaths occurred in IL rooms. Social workers were involved in the disposition of effects for decedents who died in all levels of care. Healthcare Services personnel were involved in activities related to the disposition of effects of AFRH decedents that died in Healthcare Services, AL, and LTC.

Armed Forces Retirement Home – Washington, D.C.

The DoD IG Inspection Team found that AFRH-W's staff was not adhering to established AFRH directives and SOPs.

The Administrator and Administrative Officer

While undertaking the duties assigned to the Administrator by AFRH Agency Directive 8-8, the Administrative Officer was not only failing to complete all required tasks, but also other requirements of his position as the AFRH-W Administrative Officer, as stipulated in AFRH directives and SOPs. Specifically, out of the activities delegated to the Administrator by page 10 of AFRH Agency Directive 8-8, (8), neither the Administrative Officer nor the Administrator were:

- verifying and documenting the identity/credentials of the legal representative handling the resident's affairs, and
- ensuring that property received by the AFRH (items that were lost, abandoned or otherwise unclaimed) was delivered to the owner, the heirs, the executor/executrix, the legal representative, or next of kin of the owner.

In addition, the Administrative Officer:

- did not receive valuables collected during the inventory process for safekeeping or authorize the delivery of funds and effects to the designee of the deceased resident when they were identified, as directed by AFRH Agency Directive 8-8 (7) (a)(6), page 8,
- was not upholding his responsibility over decedent's property, inventories, and all tracking forms released by the Decedent Affairs Coordinator, as directed by AFRH Agency Directive 8-8 (8), page 10. (The Administrative Officer only maintained documents received from the AFRH-W designated lawyer), and
- was not publishing forms (AFRH Forms 48 and 222) specifically required for documenting a decedent's property in Healthcare Services.

Security

Upon review of records, the DoD IG Inspection Team found that AFRH-W security failed to enter in the security blotter the reported death of a resident that occurred outside the facility, as required by W-OA-ADM-1-14, "Transitions," July 9, 2012.

Healthcare Services

During an interview, a staff member stated that there was a "[culture of] no concern or accountability" when it came to the disposition of resident effects. For instance, when an individual died and there was no claim to the decedent's effects, a staff member stated that other staff members would just give the items away without obtaining written consent of the family or documenting who obtained the items. The interviewed staff member also stated that individuals involved in the process were not following SOPs. There were variations in processes to accommodate each family's need. However, these actions, according to the staff member, were not documented.

Armed Forces Retirement Home – Gulfport

At AFRH-G, some of the individuals tasked with duties related to the disposition of a decedent's effects had only recently been given this responsibility and they were not thoroughly familiar with their duties, particularly regarding the probate processes, testamentary donations, record keeping, and the provision of oversight.

The Administrative Officer was engaged in activities assigned by AFRH Agency 8-8 (2008) to the Administrator, and was also fulfilling some of the tasks assigned to her position under the directive. The Administrative Officer only started keeping records pertaining to estate matters a couple of weeks prior to the 2012 DoD IG inspection, after being told to do so by one of the AFRH-G social workers. The Administrative Officer stated that she was not given any previous training or provided any guidance in this matter. Prior to the Administrative Officer's hiring, there was no evidence indicating what occurred in cases where decedents' lacked wills or their families could not be reached.

AFRH personnel tasked with duties related to the disposition of personal effects and the administration of estates did not provide sufficient evidence that they were actually conducting activities in the manner stipulated in SOPs and directives, primarily because of the newness of SOPs. According to the AFRH-W

Administrator, AFRH-G did not have any SOPs when it reopened in 2010. SOPs were apparently only recently adopted from AFRH-W to prepare for the 2012 DoD IG inspection. The recent date on many SOPs raised concerns that the requirements within SOPs may not have existed for AFRH personnel to follow prior to the date observed on each SOP. Additionally, the overt newness of SOPs raised concerns that SOPs and current operations were not thoroughly reviewed before the SOPs were issued. Moreover, the DoD IG Inspection Team determined that some AFRH personnel were not accurately following SOPs and SOPs may not have been providing adequate guidance or internal controls to execute the activity as intended.

Staff accounts of conduct related to the disposition of effects and estates contradicted materially in a few respects. For instance, when asked about the AFRH-G Administrative Officer's relationship with the Administrator, the Administrative Officer stated that the Administrator held meetings to ensure that everyone involved in the process was aware of their role in the disposition of effects and estates when a death occurs. However, when the DoD IG Inspection Team spoke with both AFRH-G social workers, they stated that they had never had any meetings with the past or current Administrator regarding estate matters or the disposition of decedent's effects. In fact, both social workers stated that they had to improvise on several occasions on estate matters because there was not a standard policy for AFRH-G to follow. However, AFRH-G social workers were able to communicate some events, actions, and other information of importance concerning the disposition of decedent's effects and were able to provide the Inspection Team evidence explaining some discrepancies in decedent's files.

Armed Forces Retirement Home – Gulfport and Washington, D.C., facilities

Ombudsmen at both facilities were not fulfilling their duties as stipulated in AFRH Agency Directive 8-8 (8), page 10 (2008), which stated that they were to supervise and review all actions conducted by personnel involved in the disposition of a decedent's personal effects and the administration of their estate.

Moreover, neither facility's Chief of Security was creating log records that accounted for who went in and out of locked rooms containing decedents' personal effects after they were secured, as specified by AFRH Agency Directive 8-8 (7) "Inventory and Safekeeping. . . " (b)(2), page 9.

Neither facility was adequately using forms required by SOPs W-HC-SOC-4-04 (Washington), and G-HC-SOC-4-04 (Gulfport), both titled "Residents' Personal Effects and Valuables." AFRH-G was inconsistently using Form 48, "Personal Effects Inventory," to account for all items, but was not using the Form 222, "Safekeeping Property Inventory," to account for decedents' valuables at all. AFRH-W was not using any of the required forms.

Disposition of Vehicles

AFRH Security Chiefs at both facilities were not consistent in documenting the search for and the disposition of residents' vehicles, as stipulated by AFRH SOPs.

Poor Record Keeping and Scattered Documentation

AFRH personnel involved in the disposition of AFRH decedents' effects and estates were not adequately documenting and maintaining documentation of all important activities related to the disposition of decedent personal effects and the administration of estates.

Records were poorly maintained and scattered across various divisions within the AFRH. Additionally, records were unreliable in verifying actions taken when problematic issues arose.

Although inventory sheets were found in files, AFRH personnel were not certain about what documents to retain and where these documents were to be kept. AFRH policies and procedures did not require the retention of documentation which would verify what occurred during the disposition of effects, including correspondence with additional beneficiaries not noted in the decedent's face sheet, appointee authorization by the executor, acceptable deviations from normal procedures, and other documents which might provide additional protection. In addition, AFRH did not designate a central location for storing documents related to the disposition of deceased AFRH residents' effects and estates at either location. Moreover, AFRH policies did not require employees to keep record of all actions and results.

At AFRH-G, decedent records were found in Healthcare Services, Resident Services, and in the Administrative Officer's office. At AFRH-W, documentation related to one case was found in records of multiple departments as well. An AFRH staff member was penalized in a civil suit for improper conduct related to the disposition of a particular AFRH decedent's estate in the past. At the time of the

inspection, the combination of AFRH personnel actions and poor record keeping placed AFRH at high-risk for future litigation. Maintaining accurate and complete records is necessary in the future to verify compliance with statutes and to maintain AFRH's integrity.

Recommendations, Management Comments, and Our Response

Recommendation 47

Armed Forces Retirement Home Chief Operating Officer:

a. Develop policies that ensure that each facility Administrator implements a standardized centralized record keeping process and policy specific to estate matters.

AFRH COO's Comments

AFRH COO concurred with this recommendation.

Our Response

Management's comments were partially responsive. We ask that management describe steps which have been, or will be, taken to satisfy this recommendation. We request an update in response to the final report.

b. Update directives and standard operating procedures regarding the disposition of decedent's effects and estates to ensure:

(1) They are complete and do not contradict each other, and

AFRH COO's Comments

AFRH COO concurred with this recommendation.

Our Response

Management's comments were responsive. We will request an update on the revision of the noted directives and SOPs at a later date.

(2) They expand on the documentation requirements needed to verify conduct of all employees in these matters.

AFRH COO's Comments

AFRH COO concurred, reporting that AFRH Agency Directive 8-8 is currently under revision and will incorporate, by reference, the Estate Fiduciary Codes of each facilities jurisdiction.

Our Response

Management's comments were responsive. We will request an update on the revised AFRH Agency Directive 8-8 at a later date.

c. Develop policies that require each facility Administrator to arrange for training and implement other measures to ensure that Armed Forces Retirement Home staff involved in the disposition of decedents' effects and the administration of estates are knowledgeable about their roles.

AFRH COO's Comments

AFRH COO concurred, reporting that the recommendation was complete. AFRH COO stated that the AFRH General Counsel has been tasked with the responsibility to provide training in estate matters to relevant AFRH employees. This requirement has been occurring since 2011.

Our Response

Management's comments were responsive. We ask that management provide documentation confirming any training or education of noted staff, in response to the final report.

d. Develop policies to ensure that each facility Administrator enforces policies, develops specific performance indicators, and develops a system for tracking compliance with directives and standard operating procedures, to include documentation of all required actions related to the disposition of decedents' effects and estates.

AFRH COO's Comments

AFRH COO concurred, reporting that AFRH Agency Directive 8-8 addresses this recommendation and is currently under revision. Policies developed relating to decedents' effects and estates will be drafted to ensure compliance with 24 U.S.C. § 420 (2012) and the Fiduciary codes of the respective jurisdictions of each facility.

Our Response

Management's comments were responsive. We will request an update on the revised AFRH Agency Directive 8-8 at a later date.

e. Ensure that each facility Ombudsman conduct continuous review of all actions taken and confirms that all records are on file.

AFRH COO's Comments

AFRH COO concurred, commenting that current policy requires the Ombudsman maintain an overview of all actions and conduct a quarterly review of actions taken.

Our Response

Management's comments were partially responsive. We believe that the intent of this recommendation was missed. At the time of the inspection, AFRH Agency Directive 8-8 (8), page 10 (2008) required the Ombudsman at each facility to complete this task. However, DoD IG determined that the Ombudsmen at both locations were not in compliance with this directive and were not maintaining overview of all actions or conducting reviews of actions at the time of the winspection. We will look at this area again in our next inspection.

Observation 48

Lack of Readiness in Probate Matters

Although AFRH-W was performing satisfactorily in probate matters, AFRH-G employees were unprepared in cases where the retirement home may have a legal interest as nominated fiduciary, testamentary legatee, escheat legatee, or in any other legal capacity, as stated in section 420, title 24. United States Code (24 U.S.C. § 420(b)(1)(C)[2012].

AFRH-G did not have formal training or guidelines on the probate process. There were no policies that directed AFRH staff in matters related to probate.

As a result, AFRH could be adversely affected in cases where AFRH has a legal interest.

Discussion

AFRH-W had a satisfactory process in place for administering:

- estates of residents who die intestate,
- estates of decedents whose next of kin cannot be immediately ascertained,
- estates of decedents with wills that indicate the possibility of escheating (transferring) all proceeds to AFRH after a 3-year period, and
- estate proceedings where AFRH may be named a beneficiary of testamentary gifts or any other legal capacity.

These processes met the provisions of AFRH Agency Directive 8-8 (2008), section 20, D.C. Code, and 24 U.S.C. § 420 (2012). Assurances are provided by the statutory requirements of District of Columbia code of law, and enforced in the procedural requirements of the Superior Court of the District of Columbia, to ensure transparency and eliminate any nefarious activities.

However, AFRH-G had not yet selected an attorney to act as AFRH-G's agent in probate proceedings in which the retirement home may have legal interest. The AFRH-G Administrative Officer was not knowledgeable about the legal and procedural requirement of the court in matters where the retirement

home was designated a nominated fiduciary, testamentary legatee, escheat legatee, or had other legal interest in the estate of a decedent. In addition, neither AFRH-Agency nor AFRH-G had developed guiding policies to assist the AFRH-G Administrative Officer in this regard.

Furthermore, Mississippi law differed in many respects from Washington, D.C., law. Although Mississippi code offered several protections for the proper administration of estates, it did not provide a comprehensive description of what was required regarding the disposition of estates of decedents who died intestate, the disposition of wills, and the probate process. Mississippi code of law even conflicted with the statutory requirements of 24 U.S.C. § 420 (2012) regarding which entity the proceeds of an estate may escheat, as specified by Miss. Code Ann. § 89-11-1. Therefore, AFRH-G must be prepared to meet these legal challenges, if and when they arise.

Recommendations, Management Comments, and Our Response

Recommendation 48

Armed Forces Retirement Home Chief Operating Officer:

a. Create policies that direct employee conduct in probate matters to ensure the highest level of transparency and protection.

AFRH COO's Comments

AFRH COO concurred, commenting that employee conduct in probate matters is addressed in 24 U.S.C. § 420 (2012) and AFRH Agency Directive 8-8, which is currently under revision.

Our Response

Management's comments were responsive. We will request an update on the revised AFRH Agency Directive 8-8 at a later date.

b. Develop policies that ensure that the Armed Forces Retirement Home – Gulfport Administrator arranges for training of the Armed Forces Retirement Home – Gulfport employees in areas related to estate matters in probate cases.

AFRH COO's Comments

AFRH COO concurred and reported that the recommendation was complete. The AFRH General Counsel is tasked with the responsibility to provide training in estate matters to relevant AFRH-G and AFRH-W employees by the AFRH/COO. The AFRH/General Counsel delivered training to senior management and two (2) social workers in February 2011 at a specific meeting regarding estates and wills. Training was recently conducted at AFRH-G in February 2014.

Our Response

Management's comments were responsive. We ask that the AFRH COO provide a copy of training documentation in response to the final report.

c. Ensure that the Armed Forces Retirement Home – Gulfport Administrator adopt the Armed Forces Retirement Home – Washington, D.C. designated attorney as its own or select an attorney who meets the specifications dictated in section 420, title 24, United States Code.

AFRH COO's Comments

AFRH COO concurred and reported that AFRH/General Counsel has recently settled on adesignated attorney to assist with wills and estates for AFRH-G. Prior to this selection, the AFRH-W designated attorney for wills and estates was ready to assist with and/or advise on estate matters. Furthermore, a short-list of attorneys was provided to AFRH-G prior to this selection.

Our Response

Management's comments were responsive. We ask that the AFRH COO provide documentation appointing each designated attorney in response to the final report.


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Results – Part L

Armed Forces Retirement Home Hotline Activity

Armed Forces Retirement Home Hotline Activity

Overall Assessment

The DoD IG Inspection Team's review focused on the quality of completed AFRH IG Hotline inquiries. However, the DoD IG Inspection Team did not find any AFRH IG, Federal, or DoD IG quality standards that applied to the AFRH.

Therefore, to conduct the quality assurance review (QAR) of completed AFRH IG inquiries, the DoD IG Inspection Team followed the QAR guidelines in DoD Instruction, 7050.01, "Defense Hotline Program," December 17, 2007.

The DoD IG Inspection Team reviewed all of the internally generated AFRH IG Hotline inquiries completed since the last DoD IG inspection of the AFRH (May 15, 2010 to February 21, 2012, inclusive). The QAR analyzed the quality of the inquiry based on the documentation contained in the completed hotline case file and evaluated the timeliness, independence, objectivity, and overall adequacy of the hotline inquiry. The analysis focused on identification of systemic strengths and weaknesses in the manner in which the AFRH IG conducted its inquiries.[60]

Timeliness

The time needed for the AFRH IG to complete 11 of the 15 inquiries ranged from 1 day to 130 days. No standards for timeliness were available in AFRH Agency Directive 1-9, "AFRH Inspector General Program," June 2, 2009, and none of the case files contained documentation indicating the AFRH IG failed to complete the inquiry in a timely manner.

The DoD IG Inspection Team was not able to assess the timeliness of four inquiries (26 percent of the inquiries reviewed) because the AFRH IG complaint intake function failed to document the receipt of the complaints, as required by AFRH Agency Directive 1-9.

[60] As used here, the term "inquiry" refers to and is interchangeable with the terms "audit," "investigation," "inspection," "examination," or any other type of review used to ascertain the facts in response the a DoD Hotline or AFRH IG hotline referral.

Independence and Objectivity

The DoD IG Inspection Team did not find any evidence of a lack of independence or objectivity on the part of the AFRH IG in the conduct of the 15 inquires reviewed.

Overall Adequacy of the Hotline Inquiries

The DoD IG Inspection Team did not identify any systemic strengths or weakness in the manner in which the AFRH IG conducted the 15 inquiries reviewed. Based on the documentation contained in the completed hotline case file and the timeliness, independence, and objectivity factors, the DoD IG Inspection Team found the inquiries adequately resolved the matters at issue. It should be noted that none of the inquiries addressed complex issues or required specialized investigative techniques to resolve.


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Observation 49

Lack of AFRH Inspector General Hotline Implementing Guidance

AFRH Agency Directive 1-9 requires the AFRH IG to issue implementing guidance for the AFRH Hotline program. At the time of on-site inspection, the implementing guidance was not in place.

This happened because the AFRH IG did not issue the implementing guidance for the AFRH Hotline program.

As a result of the lack of the implementing guidance, the AFRH Hotline investigations could not be evaluated against any AFRH-identified/developed standards.

Recommendations, Management Comments, and Our Response

Recommendation 49

Armed Forces Retirement Home Chief Operating Officer, ensure the Armed Forces Retirement Home Inspector General issues implementing guidance that specifies:

a. Quality standards for the Armed Forces Retirement Home Hotline Program.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but provided no additional comments.

Our Response

Although the COO did not provide comments, we note USD (P&R) comments to Recommendation 20.a related to the AFRH Hotline stating that, as an independent agency, and IAW 24 U.S.C., section 411(a), AFRH has legislative authority to set policy/guidance to meet credible standards for audits and investigations and will develop policy in this area. We find those comments to be responsive. Accordingly, we find it unnecessary, at the present time, to address the extent, if any, of their legislative authority. We will request an update from the AFRH COO on progress at a later date.

b. Procedures to ensure appropriate evaluation and action on all allegations of fraud, waste, abuse, and mismanagement.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but provided no additional comments.

Our Response

See "Our Response" to Recommendation 49.a.

c. Methods to ensure appropriate protection of the identity of sources requesting anonymity or confidentiality.

Management Comments

The AFRH COO concurred, but provided no additional comments

Our Response

See "Our Response" to Recommendation 49.a.

Results – Part M

Employee Sensing Sessions

Employee Sensing Sessions

Overall Assessment

An employee sensing session is a meeting with a cross section of the employees in group settings, to learn about their opinions and concerns and their recommendations to improve the organization. Although the DoD IG Inspection Team did not announce any confidentiality protection, no names were provided in the report or to any AFRH official.

At the AFRH-W facility, the DoD IG Inspection Team intended for staff members to voluntarily attend and participate in the sensing sessions. However, AFRH-W management instructed the staff members to attend the sensing sessions, dividing the sensing session assignments into healthcare, non-healthcare, and middle manager groups. All eight staff members selected and assigned to the sensing sessions held August 28-31, 2012, attended. This assignment did not prohibit anyone from attending the AFRH-W sensing session they wanted to attend, despite the prior assignments. At AFRH-G, the DoD IG Inspection Team emphasized the need for management to encourage staff members to voluntarily participate in the sensing sessions, rather than to assign specific staff members to attend specific sessions. Four staff members attended the sensing session held on September 11, 2012, and nine staff members attended the sensing session held on September 12, 2012.

The DoD IG Inspection Team presents employee complaints/concerns in this section primarily for the knowledge of AFRH management. The DoD IG Inspection Team has made several recommendations in the Medical section (Part A), Human Resources section (Part B), AFRH IG section (Part D), and Senior Management section (Part O) to address the root causes of the employee concerns.

Armed Forces Retirement Home – Washington, D.C., Sensing Session Summary

The staff members unanimously expressed the satisfaction they received from working for and with the residents. They all felt that serving and spending time with the residents was the most rewarding part of their jobs. They praised their fellow co-workers for their expertise and dedication to the agency

and the mission. The staff members were committed to the residents and reportedly made personal sacrifices that benefited residents and made a difference in the residents' lives. They noted that AFRH-W offered opportunities for outreach and had established partnerships with the community.

Some members of the group expressed the following concerns:

- AFRH-W was a layered agency with multiple micromanagers and limited accessibility to management, and suffered from lack of confidentiality and overt personnel favoritism. (See Part O, Senior Management Section, Observation 54 – "Organizational Climate – Fear of Reprisal.")
- Communication between management and employees was poor—staff members were often not aware of impending changes or of any plans for implementation of these changes. (See Part O, Senior Management Section, Observation 54 – "Organizational Climate – Fear of Reprisal.")
- They did not know how to improve their performance due to lack of sufficient training and guidance from management. (See Part O, Senior Management Section, Observation 56 – "Lack of Support for Employee-Oriented Programs.")
- The AFRH-W was under-staffed, resulting in over-worked staff members, with frequent unplanned assignment of additional duties to the employees. (See Part O, Senior Management Section, Observation 51 – "Hiring of Insufficiently Competent Personnel.")
- Staff members felt they were stuck at low-paying jobs. They also felt that they did not receive the benefits other Government employees receive, such as flex hours, professional development training, and opportunities for professional growth and promotion. (See Part O, Senior Management Section, Observation 56 – "Lack of Support for Employee-Oriented Programs." Both AFRH management and the DoD IG Team medical inspectors stated that CNAs cannot be promoted to a higher grade unless they obtain the next level of nursing certificate.)
- Staff members complained about unscheduled mandatory overtime work on the night shift. They also complained about not receiving any meals during such unscheduled mandatory overtime work. (See Part O, Senior Management Section, Observation 56 – "Lack of

Support for Employee-Oriented Programs." We discussed this with the AFRH-W Administrator and he stated that such mandatory overtime to fill in for last minute no-show is a normal practice in the nursing profession. Our medical inspectors also had a similar opinion.)

- Staff members felt they were treated poorly by management and they were afraid to take their complaints to management because of perceived probability of management reprisal. Also, they believed that there were one or more employees among them who were informants for the management. (See Part O, Senior Management Section, Observation 54 - "Organizational Climate – Fear of Reprisal.")

Many AFRH-W staff members who met with the DoD IG Inspection Team stated that all the above factors contributed to their diminished incentive to remain employed at the AFRH-W. (See Part O, Senior Management Section, Observation 54 – "Organizational Climate – Fear of Reprisal.")

In addition, some staff members stated that they did not believe that implementing a one-model management concept for both the AFRH-W and AFRH-G facilities was reasonable. They stated that the locations, cultures, residents, and part of internal organizational structure of the two facilities were different. However, the DoD IG Inspection Team believes that there was enough flexibility in the one-model management concept to address those differences.

Armed Forces Retirement Home – Gulfport Sensing Session Summary

There was unanimous agreement among staff members that the residents were the reason why they enjoyed working at the AFRH-G. The staff members also enjoyed working with their co-workers, whom they praised for their devotion and expertise. Some staff members noted that the PCC concept was a reason why they would approve of their parents living at the Armed Forces Retirement Home, if they had the option. The overall consensus was that the staff members believed it was an honor to serve and work with the veterans.

Some staff members expressed the following concerns:

- They believed that the *one-model* management concept did not work for both facilities. The residents, culture, location, and facilities were different, making it difficult to make the two facilities function under one system. (As previously noted, the DoD IG Inspection Team believes that there is enough flexibility in the one-model management concept to address those differences.)

- They expressed dissatisfaction with the response time and quality of assistance from the AFRH agency-level personnel. The functional chiefs at the agency level did not respond to their inquiries in a timely manner and, sometimes, did not respond at all. They felt that the agency-level functional chiefs gave less importance to AFRH-G, as it is out of sight. The agency-level administration needed a Chief of Campus Operations with whom the AFRH-G Chief of Campus Operations could coordinate facility issues. (DoD IG Inspection Team discussed these issues with the AFRH management during out-brief. AFRH management had already created and filled the position of Agency Chief of Campus Operations. However, there is a strong need for fast-responding IT technical assistance to increase employee productivity and avoid employee frustration.)

- AFRH-G staff members believed that AFRH-G contract employees were not present on-site like the regular Government employees. Some staff members felt that this was not fair to the Government employees or to the residents who needed continuity. (See Part A, Medical Section, Observation 13 – "HealthCare Services at AFRH-G." The new AFRH-G started operations with most employees working as contract employees. AFRH-G is in the process of converting most of them into Government civil service employees. Once the conversion is completed this issue should be eliminated.)


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Results – Part N

Confidential Feedback from the Residents and Employees

Confidential Feedback from the Residents and Employees

Overall Assessment

The DoD IG Inspection Team conducted individual confidential complaint sessions in pre-designated areas and during unplanned encounters with residents, staff, and other persons throughout the inspections. Confidential concerns, complaints, and observations were also received by the DoD IG Inspection Team via telephone, anonymously hand delivered documents, and postal mail. The process continued even after the on-site inspection, as some employees had more complaints to submit. This feedback collection process was different from the employee sensing sessions in that the DoD IG Inspection Team announced the non-attributable character for these complaints.

Confidential feedback sessions were held in a pre-designated area at the Sheridan Building of the AFRH-W facility during the week of August 27–31, 2012, and in a pre-designated room of the AFRH-G facility during the week of September 11–13, 2012. The DoD IG Inspection Team recorded the concerns, complaints, and observations of AFRH residents, staff, and other interested persons. This information was documented on "IG Intake Forms" and forwarded to the DoD IG Inspection Team focus area leads if necessary. In addition, DoD IG Inspection Team members were provided IG intake forms and asked to record the concerns, complaints, and observations of residents, staff, and other persons who approached them outside of the officially designated room during the course of their inspection.

In addition to the residents themselves, the DoD IG Inspection Team also received complaints from the relatives of residents who brought their concerns directly on-site to the DoD IG Confidential Feedback office.

The DoD IG Inspection Team is presenting the information in this section primarily for the knowledge of AFRH management. The Inspection Team has made several recommendations in the Medical section, Part A, and the Senior Management section, Part O, to address the root causes of these resident complaints.

The DoD IG Inspection Team received 60 IG intake forms with various concerns, complaints, requests, proposals, and observations during the course of the inspection. Contents of all intake forms were reviewed and considered in development of the observations in this report.

DoD IG personnel manning the DoD IG on-site Confidential Feedback office at the AFRH facilities noted the complaints, concerns, and suggestions from the AFRH residents and staff. Many of these complaints were mostly opinions of individuals and often from a single person. In most cases the DoD IG Inspection Team asked a series of follow-up questions to obtain additional information and to determine if a complaint had sufficient information to take further action. Some of the complaints required thorough investigation and were forwarded to the DoD IG's Administrative Investigations office.

Even though residents came to the Confidential Feedback office with a number of complaints, most of the same residents also indicated that they loved the retirement home and would not want to live at any other place.

In addition to the complaints forwarded to the DoD IG Administrative Investigations office, the following complaints are noteworthy.

- An attending nurse did not check soil bags in a timely manner or regularly empty bedpans. On one occasion, a resident's soil bag broke all over the resident. (This issue is attributable to the hiring of insufficiently competent staff and the shortage of staff as noted in Part O, Senior Management Section, Observation 51 – "Hiring of Insufficiently Competent Personnel.")
- The heavy accents of staff created communication barriers.
- An attending nurse's harsh treatment led to the rupturing and bleeding of the complaining resident's scrotum skin. (The failure of AFRH management to take disciplinary actions against staff is addressed by Part A, Medical Section Observation 12 – "Healthcare Services at AFRH-W" and the hiring of insufficiently competent staff and the shortage of staff as noted in Part O, Senior Management Section, Observation 51 – "Hiring of Insufficiently Competent Personnel" contributed to this issue.)

- A resident and relative of a resident alleged that residents were sometimes neglected. The resident stated that he was sometimes left on the toilet. In addition, the relative of the resident stated that a charge nurse was uncommunicative and inflexible in addressing medical issues of their resident family member and threatened the resident if he reported the offending staff member. (The shortage of staff and the failure of AFRH management to take disciplinary actions against staff as addressed by Part A, Medical Section, Observation 12 – "Healthcare Services at AFRH-W" and the hiring of insufficiently competent staff and the shortage of staff as noted in Part O, Senior Management Section, Observation 51 – "Hiring of Insufficiently Competent Personnel" contributed to this issue.)

- On two occasions, two residents were provided the wrong medication and medication dosages by attending nurse(s) and the attending nurse either failed to recognize errors or allegedly lied about giving the wrong medication. In another instance, a resident complained that an attending nurse did not administer pain medication in a timely manner, resulting in diminished effectiveness of pain management. (This issue is covered in Part A, Medical section, Observation 1 – "AFRH Agency and Facility Policies on Pain Medication," Part A, Medical section, Observation 12 – "Healthcare Services at AFRH-W" and Part A, Medical section, Observation 13 – "Healthcare Services at AFRH-G.")

- The relative of a resident also noted her observation of overburdened and frustrated staff. (This issue is raised in the in Part O, Senior Management Section, Observation 58 – "Hiring of Insufficiently Competent Personnel.") The DoD IG Inspection Team also received some positive feedback from the same relative of the resident about a number of dedicated healthcare staff members.

Results – Part O

Senior Management

Senior Management

Overall Assessment

As part of the DoD IG inspection of the AFRH, the DoD IG Inspection Team addressed AFRH Senior Management program elements established by the "Armed Forces Retirement Home Act of 1991," November 15, 1990, as amended by Public Law 112-81, "National Defense Authorization Act for FY 2012," December 31, 2011. The assessment of AFRH Senior Management program included a review of the qualifications, duties, and responsibilities of the following AFRH officials:

- AFRH Chief Operating Officer,
- AFRH Inspector General,
- AFRH-W Administrator,
- AFRH-G Administrator,
- AFRH-W Ombudsman, and
- AFRH-G Ombudsman.

The DoD IG Inspection Team also reviewed the roles, functions, and effectiveness of the AFRH Advisory Council and the Deputy Director of the DHA, in the role as the AFRH SMA.

Armed Forces Retirement Home Chief Operating Officer

According to section 415(a), title 24, United States Code (24 U.S.C. § 415(a) [2012]) the Secretary of Defense must appoint an appropriately qualified and experienced COO for the AFRH possessing the following:

(1) qualifications appropriate for a continuing care retirement community professional,

(2) appropriate leadership and management skills, and

(3) experience and expertise in the operation and management of retirement homes and the provision of long-term medical care for older persons.

The COO was accountable to, and must report to, the Secretary of Defense on matters pertaining to the overall direction, operation, and management of the AFRH and the administration of its two facilities – AFRH-W and AFRH-G. The AFRH COO's responsibilities, as stipulated in section 415(c)(2), title 24, United States Code (24 U.S.C. § 415(c)(2) [2012]), include:

(1) supervising the operation and management of the AFRH-W and AFRH-G facilities,

(2) issuing and ensuring compliance with appropriate rules and regulations for the operation of the retirement home,

(3) visiting and inspecting the operation of the facilities of the retirement home,

(4) performing periodic audits of the accounts of the retirement home, and

(5) establishing any advisory bodies considered to be necessary.

To assist in the performance of these duties and in the overall administration of the retirement home, section 415(e)(1), title 24, United States Code (24 U.S.C. § 415(e)(1) [2012]) gave the AFRH COO the authority to appoint a staff subject to the approval of the Secretary of Defense.

In addition to setting the COO's prescribed pay, statutory guidance required the Secretary of Defense to evaluate the COO's performance at least once every year. By statute, the Secretary of Defense has the authority to prescribe and award the COO an annual performance-based bonus. However, the basic pay and performance-based bonuses of the COO must not have exceeded the basic pay for Level I of the Executive Schedule under section 5312 of title 5.

The COO was allowed, by provision of section 415(f), title 24, United States Code (24 U.S.C. § 415(f) [2012]), to accept gifts of money, property, and facilities on behalf of the AFRH, which he was required to deposit in the AFRH Trust Fund.

The incumbent AFRH COO was officially appointed to the COO position on September 25, 2011. A review of the incumbent's resume indicated he was qualified for the position, as required in section 415, title 24, United States Code (24 U.S.C. § 415 [2012]). Further review of the incumbent's personnel action records also showed that his compensation was within

established limits, as required in section 415(d)(3), title 24, United States Code (24 U.S.C. § 415(d)(3) [2012]). In addition, the Office of the Secretary of Defense issued a Performance Evaluation report for the AFRH COO for the performance period of September 2010 through September 2011 along with a letter of a performance award. Both documents were issued on December 27, 2011, in compliance with 24 U.S.C. § 415 (2012).

Armed Forces Retirement Home Inspector General

The AFRH IG was appointed to her position by the AFRH COO on May 14, 2012, while simultaneously holding the position of AFRH Public Affairs Officer. At the time of the Inspection, the AFRH IG position was being converted to a full-time position and realigned as a special staff position under the COO. The AFRH IG was not a member of CIGIE and had neither statutory authority nor independence. The DoD IG Inspection Team interviewed the incumbent AFRH IG, former AFRH IG, and COO to assess AFRH IG operations against the criteria for Federal Offices of Inspectors General. Observations and recommendations pertaining to the AFRH IG are located in section Part D, titled, "Armed Forces Retirement Home Inspector General."

Armed Forces Retirement Home Administrators

Section 417(a), title 24, United States Code (24 U.S.C. § 417(a) [2012]) states, in part, that the Secretary of Defense shall appoint an Administrator and an Ombudsman for each facility of the AFRH.

The regulation stated that the Administrator must be either: (1) a civilian with experience in continuing care retirement community, or (2) an active-duty member of the Armed Forces, serving in a grade below brigadier general or rear admiral (lower half). Additionally, the Administrator of each facility must either be certified as a retirement facilities director at the time of appointment or be pursuing a course of study to receive certification as a retirement facilities director. The Administrator of each facility was responsible for the daily operations of the facilities as required by law. Subject to the approval of the COO, section 417(f), title 24, United States Code (24 U.S.C. § 417(f) [2012]) gave each Administrator the authority to appoint and prescribe the pay of such principal staff deemed appropriate to assist in the operation of each AFRH facility. As such, section 417(g), title 24, United States Code (24 U.S.C. § 417a [2012]) required the AFRH COO to conduct an annual evaluation of each AFRH facility Administrator and to submit any corresponding recommendations to the Secretary of Defense.

The Administrator of AFRH-W was appointed on March 17, 2008, for a period of three years. A review of the incumbent's resume indicated he was qualified for the position, in accordance with statutory requirements set forth in section 417, title 24, United States Code (24 U.S.C. § 417 [2012]). Effective as of March 17, 2011, the AFRH-W Administrator received an extension of appointment, not to exceed March 16, 2013. As part of his duties, the AFRH-W Administrator held formal, weekly meetings with all functional Chiefs. The AFRH-W Administrator met with each Chief individually, every other day and whenever an issue arose. The Administrator spent the majority of his time at the LaGarde Building to ensure the smooth operation of its medical units in Healthcare Services. In addition, the incumbent has maintained AFRH-W operations through major events including the 2011 earthquake. On February 13, 2012, the AFRH COO signed off on the performance evaluation of the Administrator for AFRH-W for calendar year 2011.

The current Administrator of AFRH-G was appointed to the position on July 1, 2012, to serve a 3-year term. However, due to administrative issues, the AFRH-G Administrator's appointment letter was issued at a later date by the OUSD (P&R). A review of the incumbent's resume indicated he met the statutory qualification requirements of the section 417(b), title 24, United States Code (24 U.S.C. § 417(b) [2012]). Although the AFRH-G Administrator was not certified as a retirement facilities director, he was pursuing a course of study to become certified as such, satisfying the qualification requirements provided by section 417(b)(3), title 24, United States Code (24 U.S.C. § 417(b)(3) [2012]). The deadline for completing the course is February 28, 2015. At the time of the inspection, the AFRH-G Administrator had not received a performance evaluation because he had only occupied his position for 2 months.

Armed Forces Retirement Home Ombudsmen

Statutory guidelines stipulated in section 417(d)(1)(A), title 24, United States Code (24 U.S.C. § 417(d)(1)(A) [2012]) required the Ombudsman of each AFRH facility to be a member or former member of the Armed Forces, serving on active duty or retired, in the grade of Sergeant Major, Master Chief Petty Officer, or Chief Master Sergeant. The Ombudsman must also have had leadership and management skills appropriate for the Ombudsman position. According to statutory guidelines, the appointed individual must serve in the capacity of an Ombudsman for the AFRH residents, while

performing any other assigned duty required by the Administrator. In addition, section 417(e), title 24, United States Code (24 U.S.C. § 417(e) [2012]) allowed the Ombudsman to provide information to the Administrator, the COO, the SMA, the DoD IG, and the USD (P&R) to fulfill the requirements of the Ombudsman position.

The current Ombudsman of AFRH-W was appointed on September 22, 2004. A review of the incumbent's resume indicated that he was qualified for the position, in accordance with 24 U.S.C. § 417(d)(1)(A)(2012). In addition to his responsibilities as the AFRH-W Ombudsman, the incumbent had been serving as an acting AFRH Agency Ombudsman for the AFRH since June 2012. Although not legislatively mandated, the COO created the new AFRH Agency Ombudsman position (GS-14) so that issues that remained unresolved at the facility level could be addressed at the agency level. According to the current AFRH COO, there were no set procedures for the Ombudsman to relay information to the DoD IG, the SMA, or the USD (P&R). In the past, issues unresolved at the facility level were brought directly to the AFRH COO for resolution. Since there are no residents at the agency level, the DoD IG Inspection Team questions the utility and cost effectiveness of having an agency-level Ombudsman. At the time of the inspection, the AFRH Acting Agency Ombudsman stated that he planned to apply for the Agency Ombudsman position. However, the position had not been announced.

The Ombudsman of AFRH-G was appointed on September 22, 2011. The incumbent was an active duty Master Chief. The incumbent was qualified for the position of Ombudsman, in accordance with 24 U.S.C. § 417 (d)(1)(A) (2012) requirements. The AFRH-G Ombudsman had orders from the Navy for assignment to AFRH-G as the Ombudsman, but not an appointment letter from the Secretary of Defense. According to a representative from the OUSD (P&R), the orders from the Navy eliminated the need for an appointment letter from the Secretary of Defense.

Armed Forces Retirement Home Advisory Council

Section 416, title 24, United States Code (24 U.S.C. § 416 [2012]) established the AFRH Advisory Council (the Advisory Council) to serve the interest of both facilities of the retirement home. As specified by this statute, the Advisory Council shall:

(1) provide guidance and recommendations on the administration of AFRH and the quality of care provided to residents;

(2) submit a summarized report to the Secretary of Defense, at least once annually, containing both its activities conducted over the preceding year and any observations and/or recommendations pertaining to the retirement home; and

(3) make recommendations to the Inspector General of the Department of Defense regarding issues that the Inspector General should investigate.

According to section 416(c)(3), title 24, United States Code (24 U.S.C. § 416(c)(3) [2012]), the Advisory Council was required to have at least 15 members. Each member must be a full or part-time Federal employee or a member of the Armed Forces. Members are also required to be either: (1) designated by the Secretary of Defense, or (2) in consultation with the Secretary of Defense, designated by the head of the Federal department or agency that employed the individual. The Advisory Council must allow participation by representatives of the RAC from each AFRH facility. From among the members of the Advisory Council, the Secretary of Defense was required to select a Chairperson to lead meetings for the AFRH Advisory Council. In addition, the Administrator of each facility was required to act as a nonvoting member of the Advisory Council.

With a few exceptions, Advisory Council members are required to serve a maximum of 2 years, unless the Secretary of Defense terminates the member before the expiration of their term or designates a member to serve an additional term. A member could serve on the Advisory Council for as long as they remained in a position that required them to provide service as a member of the Advisory Council. In addition, unless terminated by the Secretary of Defense, a member can remain in their position on the Advisory Council past his or her expiration date until a successor is designated.

A member of the Advisory Council must be provided a stipend consistent with the daily Government consultant fee and travel expenses, unless he or she is a member of the Armed Forces on active duty or a full-time officer/employee of the United States.

At the time of the DoD IG inspection, the AFRH Advisory Council consisted of 21 members, (including the Administrators and RAC Chairpersons from both facilities), satisfying the provisions of 24 U.S.C. § 416(c)(3) (2012). Of the 21 current members, the Secretary of Defense appointed 14 Advisory Council members, who all satisfied the qualification requirements of 24 U.S.C. § 416(c)(3)(2012). In addition, three representatives from DHA held membership on the AFRH Advisory Council:

- the Deputy Director of DHA,
- the DHA Executive Officer, and
- the DHA Chief of Clinical Quality.

However, AFRH had not satisfied the requirements of 24 U.S.C. § 416(c)(3) (2012) in filling all mandatory positions. The senior representative of the Chief Personnel Officer of the Armed Forces member position remained vacant and had been since at least May 2011. The Advisory Council, according to the AFRH COO, had not filled the Chief Personnel Officer position because [the Council] had not found anyone to fill the function of the position, which required a specific skill set.

According to the AFRH COO, because all of the Advisory Council members were military service members, they did not receive salaries, but were compensated with travel reimbursements. These actions complied with the provisions set forth in section 416(f)(1), title 24, United States Code (24 U.S.C. § 416(f)(1) [2012]).

The Advisory Council, according to the AFRH COO, advised him on issues concerning the retirement home, with the exception of issues pertaining to investments.

Armed Forces Retirement Home Senior Medical Advisor

In accordance with section 413a(a)(1), title 24, United States Code (24 U.S.C. § 413a(a) (1) [2012]), the Secretary of Defense appointed the Deputy Director of DHA to serve as AFRH SMA. The current SMA took over the position of Deputy Director of DHA and assumed the role of SMA during October 2011.

The SMA's primary responsibility was to provide advice to the Secretary of Defense, USD (P&R), the AFRH COO, and the AFRH Advisory Council on issues concerning the direction and oversight of:

(1) medical administrative matters at each facility of the retirement home, and

(2) the provision of medical care, preventive mental health, and dental care services at each facility of the retirement home.

Specifically, section 413a(c), title 24, United States Code (24 U.S.C. § 413a(c) [2012]) required the SMA to:

(1) ensure the timely availability of acute medical, mental health, and dental care to residents not offered by the facilities of the retirement home;

(2) ensure AFRH compliance with current accreditation standards or any applicable healthcare standards and requirements, including requirements identified in the DoD IG inspection reports;

(3) periodically visit each AFRH facility to review:

   a. medical facilities, operations, records, and reports,

   b. quality of care provided to residents,

   c. inspections and audits to ensure that appropriate corrective actions have occurred; and

(4) report on findings and recommendations developed as a result of each review conducted under paragraph (3) to the COO, the Advisory Council and the USD(P&R.)

In preparation for this inspection, the DoD IG Inspection Team conducted a background and inspection intent briefing with the current SMA on June 13, 2012. During the meeting, the DoD IG Inspection Team advised the SMA on issues/areas to be inspected and addressed items to be clarified and/or included in the inspection.

On October 11, 2012, the DoD IG Inspection Team conducted an interview with the SMA to assess compliance with requirements of 24 U.S.C. § 413a (2012), specifically related to delegated responsibilities and duties. The DoD IG Inspection Team also interviewed the AFRH COO to assess the SMA's interaction with the AFRH COO.

Observations

The DoD IG Inspection Team's observations about AFRH Senior Management were based on interviewing key personnel and the following additional factors:

(a) assessment of AFRH medical operations by the DoD IG Inspection Team medical inspectors (Part A of this report),

(b) follow-up inquiries by the DoD IG Inspection Team HR inspector (Part B of this report),

(c) feedback from employee sensing sessions and on-site DoD IG confidential feedback sessions (Part M and Part N of this report),

(d) communication with the BPD, and

(e) follow-up inquiries by the DoD IG Inspection Team financial inspectors.

Please refer to the Part A, Part B, Part M, and Part N of this report for detailed discussions on various issues that relate to the performance of the Senior Management of AFRH.

The DoD IG Inspection Team identified multiple deficiencies in the management of AFRH, particularly in the area of medical operations (Part A). These deficiencies include, but are not limited to:

- lack of clear guidance, directives, SOPs at all levels of AFRH,
- lack of competent personnel,
- lack of disciplinary actions,
- lack of employee-oriented programs,
- lack of compliant SOPs and directives, and
- lack of detailed guidance from the OUSD (P&R) to the AFRH SMA and the AFRH COO.

All these deficiencies were interrelated and impacted each other, most notably with respect to the quality of medical care and medical operations. Major observations and corresponding recommendations are listed below.

Observation 50

DoD Instruction 1000.28 is Out of Date

DoD Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010, did not address the amendments to the AFRH Act of 1991 introduced by Public Law 112-81.

This occurred because USD (P&R) did not incorporate the latest changes in the law into the DoD Instruction 1000.28.

This resulted in confusion and non-compliance with Public Law 112-81, both for DoD and the AFRH.

Discussion

DoD Instruction 1000.28 was issued prior to the amendments to the AFRH Act of 1991, by Public Law 112-81. There were specific items in the DoD Instruction 1000.28 which differed from the latest version of the law. There were also specific new requirements in the law, which were not included in the DoD Instruction 1000.28. In addition, items in the existing DoD Instruction 1000.28 that referred directly to Chapter 10, title 24, United States Code (24 U.S.C. [2012]) or specific section(s) of 24 U.S.C. Chapter 10 (Sub-Chapter I), without reference to amendments by Public Law 112-81, could lead to confusion or to conflicting guidance because 24 U.S.C. Chapter 10 (Sub-Chapter I) had not been officially updated to codify the amendments by Public Law 112-81.

In addition, the following new article, 24 U.S.C. § 411 (d)(3) (2012), created by the Public Law 112-81 amendments to the AFRH Act of 1991, states that:

> The administration of the Retirement Home, including administration for the provision of healthcare and medical care for residents, shall remain under the control and administration of the Secretary of Defense.

DoD Instruction 1000.28 did not reflect this important change that emphasized control of AFRH's healthcare and medical operations by the Secretary of Defense. At the time of the inspection, the DoD IG Inspection Team did not see evidence of any actions by the OUSD (P&R) to increase the degree of control by the Secretary of Defense, particularly in the area of medical operations. OUSD (P&R) should have identified DoD policies, regulations, and guidance that are applicable to AFRH operations and should have required AFRH to follow those policies, regulations, and guidance as recommended in the 2010 DoD IG Inspection report (Recommendation #A-6, on page 16).

In a related area, the USD (P&R) and the Deputy Director of DHA (SMA to AFRH) did not comply with 24 U.S.C. § (c)(2) (2012), which stated that, in carrying out the responsibilities set forth in subsection (b), the Senior Medical Advisor shall:

> Ensure compliance by the facilities of the Retirement Home with accreditation standards, applicable healthcare standards of the Department of Veterans Affairs (VA), or any other applicable healthcare standards and requirements (including requirements identified in applicable reports of the Inspector General of the Department of Defense).

The OUSD (P&R) should have required AFRH to follow the VA/DoD CPGs and healthcare standards of the VA, as they would have significantly improved the medical care at the AFRH facilities.

In several instances, the existing DoD Instruction 1000.28 referred to Local Boards of Trustees (one for each of the AFRH facilities) and, in section 5 of enclosure 2, provided detailed information about the features of the Local Boards of Trustees, although Public Law 112-81 amendments replaced the two Local Boards of Trustees with a single AFRH Advisory Council.

Duties of the SMA and requirements for the DoD IG inspection also were changed by Public Law 112-81 amendments to AFRH Act of 1991. Specifics provided in the DoD Instruction 1000.28 contradicted certain requirements in the amended AFRH Act. In addition to eliminating the Deputy Director positions at the AFRH facilities and changing the Associate Director position to the Ombudsman position, Public Law 112-81 amendments also added the following new paragraph (2) of 24 U.S.C. 417, re-designated subsection (e):

> The Ombudsman may provide information to the Administrator, the Chief Operating Officer, the Senior Medical Advisor, the Inspector General of the Department of Defense, and the Under Secretary of Defense for Personnel and Readiness.

In addition to these important changes, there were other amendments to the AFRH Act of 1991 introduced by Public Law 112-81 which needed to be incorporated into an updated version of DoD Instruction 1000.28.

Recommendations, Management Comments, and Our Response

Recommendation 50

Under Secretary of Defense for Personnel and Readiness, update the Department of Defense Instruction 1000.28 to incorporate the Public Law 112-81 amendments to the Armed Forces Retirement Home Act.

USD (P&R) Comments

USD (P&R concurred, commenting that DoD Instruction 1000.28 has been revised, coordinated within USD (P&R), and is in the issuance process for final edits and formal coordination.

Our Response

Management's comments were responsive. We ask that USD (P&R) provide a copy of the draft DoD Instruction 1000.28 to us in response to the final report.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Observation 51

Hiring of Insufficiently Competent Personnel

As explained in the Medical section observations, a number of senior personnel at the AFRH Agency and AFRH-W, mostly in the medical operations and performance improvement areas, were insufficiently competent to run the medical operations and to develop and implement meaningful PI programs. In addition, during the August 2012 inspection, the DoD IG Inspection Team was notified by the CHS at the Washington facility that two supervisory nursing positions at the AFRH-W facility were vacant.

A contributing factor was that AFRH management did not open the vacancy announcements to external candidates. There were indications that, in two cases, no vacancy was announced before an internal candidate was promoted into the vacant position. In some instances of internal announcement, there was reportedly only one candidate for the position. Additionally, the salary reportedly offered by AFRH management was not sufficient to attract the candidates with the required qualifications and competency.

This contributed to reduced quality of medical services, particularly for the residents of the AL unit and the LTC unit (includes the Dementia unit) in the AFRH-W facility.

Discussion

Based on the observations of the DoD IG Inspection Team's medical inspectors, a number of senior medical personnel were determined to be insufficiently competent for their positions. (See Observation 7 in the Medical section.)

Marginally competent senior medical leadership and nursing staff were contributing to low quality of overall medical care. The situation worsened at the AFRH-W facility after the DoD IG Inspection Team's August 2012 field work as a result of disciplinary action recommended by BPD for a number of nursing staff and a medical officer for "patient neglect (failure to meet standards of care)." The BPD recommendations included:

- termination of 3 LPNs,
- 14 to 30 days suspension of 21 LPNs and CNAs, and
- a 14-day suspension of one medical officer. (At AFRH-W there was one other Medical Officer beside the CMO, two Nurse Practitioners, one Podiatrist, and one Optometrist (P/T).)

If these disciplinary actions are implemented, AFRH-W facility will have even fewer nursing staff to provide the necessary care to the residents. In addition, the DON at AFRH-W, who was quite competent and qualified (as per the DoD IG Inspection Team medical inspectors), resigned in January 2013 due to frustration over the situation at the facility. As a result, the CHS was having difficulty managing the healthcare services effectively.

Recommendations, Management Comments, and Our Response

Recommendation 51

Armed Forces Retirement Home Chief Operating Officer:

a. Offer market salary to attract highly qualified healthcare personnel, from both internal and external sources, to create competent senior medical leadership at the AFRH Agency and Armed Forces Retirement Home-Washington, D.C., and to fill vacant nursing supervisory positions.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that AFRH is governed by Title 5 and OPM. As such, all salaries are set by the GS Pay Tables published annually by OPM. The AFRH will continue to hire competent senior medical leadership within Title 5 OPM guidelines and dictated salaries. As supervisory positions become vacant, AFRH will place priority on hiring these positions within Title 5 OPM guidelines and salaries.

Our Response

Although AFRH Management concurred with the recommendation, the actions described may not meet intent of the recommendation. The intent of the recommendation was that management should discontinue the practice of offering the lowest allowable (by OPM) step within a GS grade for key health service positions when making a job offer to a chosen applicant. Although this may be in compliance with OPM guidelines, the ultimate outcome is detrimental to the AFRH residents because it is difficult to get highly qualified health care service personnel at the lowest allowable step-level for these positions. The AFRH COO has the authority to offer a higher step to attract highly qualified healthcare personnel. Management should also consider the options offered by:

Title 38 Physician and Dentist Pay (PDP)
This provides a hybrid pay authority intended to recruit and retain highly qualified physicians and dentists by providing a mechanism to compensate them at levels comparable to private sector physicians and dentists within the same locality.

Title 38 Nurses and Allied Health Professionals
This provides higher base pay scales authorized for nurses and allied health professionals when necessary to address documented recruitment/ retention problems and to provide rates that are competitive with the relevant labor market.

Management should continue to advertise these positions to external candidates through various means, such as USAJobs and professional magazines/newspapers. The positions should be open to all U.S. citizens. We will look at this area again in our next inspection.

b. Implement effective professional development programs for the current senior medical personnel to rapidly improve their medical knowledge and administrative competency. Replace those who fail to meet the required knowledge and competency after the completion of these programs.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, reporting that the recommendation was complete. He stated that the DoD IG Inspection Team's inference that some senior medical personnel at the AFRH were insufficiently or marginally competent was demeaning to the professional qualifications and integrity of these professionals. He also stated that the AFRH will continue to conduct professional development programs and promote growth for employees. The dedicated senior medical professionals of AFRH are considered competent and qualified to perform the duties of their position.

Our Response

Although AFRH Management concurred with the recommendation, we are not certain they understood the intent of the recommendation. Our medical inspectors interviewed the AFRH senior medical personnel, in addition to reviewing all their credentials (see Observation 7). We note that credentials and certificates do not guarantee that a healthcare professional will be able to run a complex program effectively and efficiently unless the professional also has a sound footing in administrative/leadership skills. Senior healthcare professionals must continuously seek to expand their professional and leadership capabilities to keep abreast of the rapidly expanding sphere of knowledge and technology in the area of healthcare. Based on interviews with senior AFRH healthcare professionals and document review, DoD IG medical inspectors determined that this was not occurring with regard to senior healthcare professionals at the agency and AFRH-W. We note that DoD IG medical inspectors developed a positive conclusion about the Gulfport healthcare leadership. While we still believe our observations in this area are valid and supportable, we accept management's analysis of the risk associated with their analysis of the capabilities of their senior medical personnel. No further action is required at this time.

Observation 52

Senior Medical Advisor Lacked Clear Authority and Responsibility to Effectively Address Medical Operations Issues at the Armed Forces Retirement Home

The SMA was not aware of a number of significant medical operational issues at AFRH and lacked the authority to decisively intervene in AFRH management decisions related to medical operations.

This occurred because DoD Instruction 1000.28 did not give the SMA the authority to go beyond an advisory role, and the SMA did not perform an in-depth inspection of the AFRH medical operations.

This has contributed to less than optimal medical care at the AFRH.

Discussion

While the SMA was doing an excellent job arranging off-campus medical services for the residents by partnering with external organizations, he was not aware of many important medical issues at the AFRH. Also, the USD (P&R), through DoD Instruction 1000.28, did not give the SMA clear authority to prevent/correct problems of which the SMA was aware. Examples of issues requiring the USD (P&R) and SMA attention were:

- the hiring of medical leadership-level personnel on the basis of length of tenure at, and loyalty to, the AFRH, instead of opening the position to external candidates;
- vacant key supervisory nursing positions and marginally competent nursing staff at the certified nursing assistant level;
- lack of necessary training for supervisory-level medical personnel to keep them current on medical administrative standards;
- frustrated nursing management and nursing staff at the AFRH-W facility; and
- cases of serious negligent care of residents.

The recent SMA was unaware of Recommendation I-2 in the 2010 DoD IG Inspection report that required the SMA's direct involvement in selecting an accrediting organization to supplement CARF accreditation. Although the USD (P&R) in its February 18, 2010, management comments stated that "the SMA [was] ... reviewing this recommendation," the former SMA did not respond, in writing, to the DoD IG addressing the intent of the recommendation. Due to the nature of the advisory role to the AFRH (an additional duty for the Deputy Director of DHA), medical operations at AFRH were not getting the necessary oversight by the SMA's office.

Section 411(d)(1), United States Code, states that the COO of the AFRH is the head of the retirement home, and subject to the authority, direction, and control of the Secretary of Defense. Also, 24 U.S.C. § 411(d)(3) (2012) states that AFRH Administration, including providing healthcare and medical care for residents, shall remain under the control and administration of the Secretary of Defense.

However, the USD (P&R), in DoD Instruction 1000.28, did not give the SMA sufficient authority and responsibility for oversight of medical operations at the AFRH facilities.

Current medical leadership at AFRH was inadequate, contributing to poor healthcare services, frustrated nursing management, as well as insufficiently competent lower-level nursing staff. There was a high-risk of "failure to meet standards of care" for the residents, as evidenced by the oral care negligence case, and from other complaints from the residents about alleged negligence by CNAs (see On-Site DoD IG On-site Confidential Feedback Sessions section).

DoD Instruction 1000.28 needs to be revised to assign the SMA continuous oversight responsibilities for the medical operations of the AFRH facilities. The revision should include the following responsibilities:

- The SMA shall provide sufficient oversight of the medical operations of the AFRH to quickly identify problems with the staff and their services to the residents.
- The SMA shall play an active role to ensure that the medical leadership at the AFRH (Agency Medical Director, facility CMOs, PI Directors, facility CHS, and facility DONs) is selected in a timely manner, on the basis of qualification and demonstrated competency, rather than length of past affiliation with AFRH (see Observation 7).

- The SMA shall ensure that the facilities have an adequate number of qualified and competent (including physical fitness) nursing staff who are capable of performing their assigned duties.
- The SMA shall notify the USD (P&R) when the SMA has a disagreement with the AFRH COO over management issues affecting medical care at the AFRH facilities.

Recommendations, Management Comments, and Our Response

Recommendation 52

Under Secretary of Defense for Personnel and Readiness, under the authority given to the Secretary of Defense in section 411(d)(3), title 24, United States Code, issue a directive-type memorandum for immediate action, followed by a revision of Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," dated February 1, 2010, to provide the Senior Medical Advisor appropriate authority and responsibility for the continuous oversight of medical operations of the Armed Forces Retirement Home to ensure appropriate medical care is provided to the residents.

Management Comments

USD (P&R) non-concurred, noting that statutory language establishes the SMA requirements, stating that the SMA shall provide advice to the Secretary of Defense, the USD (P&R), the AFRH COO, and the Advisory Council regarding the direction and oversight of medical administrative matters, and provision of medical, and dental care services. The SMA has no authority over the AFRH. Moreover, there is no need for additional guidance as 24 U.S.C. § 413a(c)(2) states that the SMA shall "...ensure compliance by the facilities of the AFRH with accreditation standards, applicable health care standards of the Department of Veterans Affairs, or any other health care standards and requirements (including requirements identified in applicable reports of the Inspector General of the Department of Defense."

Our Response

After evaluating management's response and noting that USD (P&R) had approved an AFRH oversight plan developed by the SMA, as reported in the response to Recommendation 6.a(2), we determined management's proposed alternative course of action to be responsive, notwithstanding their non-concurrence. No further action is required.

Observation 53

Lack of Detailed Guidance from Under Secretary of Defense for Personnel and Readiness Regarding Applicable Department of Defense Policies and Standards

The DoD IG Inspection Team observed that the AFRH was following policies and standards drawn from multiple Government and private sector sources, even when DoD policies and standards (including applicable VA healthcare standards) are more appropriate for AFRH.

This happened because the USD (P&R) did not identify the specific DoD policies, procedures, and guidelines (including applicable VA healthcare standards) that were appropriate for AFRH, and did not direct AFRH to follow them.

In some areas, including the medical section, this resulted in standards drawn from multiple sources that did not contain sufficient rigor in the quality of care provided and often would not meet corresponding applicable DoD and VA healthcare standards.

Discussion

Section 411, title 24, United States Code (24 U.S.C. § 411 [2012]) states that:

> The administration of the Retirement Home, including administration for the provision of healthcare and medical care for residents, shall remain under the control and administration of the Secretary of Defense.

Also, 24 U.S.C. § 413a(c)(2) (2012), states that, in carrying out the responsibilities set forth in subsection (b), the SMA shall:

> Ensure compliance by the facilities of the Retirement Home with accreditation standards, applicable healthcare standards of the Department of Veterans Affairs, or any other applicable healthcare standards and requirements (including requirements identified in applicable reports of the Inspector General of the Department of Defense).

However, the USD (P&R) did not direct the AFRH to follow applicable DoD instructions and regulations or to implement existing evidence-based clinical practice guidelines, such as the VA/DoD CPG.[61]

Additionally, the 2010 DoD IG Inspection report (Recommendation No. A-7) recommended that the USD (P&R) promulgate all DoD guidance deemed applicable to AFRH. This did not occur as the USD (P&R) declined to identify DoD instructions and regulations applicable to the AFRH, citing DoD Instruction 1000.28, titled "Armed Forces Retirement Home (AFRH)," February 1, 2010, paragraph 4.b, which states, "The AFRH is not part of the Department of Defense and is not subject to DoD policy and issuances except when expressly made applicable to the AFRH." This USD (P&R) position missed the intent of the recommendation in that the USD (P&R) was supposed to identify the applicable DoD policy and issuances and expressly direct AFRH to follow them. Failure to implement the recommendation in the 2010 DoD IG Inspection report was a significant contributing factor in the currently identified issues.

Also, 24 U.S.C. § 413 (c)(2) (2012), as amended by Public Law 112-81, specifies use of applicable VA healthcare standards. It should be noted that, as per the DoD IG Inspection Team medical inspectors, VA healthcare standards are more stringent than the national health standards and are more applicable to AFRH. DoD IG Inspection Team medical inspectors concluded that, in order to improve the quality of healthcare at AFRH, applicable VA healthcare standards should be strictly followed. Not applying applicable VA healthcare standards will be detrimental to the quality of medical care at AFRH.

Recommendations, Management Comments, and Our Response

Revised Recommendation 53.a

Under Secretary of Defense for Personnel and Readiness:

a. Under the authority given to the Secretary of Defense in section 411(d)(3), title 24, United States Code, determine what standards the Armed Forces Retirement Home is following in areas other than medical and determine whether those standards are appropriate for the Armed Forces Retirement Home.

[61] VA/DoD Clinical Practice Guidelines available on the Web http://www.healthquality.va.gov/

USD (P&R) Comments

USD (P&R) non-concurred with the original recommendation in the draft report, which stated "…issue a directive-type memorandum for immediate action, (followed by a revision of Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010) to identify Department of Defense instructions, directives, and regulations that could be applicable to the AFRH, in all areas of operation, and direct AFRH COO to implement them." USD (P&R) stated that requiring AFRH to follow DoD/VA instructions/directives/ standards for which they have no input to the content would create risk for noncompliance with nationally recognized medical standards focused on the population and organization of the AFRH.

Our Response

Based on these and previous USD (P&R) management comments stating that AFRH would follow national medical standards/guidelines, and Paragraph d (3) of the amended 24 U.S.C. § 411 (2012), stating that "The administration of the Retirement Home, including administration for the provision of health care and medical care for residents, shall remain under the control and administration of the Secretary of Defense," we revised the recommendation to read as written above. We ask that the USD (P&R) respond/comment on this revised recommendation in response to the final report.

Revised Recommendation 53.b

b. Under the authority given to the Secretary of Defense in section 411(d)(3), title 24, United States Code, issue a directive-type memorandum for immediate action (followed by a revision of Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010) to codify the results from recommendation 53.a.

USD (P&R) Comments

USD (P&R) non-concurred with the original recommendation in the draft report, which stated "…issue a directive-type memorandum for immediate action, (followed by a revision of Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010) to identify other Guidance (such as applicable Department of Veterans Affairs or Military Service guidelines and standards) where Department of Defense policy is not specific enough or

appropriate for the Armed Forces Retirement Home. Require the Armed forces Retirement Home to follow/implement such guidance." USD (P&R) stated that requiring AFRH to follow DoD/VA instructions/directives/standards for which they have no input to the content would create risk for noncompliance with national recognized medical standards focused on the population and organization of the AFRH.

Our Response

Based on management comments, we revised the recommendation to read as written above. We ask that the USD (P&R) respond/comment on this revised recommendation in response to the final report.

Observation 54

Organizational Climate – Fear of Reprisal

A number of AFRH employees, including some senior officials, expressed concerns about the quality of the work environment and fear of management reprisal. They also complained about supposedly inappropriate intervention by the AFRH COO in hiring decisions, for example, not allowing the AFRH-W Administrator and the AFRH-W CHS to make the hiring decisions to fill vacant positions.

This occurred because some employees had experienced management actions that they perceived as reprisal and inappropriate intervention. Also, some employees perceived the management environment at AFRH to be unsupportive of some senior officials, such as the Facility Administrator and CHS.

As a result, AFRH had developed an unacceptable organizational management climate and personnel relations problem, particularly at AFRH Agency and AFRH-W.

Discussion

The DoD IG Inspection Team received significant negative feedback through employee sensing sessions, on-site DoD IG confidential feedback sessions, on-site interviews, and follow-up communications with senior AFRH officials.

A number of employees (mostly AFRH-W facility nursing staff) expressed their frustrations about the working environment and management's treatment of lower-level staff. Employees stated that they had seen cases of past reprisal against employees who tried to voice opinions critical of management. According to them, bringing the grievances to the attention of upper management did not resolve the problems. Employees were allegedly afraid to express their feelings and opinions about the decisions of upper management, especially regarding the quality of medical care. As a result, employee morale was quite low, particularly among the AFRH-W facility nursing staff and their supervisors. Some AFRH officials also reported concern about what they perceived as upper management's excessive and inappropriate intervention in the hiring process and other decision making processes.

Recommendations, Management Comments, and Our Response

Recommendation 54

Armed Forces Retirement Home Chief Operating Officer:

a. Establish an open door policy and host town hall meetings to learn about the concerns of employees. Acknowledge, record, and respond to grievances and suggestions from the employees.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but provided no further comments.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

b. Keep the employees informed of all the corrective actions taken as a result of investigations into past cases of reprisal, unless privacy laws prohibit such communications.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but provided no further comments.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

c. Share with all the employees, particularly the lower-level staff, the FedView survey results and subsequent actions taken to improve the working conditions and organizational climate.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, but provided no further comments.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

Observation 55

Current Chief Operating Officer Also Effectively Holding the Combined Position of Deputy Chief Operating Officer/Chief Financial Officer

The combined Deputy COO/CFO position had been vacant for more than a year, with the current COO performing those duties.

This has occurred because the current COO had held the combined Deputy COO/CFO position previously and, after becoming the AFRH COO, he did not believe that filling the combined Deputy COO/CFO position was a priority.

Consequently, some AFRH employees perceived this concentrated too much authority in a single individual.

Discussion

The current COO was the AFRH CFO for more than 5 years – from October 2002 to March 2008. For approximately 6 months, he left to work for another independent organization and then returned to AFRH in September 2008, in the newly created combined position of Deputy COO/CFO. Appointed as the COO in September 2011, the current COO had been also effectively holding the combined position of Deputy COO/CFO for more than a year. In addition to being a weak management control practice, this fueled a perception of too much authority in a single individual.

Some functional chiefs have complained that their professional opinions often do not get due consideration because of too much authority vested in the top executive. They also complained that external consultants are brought in to support the position of the COO. In one case, the external consultant was perceived as not qualified to perform the assigned assessment tasks related to nursing shift duration.

This appeared to be an unacceptable management control practice for a Government organization because of the lack of checks and balances. It is necessary to have a CFO who can have opinions independent of the COO about important financial issues and procedures.

Furthermore, since there was no Deputy COO at AFRH, it was unclear which position or person was identified, trained, and prepared to immediately take over the administration of the agency in the event of sudden absence and/or sudden departure of the COO. Hiring of a new Deputy COO/CFO (combined position) will reduce the concentration of authority in a single person, create a line of succession in case of emergencies, and could create a more favorable work environment.

Recommendations, Management Comments, and Our Response

Recommendation 55

Armed Forces Retirement Home Chief Operating Officer, expeditiously fill the vacant position of the Deputy Chief Operating Officer/Chief Financial Officer (combined position) with a highly qualified and competent candidate.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that the U.S. Army Force Management Support Agency (USAFMSA) Manpower and Organizational analysis recommended elimination of the Deputy COO/CFO position, but supported a CFO position. A highly qualified and competent CFO has been hired.

Our Response

Management comments were responsive. No further action required.

Observation 56

Lack of Support for Employee-Oriented Programs

The lower-level staff, particularly the nursing assistants at the AFRH-W facility, expressed their frustrations about the lack of support from management for professional recognition, development, and career advancement among other concerns identified. Work schedule inflexibility was also cited as an issue.

This happened because AFRH management had not developed or implemented an effective professional development program and employee recognition program.

This contributed to frustration and low morale among the staff, particularly the lower-level nursing assistant staff at the AFRH-W.

Discussion

During employee sensing sessions and subsequent on-site DoD IG confidential feedback sessions, the nursing staff at the AFRH-W stated that they lacked adequate support from the administration for their professional development. According to staff members, there were little to no employee-oriented programs to assist them in advancing their careers. Lack of flexible work schedule was another highlighted issue.

Details from the AFRH management off-site meeting minutes of August 2012, indicated that the following employee-oriented programs were in the early stage of planning at the time of DoD IG inspection:

- tuition assistance plan;
- basic computer skills training;
- assessment of individual training needs;
- training budget;
- flexible schedule opportunity;
- staff wellness program;
- awards and recognition program; and
- availability of meals for staff working extra hours on short notice.

Recommendations

Recommendation 56

Armed Forces Retirement Home Chief Operating Officer, expedite the development and implementation of an effective professional development/ employee recognition program and an employee morale and welfare program (including the items identified above), with a priority on lower-level employees.

Armed Forces Retirement Home Chief Operating Officer Comments

The AFRH COO concurred, commenting that AFRH has established a team to review education and tuition assistance programs for all employees. Subsidized Toastmasters classes has been offered to employees who wish to attend on the campus. The Toastmasters Program was a joint program with employees and residents. The current Incentive Awards program has been implemented at both campuses. Employee of the Quarter and Employee of the Year awards have been established and implemented. Planning for guest speakers on topics of interest to staff is in development.

Our Response

Management's comments were responsive. We will request an update on progress at a later date.

Observation 57

Creation of the Agency-Level Ombudsman Position

The AFRH COO created an agency-level Ombudsman position, even though it is not legislatively mandated.

The agency-level position was created because the AFRH COO believed that there was a need at the agency level to coordinate resident complaints that were not resolved at the facility level by the facility Ombudsmen.

This newly proposed GS-14 level position will be consuming funds that are badly needed to hire competent medical and nursing personnel.

Discussion

During the DoD IG Inspection Team's interview of the AFRH-W Ombudsman, the DoD IG Inspection Team was informed that he was also performing the duties of Acting AFRH Agency Ombudsman. At the time of the inspection, a PD was prepared for the AFRH Agency Ombudsman, but the position was not advertised.

The DoD IG Inspection Team has concerns about the creation of the agency-level Ombudsman position at a time when the AFRH was not willing to offer the market salary to external qualified medical and nursing candidates. The DoD IG Inspection Team found the AFRH medical and nursing leadership at the AFRH Agency and AFRH-W to be inadequate (See Observation I.7), many of the nursing staff were marginally competent, and a number of nursing supervisory positions were vacant for a significant length of time. Any available funds should be first utilized to hire competent medical and nursing personnel by offering the market salary, instead of hiring an agency-level Ombudsman.

In addition, there are no residents at the agency level and hence no serious need for an Ombudsman at the agency level. During the on-site inspections and subsequent review of resident complaint logs, the DoD IG Inspection Team found that the two Ombudsmen at the two AFRH facilities were addressing the concerns of the residents in a timely manner.

The DoD IG Inspection Team has no objection if the current Ombudsman for AFRH-W is also assigned as the lead Ombudsman for handling common issues with the AFRH COO. However, the DoD IG Inspection Team feels that there are very few common issues involving residents at the two facilities that need to be handled by someone beyond the facility Ombudsman. Additionally, the AFRH has an IG at the agency level.

Recommendations

Recommendation 57

Armed Forces Retirement Home Chief Operating Officer, cancel and do not fill the proposed agency-level Ombudsman position and utilize the funds towards improving the quality of the medical and nursing care by offering market salary to competent external candidates.

AFRH Comments

The AFRH COO non-concurred. He stated that the Ombudsman position was validated by the USAFMSA Manpower and Organizational Review.

Our Response

We note that the USD (P&R) report on the "Armed Forces Retirement Home Review Board, April 2013, states in the first bullet in the Results section of the Human Resources Section (page 10): "A new Corporate-level Ombudsman is vacant and is being recruited. The Ombudsman's duties are focused on resident interaction. This position was not recommended by the USAFMSA manpower study. With the existence of a campus-level Ombudsman, there appears to be limited value for a corporate-level Ombudsman." We note the difference between what AFRH management has said (approved) and what USD (P&R) reported (not recommended) about the Ombudsman position. In response to the final report, we ask that the AFRH COO, in coordination with USD (P&R), clarify what USAFMSA recommended about the corporate-level Ombudsman position.

Appendix A

Scope and Methodology

We conducted this assessment from May 15, 2012 to December 16, 2013 in accordance with Quality Standards for Inspection and Evaluation. We planned and performed the assessment to obtain sufficient and appropriate evidence to provide a reasonable basis for our observations, conclusions, and recommendations based on our objectives. Site visits to the AFRH facilities in Washington, D.C. and Gulfport, Mississippi were conducted from August 27, 2012 to August 31, 2012 and September 10, 2012 to September 14, 2012, respectively.

We reviewed documents such as Federal laws and regulations, including:

- Subtitle F, Title 5, Public Law 112-81, "National Defense Authorization Act for FY 2012," December 11, 2012,
- Section 411-424, Chapter 10, title 24, United States Code; as amended,
- Department of Defense Instruction 1000.28 "Armed Forces Retirement Home," February 1, 2010,
- all applicable AFRH Agency directives and associated regulations, Standard Operating Procedures (SOPs) of the agency and the facilities, and other locally developed implementing guidelines,
- Section 3512, title 31, United States Code; "Executive agency accounting and other financial management reports and plans,"
- Title 5, United States Code,
- Title III, Public Law 107-347, E Government Act 2002 (aka title 48, United States Code of Federal Regulations)
    - National Institute of Standards and Technology, Special Publications 800-53, Revision 3,
- Section 3541, title 44, United States Code, Federal Information Security Management Act of 2002 as amended,
- Department of Defense Instruction 1332.18,
- DoD Instruction, 8500.1, 8500.2,

- Office of Management and Budget Circular A-123, December 21, 2004,
- Army regulations, and
- VA/DOD CPGs.

The purpose of this project was to conduct a comprehensive inspection of all aspects of each facility of the AFRH to determine compliance with applicable laws and regulations as per the requirements of the Section 1518 of the Armed Forces Retirement Home Act of 1991, as amended by Section 566, Public Law 112-81, "National Defense Authorization Act for FY 2012."

The following areas were within the scope of this project:

- elements of Long Term care including: medical, nursing, dental, pharmacy, independent living operations,
- Senior Management including the overall administration and management of the AFRH,
- Human Resources Management,
- Financial Management,
- AFRH IG,
- Admissions and Eligibility,
- Facilities Engineering and Safety,
- IA,
- Resident Recreation Services,
- Contracts Management,
- Security,
- Estate Matters and Disposition of Effects,
- responses derived from employee sensing sessions and confidential feedback sessions, and
- responses/actions taken on previous inspection recommendations.

The following areas were outside the scope of this project:

- The Voting Program, included in the 2009 DoD IG AFRH inspection.

We visited or contacted:

- Tricare Management Activity, Arlington, Virginia,
- Armed Forces Retirement Home, Washington, D.C.,
- Armed Forces Retirement Home, Gulfport, Mississippi,
- Department of Treasury, Bureau of Public Debt, Parkersburg, West Virginia, and
- National Business Center, Herndon-Reston, Virginia.

The DoD IG Inspection team chronology was:

May – August 2012 ..... Research

August – September 2012 ..... Fieldwork

October – December 15, 2014 ..... Analysis and report writing

December 16, 2013 ..... Draft assessment report issued

April 25 – June 20, 2014 ..... Management comments received and evaluated

July 23, 2014 ..... Final Report Issued

Limitations

We had no limitations in our review of the operations of the AFRH and its governing statutes and organizations.

Use of Computer-Processed Data

We did not use computer-processed data to perform this assessment.

Use of Technical Assistance

We received assistance from the Technical Assessment Division (TAD). Personnel from the TAD provided us with technical expertise that allowed us to conduct the inspection of AFRH's IT and security system(s), and the safety of each AFRH facility and assess AFRH's compliance with Federal and industry standards and regulations.

Prior Coverage

GAO

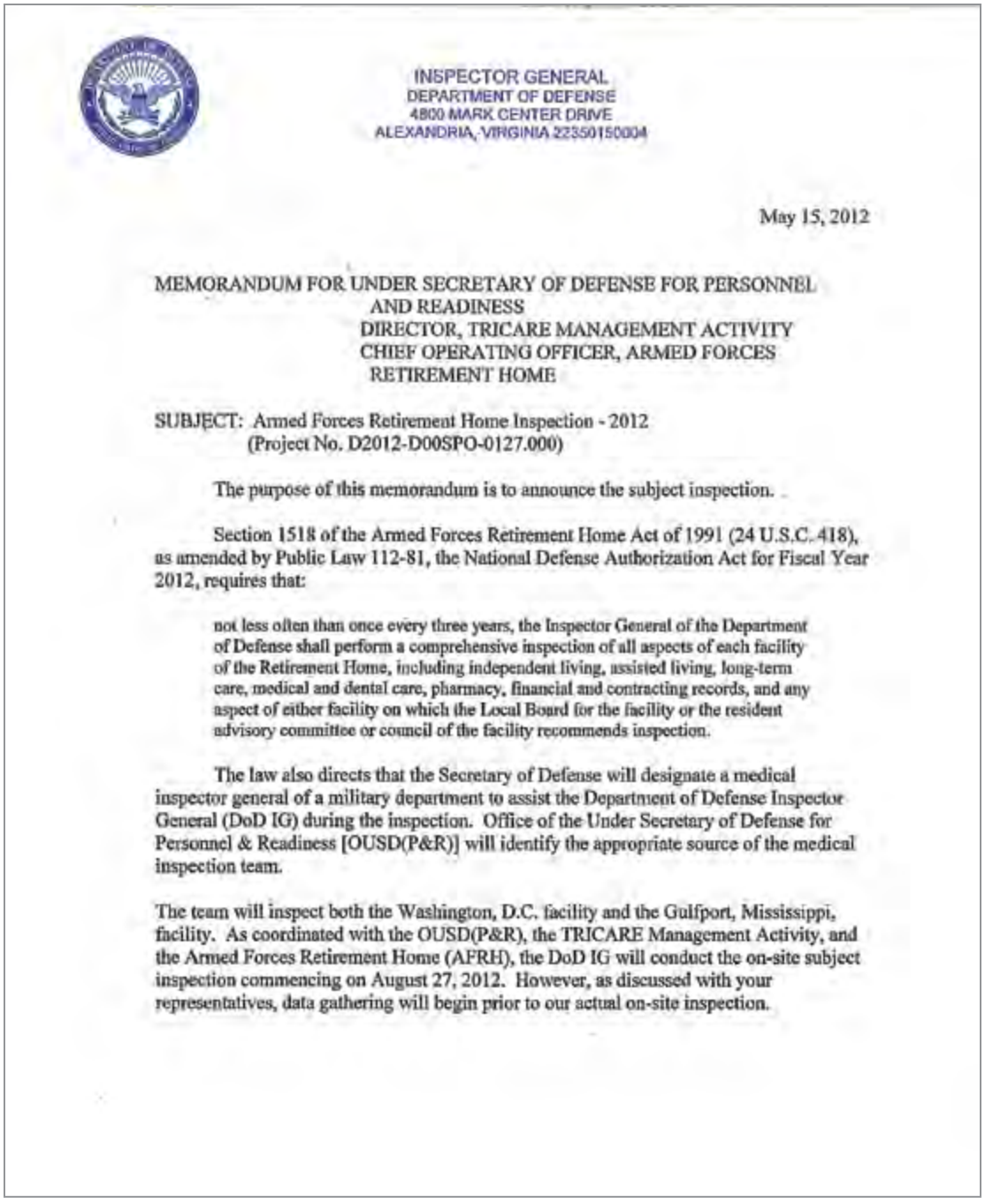
Report No. GAO-07-790R, "Armed Forces Retirement Home," May 30, 2007. Unrestricted GAO reports can be accessed over the Internet at http://www.gao.gov.

DoD IG

Report N. IE-2010-002, "Inspection of the Armed Forces Retirement Home," February 25, 2010. Unrestricted DoD IG reports can be accessed at http://www.dodig.mil/pubs/index.cfm.

Appendix B

Inspection Announcement Letter



INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350150004

May 15, 2012

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
DIRECTOR, TRICARE MANAGEMENT ACTIVITY
CHIEF OPERATING OFFICER, ARMED FORCES RETIREMENT HOME

SUBJECT: Armed Forces Retirement Home Inspection - 2012
(Project No. D2012-D00SPO-0127.000)

The purpose of this memorandum is to announce the subject inspection.

Section 1518 of the Armed Forces Retirement Home Act of 1991 (24 U.S.C. 418), as amended by Public Law 112-81, the National Defense Authorization Act for Fiscal Year 2012, requires that:

> not less often than once every three years, the Inspector General of the Department of Defense shall perform a comprehensive inspection of all aspects of each facility of the Retirement Home, including independent living, assisted living, long-term care, medical and dental care, pharmacy, financial and contracting records, and any aspect of either facility on which the Local Board for the facility or the resident advisory committee or council of the facility recommends inspection.

The law also directs that the Secretary of Defense will designate a medical inspector general of a military department to assist the Department of Defense Inspector General (DoD IG) during the inspection. Office of the Under Secretary of Defense for Personnel & Readiness [OUSD(P&R)] will identify the appropriate source of the medical inspection team.

The team will inspect both the Washington, D.C. facility and the Gulfport, Mississippi, facility. As coordinated with the OUSD(P&R), the TRICARE Management Activity, and the Armed Forces Retirement Home (AFRH), the DoD IG will conduct the on-site subject inspection commencing on August 27, 2012. However, as discussed with your representatives, data gathering will begin prior to our actual on-site inspection.

Inspection Announcement Letter (cont'd)

We will consider suggestions from the OUSD(P&R), the TRICARE senior medical advisor to the AFRH, the Local Board, and the AFRH Resident Advisory Committee in determining additional inspection objectives. My point of contact is [redacted]

Kenneth P. Moorefield
Deputy Inspector general
Special Plans and Operations

cc:
Principal Deputy Under Secretary of Defense for Personnel & Readiness
Deputy Under Secretary of Defense for Personnel & Readiness
Deputy Under Secretary of Defense for Military Community and Family Policy
Inspector General of the Army
Naval Inspector General
Inspector General of the Air Force
Inspector General of the Marine Corps
Deputy Director, TRICARE Management Activity
Deputy, Chief Operating Officer, Armed Forces Retirement Home

Appendix C

Department of Defense Inspector General/Army Medical Command Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING
BETWEEN THE
DEPARTMENT OF DEFENSE INSPECTOR GENERAL
AND THE
U.S. ARMY MEDICAL COMMAND IN THE CONDUCT OF THE 2012
INSPECTION OF THE ARMED FORCES RETIREMENT HOME

This Memorandum of Understanding (MOU) is entered into between the Department of Defense Inspector General (DODIG) and the U.S. Army Medical Command (MEDCOM) and collectively referred to as the Parties.

I. REFERENCES

A. Section 1518 of the Armed Forces Retirement Home Act of 1991 (24 U.S.C. 418), amended by Public Law 112-81, the National Defense Authorization Act for Fiscal Year 2012, and DoD Instruction 1000.28: Armed Forces Retirement Home (AFRH), February 1, 2010.

B. DODIG Email: Request to OUSD (PR) for Service Medical Inspection Team from Dr. Sardar Hassan to Ms. Briget Patrick dated April 13, 2012.

C. DODIG AFRH Inspection Announcement Memorandum, May 15, 2012.

II. PURPOSE AND SCOPE

The purpose of this MOU is to clarify roles, responsibilities and relationship between the Parties in planning, executing the inspection of the AFRH and preparing the report with recommendations.

Pursuant to Section 1518 of the Armed Forces Retirement Home Act of 1991 (24 U.S.C. 418), amended by Public Law 112-81, the National Defense Authorization Act for Fiscal Year 2012, legislates that:

> (1) Not less often than once every three years, the Inspector General of the Department of Defense shall perform a comprehensive inspection of all aspects of each facility of the Retirement Home including independent living, assisted living, long-term care, medical and dental care, pharmacy, financial and contracting records, and any aspect of either facility on which the Local Board for the facility or the resident advisory committee or council of the facility recommends inspection.
>
> (2) The Inspector General shall be assisted in inspections under this subsection by a medical inspector general of a military department designated for purposes of this subsection by the Secretary of Defense.

Department of Defense Inspector General/ Army Medical Command Memorandum of Understanding (cont'd)

Reference B requested OUSD(PR) to identify and select medical personnel from one of the Military Services IAW with 24 U.S.C 418.

Reference C announced the inspection of the Armed Forces Retirement Home. Inspection research and preparation began on May 1, 2012. On-site inspection of the AFRH will commence on August 27, 2012.

III. OBJECTIVES

In accordance with Reference A, the objective of this inspection is to perform a comprehensive inspection of all aspects of the AFRH - Washington D.C. and Gulfport, Mississipi, to determine compliance with applicable laws and regulations pertaining to:

- Senior Management
- Human Resources
- Admissions Eligibility
- Resident Services
- Information Technology
- Civil Engineering
- Financial Operations
- Contracting
- Voting Program
- Estate Matters
- Medical Care
- Dental Care
- Pharmacy Operations
- Hotline Activity
- Response/action taken on previous inspection/evaluation recommendations

IV. SCOPE

This MOU describes the roles, responsibilities, and relationship of the DODIG and MEDCOM in the conduct and completion of the 2012 inspection of the AFRH.

V. PROCEDURES

A. DODIG:

1. DODIG will lead the inspection.

2. The scope, objectives and design for the inspection will be directed by the DODIG.

3. DODIG will fund all inspection related MEDCOM personnel travel, lodging and per diem.

Department of Defense Inspector General/ Army Medical Command Memorandum of Understanding (cont'd)

4. DODIG will provide MEDCOM detailees with office space, badges for office access, equipment and computer network access.

5. DODIG will archive working papers associated with this project. All working papers will be made available to MEDCOM upon request.

6. DODIG Project Team Leader will hold pre-inspection planning and in-process reviews, as required.

7. DODIG Project Team Leader will supervise a collaborative process to draft and edit the final report.

8. DODIG will sufficiently train MEDCOM assigned inspectors to use DODIG information systems to accomplish inspection planning and execution steps.

9. DODIG shall publish the final report.

B. MEDCOM:

1. MEDCOM will provide a minimum of two medical inspectors to address medical care, dental care, pharmacy operations, and previous medical facility certification or evaluation recommendation/compliance status follow-up.

2. MEDCOM will attend meetings as scheduled by the DODIG during the inspection planning phase. (Dates and times of meetings will be determined collaboratively to best accommodate MEDCOM and outside inspection commitments.)

3. MEDCOM will develop guide/checklists for their assigned inspection areas that meet DODIG quality standards as determined by the DODIG.

4. MEDCOM will conduct inspection of the AFRH for their assigned inspection areas IAW DODIG quality standards and processes.

5. MEDCOM will contribute work papers and report findings for their assigned inspection areas subsequent to inspection and provide continuous liaison and required follow-up work with DODIG until release of the final report product.

6. MEDCOM will arrange all travel and lodging requirements for MEDCOM assigned personnel.

VII. EFFECTIVE DATE:

This MOU takes effect upon the signature of the Department of Defense Inspector General and the Department of the Army Inspector General and shall remain in effect for 90 days post the publication of the final report.

Appendix D

Inspection Input from the AFRH Advisory Council Chair, AFRH-W RAC Chair and AFRH-G RAC Chair

From: [redacted]
To: [redacted]
Subject: FW: DODIG Inspection of the AFRH - Soliciting concerns, observations, and recommendations from the AFRH Advisory Council
Date: Tuesday, March 12, 2013 10:06:01 AM

[redacted] hopefully this is what you need.

-----Original Message-----
From: [redacted]
Sent: Friday, August 10, 2012 1:34 PM
To: [redacted]
Cc: [redacted]
Subject: RE: DODIG Inspection of the AFRH - Soliciting concerns, observations, and recommendations from the AFRH Advisory Council

[redacted] I've polled the Advisory Council and we have no concerns to share. We've actually all been very impressed with the management of the AFRH. We look forward to the results of your inspection.

Respectfully,
[redacted]

[redacted]
Chief, Budget Integration Division (SAF/FMBOI)
[redacted]

Inspection Input from the AFRH Advisory Council Chair, AFRH-W RAC Chair and AFRH-G RAC Chair(cont'd)

From: AFRHW Resident Advisory Committee
To: [redacted]
Subject: Re: DOD IG Inspection of the AFRH - soliciting concerns, observations, and recommendations from the Resident Advisory Committee of the AFRH Washington, DC Facility
Date: Friday, August 10, 2012 8:55:46 PM

[redacted]

In speaking with members of the Resident Advisory Committee the thinking was that most problems that pop up appear to be caused by the rebuilding of the Scott Building, the repair of the Sherman Building (damage caused by the recent earthquake in the Washington area), the replacement of the old Eagle Gate entry to the home and other projects that are ongoing here at the home. All these projects occurring in a population that is aging, causes problems to be amplified. So that everyday problems appear larger than they really are.

The area of medical care of another area of interest. The committee has found that many of the problems are caused by either Residents or Staff not following proper procedures that make life easier. But after the Resident or Staff voices their concerns problems are quickly solved making everyone feel better about changes that might occur. Problems in the medical area are sometimes caused by Residents feeling that they are due more treatment at this location that the staff is not supposed to take care of.

Other than that, most problems here are just day-to-day problems that if taken care of quickly, solve the problems and make staff and Residents feel better about themselves and the environment they liv in.

Hope that this email assist you in your upcoming inspection.

[redacted]
Chair
Resident Advisory Committee
Armed Forces Retirement Home Washington
[redacted]

Inspection Input from the AFRH Advisory Council Chair, AFRH-W RAC Chair and AFRH-G RAC Chair

From: [redacted]
To: [redacted]
Subject: Re: DOD IG Inspection of the AFRH - soliciting concerns, observations, and recommendations from the Resident Advisory Committee of the AFRH Gulfport, MS Facility
Date: Tuesday, August 14, 2012 1:09:32 PM

[redacted]

Thank You for asking for the Residents Advisory Committee's (RAC) Concerns, Observations and Recommendations concerning the upcoming DOD IG Inspection.

The AFRH Gulfport RAC is a progressive group and we handle any and all concerns immediately and do not have any issues that would require DOD IG assistance. We are totally focused on caring for the Residents and any issues they may have. Therefore, all issues effecting the Residents have allready been handled promptly.

Thanks again for your concern. Each RAC member understands they still have the right to meet with you personally when you are on site.

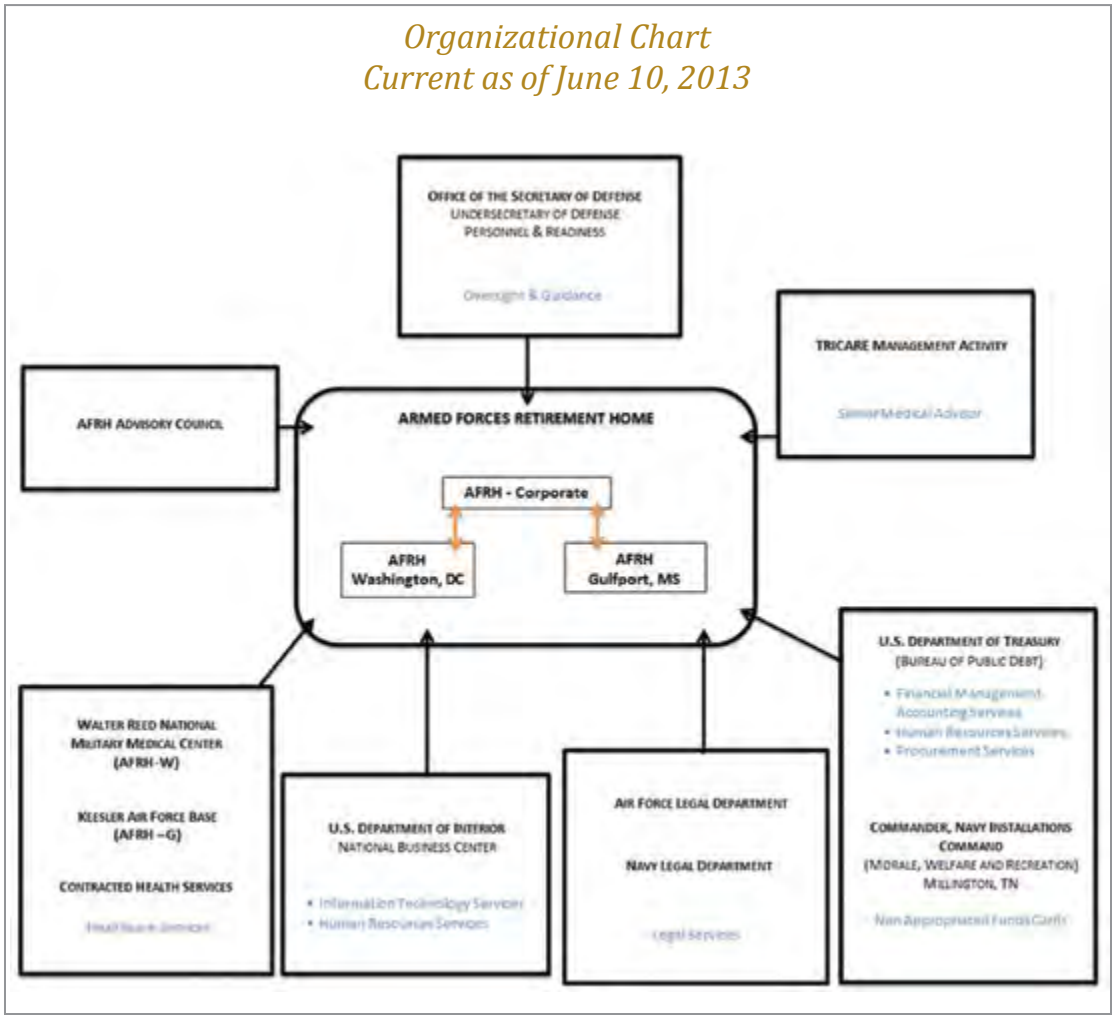
Sincerely,

[redacted]
Chair, Resident Advisory Committee
AFRH-Gulfport
[redacted]

Appendix E

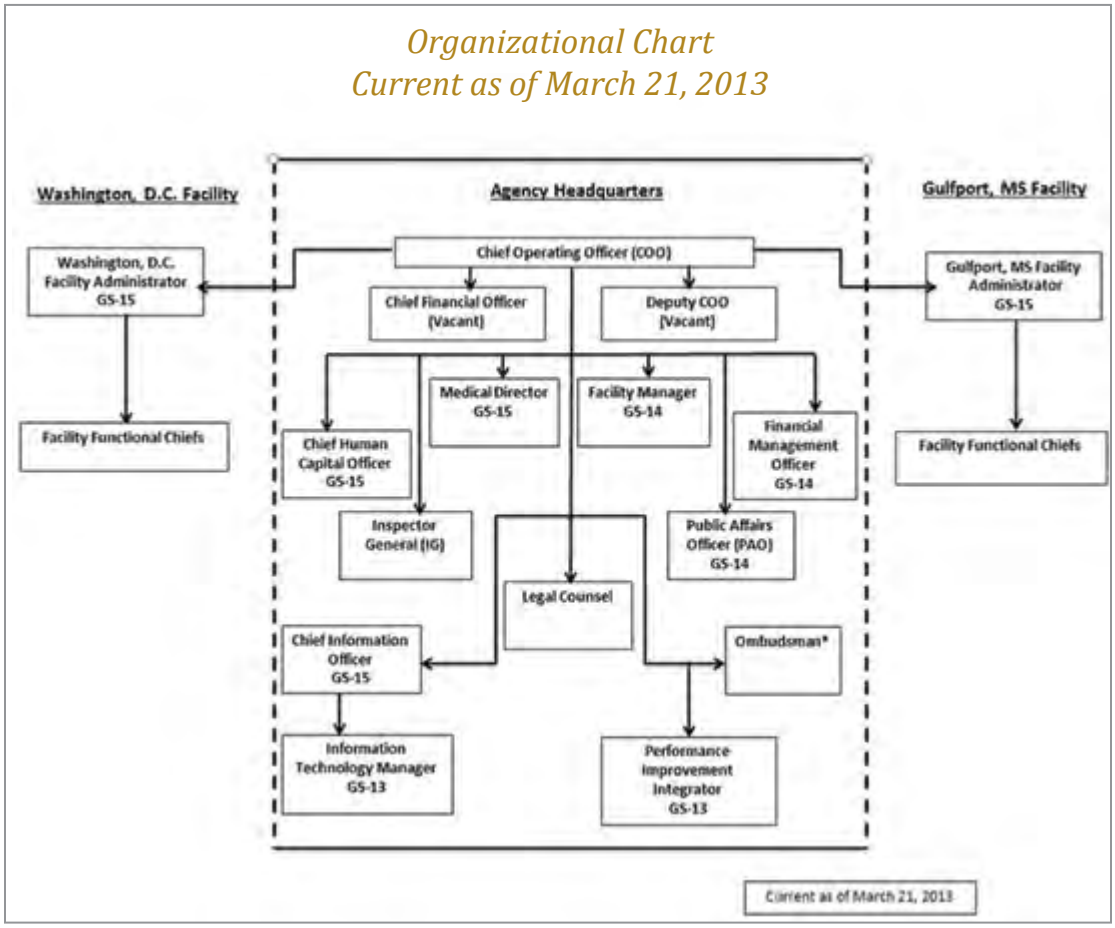
Armed Forces Retirement Home Organizational Charts

Figure E.1 Armed Forces Retirement Home External Stakeholders (Selected)



Armed Forces Retirement Home Organizational Charts (cont'd)

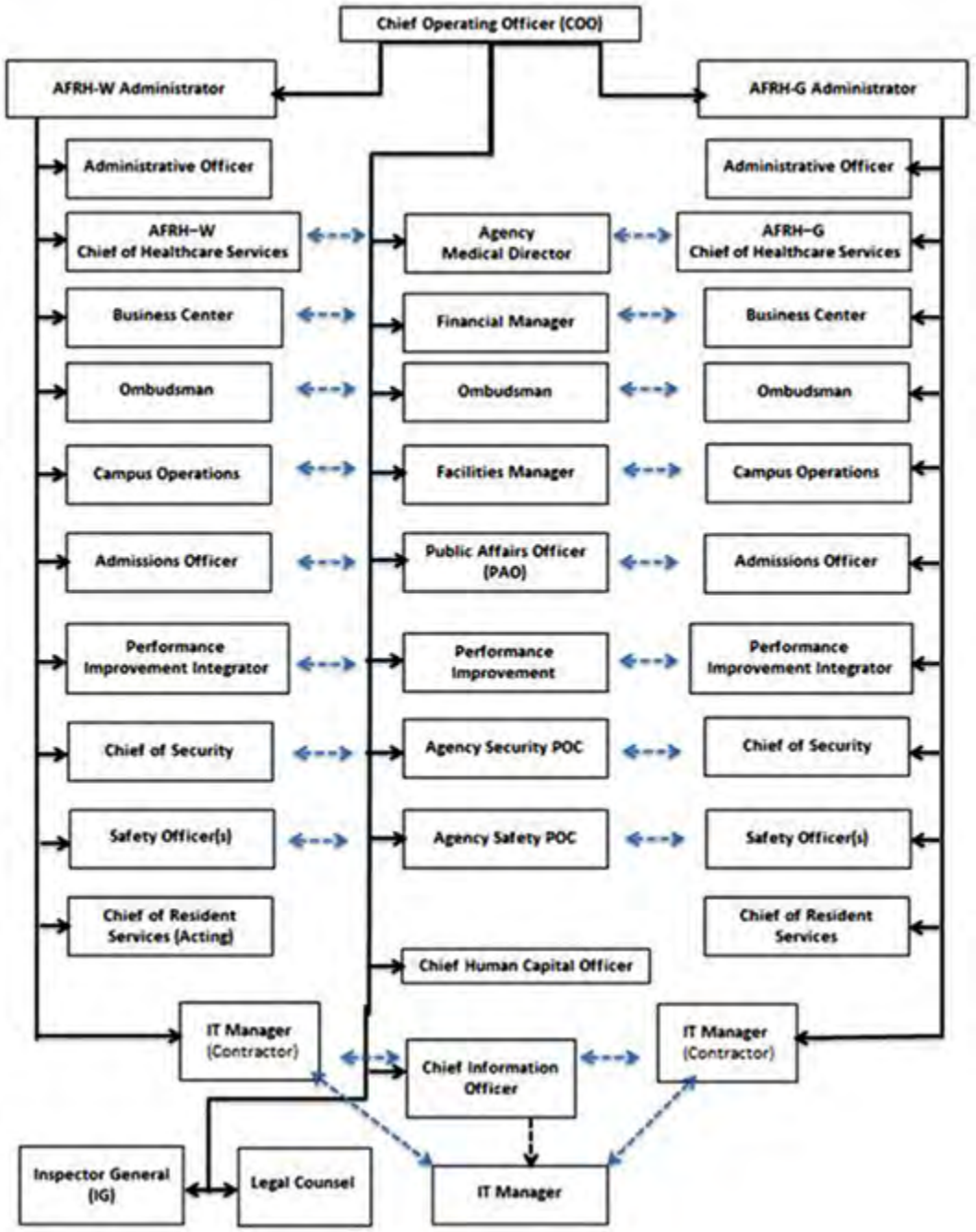
Figure E.2 Armed Forces Retirement Home – Agency



Armed Forces Retirement Home Organizational Charts (cont'd)

Figure E.3 Facility Administration Personnel

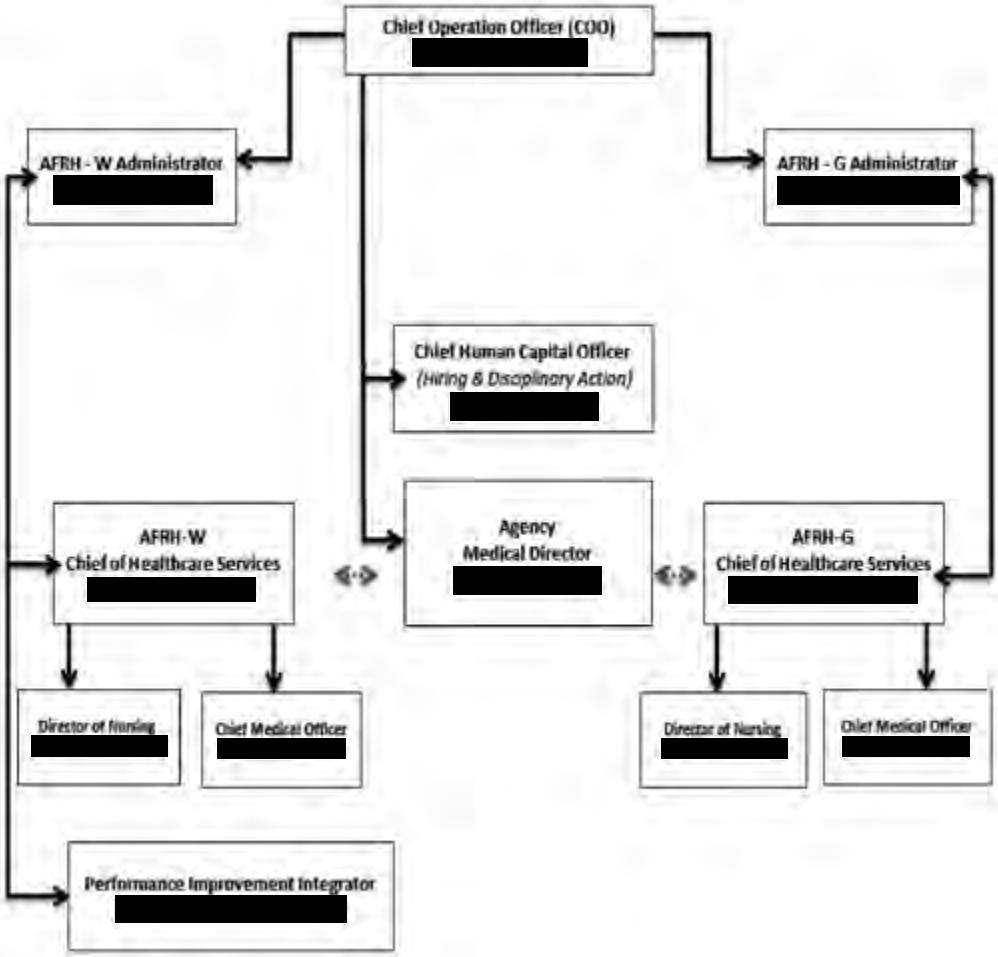
Facility Administration Personnel and Their Functional Counterparts at the Agency Headquarters
Current as of January 3, 2013



Armed Forces Retirement Home Organizational Charts (cont'd)

Figure E.4 Healthcare Administration Personnel

Organizational Chart Depicting Personnel in Healthcare Administration at the Armed Forces Retirement Home
Current as of January 4, 2012



Appendix F

DoD OIG Inspection Team Medical Evaluators

The Colonel (O-6) physician assigned by the Army Medical Command to the DoD IG Inspection team as the medical Subject Matter Expert (SME) had extensive expertise in geriatric medicine and familiarity with the AFRH. At the time of inspection, she had 24 years of experience in military medicine and was the Army Internal Medicine Physician Representative to the Department of Defense Pharmacy and Therapeutics Committee. She was certified in the area of Geriatric Medicine by the American Board of Internal Medicine in 1992, and in 1995 she became a Fellow of the American College of Physicians. In 1994, she also became a member of the American College of Physician Executives. In 1992, she received the Robert H. Moser Award for Excellence in Internal Medicine from the United States Army Office of the Surgeon General. She was the Co-Chair of the VA/DoD Evidence-Based Practice Working Group for 5 years (from July 2007 through May 2012).

The other military medical evaluator was a Lieutenant Colonel (O–5) nurse in the Army Medical Command. At the time of inspection, she was the Assistant Chief Nurse at the 28th Combat Support Hospital, Fort Bragg, NC. She had 20 years of experience in the military in various capacities. She has been certified as a Nurse Practitioner by the American Nurses Credentialing Center Board since 2004. She is also a member of the following professional organizations – American Academy of Nurse Practitioners, American Academy of Ambulatory Care Nursing, National Association of Clinical Nurse Specialists, and Sigma Theta Tau International Honor Society of Nursing. She has a Master of Science degree in Nursing (2003) and a Master of Health Administration degree (1998). She is licensed as an RN in Texas and Colorado.

The professional judgment of the two medical SMEs assigned to the DoD IG Inspection Team was a key factor in evaluating the medical operations at the AFRH. The O–6 physician is the lead author of this report's medical section. In addition to identifying non-compliance with existing laws and AFRH internal requirements (directives, notices, policies, and SOPs), she also used her experience, knowledge, and professional judgment to identify shortcomings in comparison to the industry best practices.

Appendix G

Draft and Final Report Observations and Recommendations Referencing

Table D.1 Draft Report Observations Numbering Matched with the Final Report Observations Numbering

Old Observations Numbering	New Observations Numbering
A.1	1
A.2	2
A.3	3
A.4	4
A.5	5
A.6	6
A.7	7
A.8	8
A.9	9
A.10	10
A.11	11
A.12	12
A.13	13
A.14	14
B.1	15
B.2	16
C.1	17
C.2	18
D.1	19
D.2	20
E.1	21
E.2	22
E.3	23
F.1	24
F.2	25
F.3	26
F.4	27
F.5	28
F.6	29
G.1	30

Old Observations Numbering	New Observations Numbering
H.1	31
H.2	32
H.3.a	33
H.3.b	34
H.4	35
H.5	36
I.1	37
I.2	38
I.3	39
I.4	40
I.5	41
I.6	42
I.7	43
J.1	44
J.2	45
K.2	46
K.2	47
K.3	48
L.1	49
O.1	50
O.2	51
O.3	52
O.4	53
O.5	54
O.6	55
O.7	56
O.8	57

Table D.2 Draft Report Recommendations Numbering Matched with Final Report Recommendations Numbering

Old Recommendations Numbering	New Recommendations Numbering
A.1.a	1.a
A.1.b	1.b(1)
A.1.c	1.b(2)
A.2.a	2.a
A.2.b	2.b(1)
A.2.c	2.b(2)
A.3.a	3.a
A.3.b	3.b
A.3.c	3.c
A.4.a	4.a(1)
A.4.b	4.a(2)
A.4.c	4.b
A.5.a	5.a
A.5.b	5.b
A.5.c	5.c
A.5.d	5.d
A.5.e	5.e
A.6.a	6.a(1)
A.6.b	6.a(2)
A.6.c	6.a(3)
A.6.d	6.b
A.7.a	7.a
A.7.b	7.b(1)
A.7.c	7.b(2)
A.8.a	8.a(1)
A.8.b	8.a(2)
A.8.c	8.b
A.9.a	9.a
A.9.b	9.b
A.9.c	9.c
A.10.a	10.a
A.10.b	10.b
A.10.c	10.c
A.10.d	10.d

Old Recommendations Numbering	New Recommendations Numbering
A.11.a	11.a
A.11.b	11.b
A.11.c	11.c
A.11.d	11.d
A.12.a	12.a
A.12.b	12.b
A.12.c	12.c
A.12.d	12.d
A.12.e	12.e
A.12.f	12.f
A.13.a(1)	13.a(1)
A.13.a(2)	13.a(2)
A.13.a(3)	13.a(3)
A.13.a(4)	13.a(4)
A.13.b	13.b
A.13.c	13.c
A.13.d	13.d
A.14.a	14.a
A.14.b	14.b(1)
A.14.c	14.b(2)
A.14.d	14.b(3)
A.14.e	14.b(4)
A.14.f	14.b(5)
B.1	15
B.2.a	16.a
B.2.b	16.b
B.2.c	16.c
B.2.d	16.d
B.2.e	16.e
C.1.a	17.a
C.1.b	17.b
C.2.a	18.a
C.2.b	18.b
C.2.c	18.c

Table D.2 Draft Report Recommendations Numbering Matched with Final Report Recommendations Numbering (cont'd)

Old Recommendations Numbering	New Recommendations Numbering
D.1	19
D.2.a	20.a
D.2.b	20.b
E.1	21
E.2	22
E.3	23
F.1	24
F.2.a	25.a
F.2.b	25.b
F.2.c	25.c
F.3	26
F.4.a	27.a
F.4.b	27.b
F.5	28
F.6	29
G.1.a	30.a
G.1.b(1)	30.b(1)
G.1.b(2)	30.b(2)
G.1.b(3)	30.b(3)
G.1.b(4)	30.b(4)
G.1.b(5)	30.b(5)
G.1.b(6)	30.b(6)
G.1.b(7)	30.b(7)
H.1	31
H.2	32
H.3.a	33
H.3.b	34
H.4.a	35.a
H.4.b	35.b
H.5	36
I.1	37
I.2	38
I.3	39
I.4	40

Old Recommendations Numbering	New Recommendations Numbering
I.5	41
I.6	42
I.7.a	43.a
I.7.b	43.b
J.1.a	44.a
J.1.b	44.b
J.2	45
K.1.a	46.a
K.1.b	46.b
K.1.c	46.c
K.2.a	47.a
K.2.b(1)	47.b(1)
K.2.b(2)	47.b(2)
K.2.c	47.c
K.2.d	47.d
K.2.e	47.e
K.3.a	48.a
K.3.b	48.b
K.3.c	48.c
L.1.a	49.a
L.1.b	49.b
L.1.c	49.c
O.1	50
O.2.a	51.a
O.2.b	51.b
O.3	52
O.4.a	53.a
O.4.b	53.b
O.5.a	54.a
O.5.b	54.b
O.5.c	54.c
O.6	55
O.7	56
O.8	57

Management Comments

Assistant Secretary of Defense

ASSISTANT SECRETARY OF DEFENSE
3000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

APR 22 2014

MEMORANDUM FOR OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Response Armed Forces Retirement Home Inspection – 2012
(Project No. D2012-D00SPO-0127.000)

Attached is the consolidated response to December 16, 2013 memo for the 2012 Department of Defense (DoD) Inspection of the Armed Forces Retirement Home. Our office remains vigilant on the areas addressed in the report and is committed to ensuring our veterans receive the highest standard of care.

The report contains 131 recommendations. We concur with 20 of the recommendations and concur with comment on 101 recommendations. Many of the recommendations were incorporated prior to your memo dated December of 2013. We non-concur on 10 recommendations, most on the premise that they exceeded statutory language regarding the operations of the AFRH, or lacked specific evidence to support the comment.

The AFRH is governed by unique legislative requirements and oversight. Going forward, I suggest the use of an industry standard and approved checklist to aid in ensuring an objective, comprehensive review that will be most helpful to all parties. We further suggest the Inspector General (IG) consider aligning future inspections with the Joint Commission accreditation survey to prevent redundancy, strengthen the review of medical care and ensure access to appropriate subject matter experts. I believe this will improve the inspection process by incorporating professionals more closely aligned with the AFRH mission and population.

AFRH staff is comprised of professionals that are highly-trained, competent public servants who are dedicated to the care of others. The residents' health, safety and welfare are tantamount to the core mission of the AFRH and the staff's vision to provide "the premier retirement community for America's veterans." I look forward to future collaboration to ensure excellence in our operations. Our Veterans deserve no less.

F. E. Vollrath

Attachments:
As stated

Assistant Secretary of Defense (cont'd)

Department of Defense Office of the Inspector General
2012 Inspection of the Armed Forces Retirement Home

Observation & Recommendations
(Highlights: Green – Observation/Recommendation Gray – Non-Concur)

[redacted]

Discussion:

IG – "Agency Directive 9-5, "AFRH Pain Management Program," April 12, 2012, contained descriptions and requirements for services that were not offered at AFRH and were not part of their operational capabilities."
AFRH - The Agency Directive 9-5 'AFRH Pain Management Program" does not exceed the scope of services provided at the AFRH-W. Observation does not give examples of where scope of services was exceeded.

IG – "During the review of long term care (LTC) records at AFRH-W, the DoD IG Inspection Team identified an issue with chronic opioid use in an 85-year-old resident with chronic pain. He was prescribed and taking two Percocet tablets (5mg oxycodone/325 mg acetaminophen per tablet) every 4 hours. This regimen controlled his pain, but also resulted in him receiving 3,900 mg of acetaminophen per day. This was too large a dose for an 85-year-old, with significant potential for adverse effects, based on guidelines discussed in the next paragraph. The DoD IG Inspection Team discussed the case with the nurse responsible for this resident's care and recommended changing the dosage to a long acting opioid that did not contain acetaminophen."
AFRH - Cited case was not discussed with the Medical Director or the Chief Medical Officer. Rather than discussing the course of treatment with the responsible nurse, it would have been more appropriate to discuss with the provider so that a better understanding of the history of treatment for this resident could have been better understood.

IG – "Implementation of existing evidence-based clinical practice guidelines, such as VA/DoD Clinical Practice Guidelines (CPGs) on Opioid Therapy for Chronic Pain and Low Back Pain, would have been useful in this instance and should be adopted in subsequent SOPs."
AFRH - The recommended VA/DoD Clinical Practice Guideline (CPG's) on Opioid Therapy for Chronic Pain and Low Back Pain may have been useful but was published 10 months after the time of the survey. This document does not provide significant information or insight to change the pain management at AFRH. Presently residents with chronic pain that cannot be controlled at the AFRH are referred for evaluation and treatment at the pain clinic at the VAMC and the Walter Reed National Military Medical Center.

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Assistant Secretary of Defense (cont'd)

Recommendations
A.1.a. Under Secretary of Defense for Personnel and Readiness, determine applicable medical standards of the Department of Veteran Affairs and the Department of Defense, such as Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines, and ensure the Armed Forces Retirement Home meets those standards.
Non-concur - AFRH will follow national standards as does the Department of Veterans Affairs and DoD when developing medical policies. AFRH should consider incorporating relevant information from the Department of Veterans Affairs/DoD Clinical Practice Guidelines during their policy development/review process. Requiring AFRH to follow Department of Veterans Affairs and/or the DoD medical standards for which they have no input to the content and which are written for organizations with different structure, systems, and processes would create risk for noncompliance with nationally recognized medical standards focused on the population and organization of AFRH.
A.1.b. AFRH COO ensures appropriate corrections to Agency directives, including the incorporation of evidence-based Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines related to pain management. Utilize other Clinical Practice Guidelines, such as those published by the Annals of Long Term Care, as appropriate.
Concur with comment: Recommendation in progress. AFRH will review the existing document to determine whether the VA/DoD clinical practice guideline cited would be useful in as one of its references. AFRH uses as its primary source of standards those that are published by its accreditations organizations such as The Joint Commission and CARF. In addition currently used guidelines are those that are developed for the geriatric population.
A.1.c. The COO Ensure that the Armed Forces Retirement Home – Washington, D.C., and Armed Forces Retirement Home – Gulfport facilities implement the revised Agency directive to ensure residents with pain receive appropriate assessment, treatment, and re-assessment of pain.
Concur with comment: Recommendation complete. If any changes are made to Agency directives both facilities will be included in the implementation.
[illegible]
Discussion: IG – "The DoD Directive 1010.10 did not mention suicide or suicide prevention. The article on bipolar disorder was dated and had nothing to do with development of a suicide awareness and prevention program. The Agency Directive 9-6 appeared to be taken directly from the Coast Guard Instruction. Unfortunately, the instruction was not tailored to fit AFRH residents' needs." **AFRH** - The Agency Director 9-6 Suicide Awareness and Prevention Program was specifically tailored to the AFRH environment. The

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Assistant Secretary of Defense (cont'd)

directive's primary author was the clinical psychiatrist serving the residents at the time of the development of the suicide prevention program. The three references were chosen for the following reasons:

1) DoD Directive 1010.10 was selected because it addresses general health promotions and disease/injury prevention;
2) Coast Guard-Commandant Instruction 1734.1A was used because of its reference to a pneumonic ISPATHWARM (pgs. 19-23) used by AFRH-W clinical psychiatrist during the suicide prevention class to help identify at risk individuals.
3) Depression and Bipolar Alliance, Bipolar Disorder and Suicidal Behavior, Psychiatric Clinics of North America, Volume 2, Issue 3, was used despite its publication date and continues to be clinically sound in addressing the correlation between bipolar disorders and the occurrences of suicidal actions by one of the foremost authorities on the topic.

IG – "While AFRH-G had some on-going training for privileged healthcare providers on suicide and related issues ("Provider's Wellness Manual" for the Summer/Fall 2012), the DoD IG Inspection Team could not document similar training at AFRH-W."
AFRH -DoD IG Inspection team did not address or request documentation for suicide prevention training on the Washington Campus. AFRH suicide prevention awareness training originated on the Washington campus. It was incorporated into the mandatory training for all AFRH personnel and added to all employees' annual performance plan and attendance to the class was tracked by a Performance Improvement committee component. The AFRH-W is meeting industry standards.

IG - "Multiple VA/DoD CPG guidelines (for example Depression, Bipolar Disorder, and Post Traumatic Stress Disorder) addressed suicide, as well as the VA/DoD CPG on Suicide Prevention, which was issued in June 2013."
AFRH -The referenced VA/DoD CPG guidelines were published 10 months after the time of the survey so could not be used as a reference.

[redacted]

A.2.a. Under Secretary of Defense for Personnel and Readiness, require that the Armed Forces Retirement Home Agency Directive 9-6 on Suicide Awareness meet applicable standards of the Department of Veterans Affairs, such as Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines.

Concur with comment: At the time of the inspection, the DoD/VA suicide guideline was still under development and was not published until June, 2013. AFRH will incorporate relevant information from the Department of Veterans Affairs/DoD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide as policy is updated.

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Assistant Secretary of Defense (cont'd)

A.2.b. AFRH COO ensures appropriate corrections to Agency Directive 9-6 on Suicide Awareness, including the incorporation of evidence-based Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines related to suicide evaluation and prevention.

Concur with comment: Agency Directive 9-6 was tailored for population and community of the AFRH. The recommended VA/DoD Clinical Practice Guideline for suicide prevention published June 2013 ten months after the IG's inspection. In addition, mandatory suicide prevention training was initiated in the early 2012. Training attendance is documented to ensure maximum participation in the program. The content of AFRH Directive 9-6 was taught during the training by the Board-certified psychiatrist that was working at AFRH during that time who also participated in the development of the training. Suicide prevention training is provided to residents as well as staff.

A.2.c. AFRH COO ensure the Armed Forces Retirement Home – Gulfport handbook for privileged providers is shared with and appropriately applied by the Armed Forces Retirement Home – Washington, D.C.

Concur with comment: The AFRH-G "Provider's Wellness Manual" will be distributed for use on both campuses.

[redacted]

Discussion: AFRH will review all SOPs for content, consolidation and updating of references. In addition new SOPs will be developed for Anticoagulation management and End of Shift Narcotics Counts.

[redacted]

A.3.a. AFRH COO ensure medical standard operating procedures are re-written by individuals with subject matter expertise, including knowledge of current medical evidence-based practice, and that the Armed Forces Retirement Home staff is trained on the updated standard operating procedures.

Concur with comment: Recommendation in progress. Medical SOPs will be reviewed, consolidated when applicable and rewritten where necessary using evidence-based practice guidelines. After any modifications SOP's staff will be trained in a standardized method that ensures that all are able to effectively articulate the content of the SOP. In addition tracer activities will be established to document consistency in use of SOPs.

A.3.b. AFRH COO develops appropriate standard operating procedures for the identified high-risk areas.

Concur with comment: Recommendation in progress. Standard operating procedures will be developed for high-risk activities such as the Coumadin clinic and End of Shift Narcotics Counts.

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Assistant Secretary of Defense (cont'd)

A.3.c. AFRH COO revises AFRH-G standard operating procedures to make them specific to AFRH-G needs and requirements.
Concur with comment: Recommendation complete. Standard operating procedures at AFRH are developed to be standardized in areas that requirement documentation and measurement for performance or reporting. Where there are differences in operations due to the uniqueness of each campus the SOP will reflect it.
[redacted]
Discussion: Since the IG review, all AFRH personnel participating in the credentialing process have undergone training by the National Committee for Quality Assurance, NCQA, that covered basic and advanced credentialing. Upon the recommendation of the NCQA trainer, the Medical Staff Bylaws have been eliminated. Credentialing policy was reviewed by external credentialing specialists, hired to review the policy for content and coverage. They suggested changes for clarification purposes in the SOP and Agency Directive 12-11. Any deficiencies discovered during the review were immediately corrected. All existing policy is being considered as a draft document as we realign the process to incorporate the needs for both campuses. Applicable nursing practice policy will be addressed at the Agency level. AFRH is currently investigating the use of a Credentialing Verification Organization (CVO). When these services are obtained all policy will be modified and finalized to reflect the use of the CVO.
[redacted]
A.4.a. AFRH COO ensures appropriate corrections to Agency and facility policies, including bringing the policy into compliance with applicable Department of Defense medical instructions, directives, and regulations.
Concur with comment: AFRH will ensure that policies are appropriate and specific to its needs. Medical instructions, directives and regulations from other federal agencies will be used as references in the development of its policies. Standards of the accreditation organizations such as The Joint Commission and CARF will lead the policy development at AFRH. Leadership will ensure the adherence to AFRH policy.
A.4.b. AFRH COO provides a process for the investigation of nursing practice and subsequent reporting to state boards of nursing.
Concur with comment: Recommendation in progress. Nurse practice policy will be broadened to include investigation of incidents and subsequent reporting to state boards of nursing.

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Assistant Secretary of Defense (cont'd)

Discussion:

IG – "The DoD IG Inspection Team observed that privileges granted to providers included types of services that were not offered at the AFRH facilities. The Inspection Team also found that no data was being tracked for use in re-privileging decisions."

AFRH - Data collection association with a peer review is performed at the AFRH and documented through the Performance Improvement process. Records audits are performed for the practitioners by the area in which they provide services. Trends are identified for risks, which are monitored by the facility Performance Improvement Integrator and reported to the COO through the Campus Administrator if negative trends are observed.

IG – "Consequently, inadequate credentialing and privileging allowed one unqualified healthcare provider to work at AFRH and could allow other similar cases in future."

AFRH – Since the practitioner is not identified in the discussion AFRH believes that this refers to a self-reported loss of license by a psychiatrist that was formally a contract employee at AFRH. When the practitioner reported the loss of his license to the AFRH, the former COO instructed the current Medical Director and the Facility Administrator continue to use him in a limited capacity. The practitioner's privileges were modified and the letter was send to the Maryland licensing board outlining the changes. Subsequent to this the Senior Medical Advisor was brought into the process. As a part of the oversight process, the Senior Medical Advisor reviewed the credentialing process and asked the DoD Medical Team Lead to come to AFRH as a consultant to give credentialing training to the staff. Immediately after the SMA consultant's visit, the credentialing process was updated to reflect her recommendations and the practitioner was removed from the AFRH staff. See attached document concerning this incident (Attachment-1).

IG – "The AFRH-G SOP G-HC-MED-4-03, "Credentialing," June 29, 2012, indicated that AFRH-G did their own privileging, although all privileging was actually done in AFRH-W by the AFRH-W credentials committee."

AFRH - AFRH-G SOP did at the time of the DoD IG indicate that they did their own credentialing. The Facility Administrator has been advised that all SOPs be reviewed and updated for accuracy.

IG – "Although an AFRH-W staff member attended a briefing on credentialing and privileging provided by the Chief of Quality Management (QM), U.S. Army Medical Command (MEDCOM), in March 2011 and hoped to attend the Army training offered at that time, she did not receive the training. This happened because the Agency Medical Director did not send any staff to attend this training."

AFRH – There were several obstacles to pursuing the training offered by the DoD IG medical lead when in their capacity of Chief, QM MEDCOM. AFRH was turned over to a junior officer who did not have the power and authority to have the AFRH staff attend this training. The training included learning to use an electronic credentialing system that AFRH did not have permission to use after completion of the training by all the other stakeholders. The weeklong training was in San Antonio, Texas. The cost of sending all of the concerned parties exceeded the training budget projections. The current Medical Director requested training support to come to AFRH but

Assistant Secretary of Defense (cont'd)

this request was denied. Ultimately it was decided to find training locally that was within the AFRH budget.

IG – "AFRH staff members were not using the Department of the Army (DA) Form 5754 and SOP W-HC-MED-3-01 did not require the use. Had they used DA Form 5754, it would allow AFRH to capture information about the seeking provider related to previous adverse actions taken against a provider's licensure and/or privileges, malpractice cases, and conditions that may affect the provider's ability to deliver care."

AFRH - The statement that AFRH was not using DA 5754 (Malpractice History form) or its equivalent is not true. This document has been used for over twelve years. While this form does address the history of malpractice and adverse actions taken against practitioners, it is updated every two years at the time of renewal of the practitioner's privileges; therefore it will not reveal any negative actions that occur between updates.

IG – "In addition, AFRH staff members were not querying, and SOP W-HC-MED-3-01 did not require, AFRH staff members to query the NPDB prior to privileging medical providers, even though this was a requirement of both Army and DoD regulation."

AFRH - The statement that AFRH was not performing queries of the NPDB is not true. These queries have been performed for over twelve years.

IG – "On the first occasion, the DoD IG Inspection Team identified an issue with expired licenses and credential-issuing organizations' verification of a credential on a dietitian."

AFRH - Since the specific cases with expired licenses were not indicated in the discussion and so much time has passed since the inspection, AFRH credentialing staff cannot respond. Contrary to the written discussion, the Medical Director was not informed that there were files with expired licenses. We were proactively reviewing files for expiration dates. The Administrative Specialist coordinates the process in which a monthly list of expiration dates is created and informs all practitioners that have license pending expiration that the new license is required by a specific date.

IG – "The credentials file review identified one social worker at AFRH-G who did not have the correct level of licensure for the privileges she was granted. She also did not meet the licensure requirements in her job description."

AFRH - Issue mentioned twice. Answered below.

IG – "The most significant credentials finding was a social worker at AFRH-G who was not licensed to work independently. Both her job description and the privileges granted by the credentials committee required licensure at an independent level."

AFRH - AFRH acknowledges that the social worker's license did not allow her to work independently. While she met all of the other employment criteria, the difference in the types of licenses in Mississippi eluded both the position specialist at the Bureau of Fiscal Services who put her on the certification as well as the members of the credentials committee. This individual no longer is employed at AFRH as she did not have the appropriate license and now the Credentials Manager researches each type of license requirement in the state in which the individual is licensed prior to the approval of privileges.

Assistant Secretary of Defense (cont'd)

IG – "Privileges must be specific to the medical capabilities of the facilities. Multiple practitioners from Walter Reed had been granted privileges by AFRH to provide services in areas that did not exist at AFRH." AFRH - In order to respond to the allegation that multiple practitioners from Walter Reed have been granted privileges by AFRH we would need to know the names of these providers. AFRH does not grant privileges for areas outside its scope of practice. Privileges are delineated upon request and are reviewed by discipline specialists or Chief, Medical Officer.
Recommendation(s)
A.5.a. AFRH COO ensure appropriate training for those personnel performing credentials verification and ensure oversight by qualified medical leadership to oversee the credentialing process.
Concur with comment: Recommendation complete. Training for all personnel performing credentialing verification has been accomplished as of April 2013. An additional level of oversight has been added in the assignment of a Credentialing Manager who has over 8 years of credentialing experience.
A.5.b. AFRH COO ensure that privileges on the Armed Forces Retirement Home forms are limited to those procedures and practices that are within the operational scope of the facilities.
Concur with comment: Specialist in the each discipline review requests to ensure that all requested privileges are within the scope of the facility.
A.5.c. AFRH COO immediately institute peer review and tracking of peer review data by provider for use in evaluation of their competence for re-privileging.
Concur with comment: Recommendation in progress. AFRH has been performing peer review for over 12 years. Data documenting peer review has been collectively tracked since Performance Improvement realignment in early 2011. The data documentation will be reported in a manner that more clearly demonstrates its connection to the renewal of clinical privileges.
A.5.d. AFRH COO include the qualification requirements in policy, by specialty. (Chapter 7 of Army Regulation 40-68 could be used as a guide to placing qualification requirements into the Armed Forces Retirement Home Agency guidance for those specialties employed or contracted to work at Armed Forces Retirement Home facilities.)
Concur with comment: Recommendation complete. AFRH elected not to have a chapter in policy referring to qualifications instead it uses position descriptions for federal employees and qualification in the contractor's Performance Work Statement to delineate qualifications. To ensure practitioners being credentialed meet all qualification requirements, a copy of the position description or the PWS qualification requirements is included in each credentialing package.

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A.5.e. AFRH COO take immediate action to remove the privileges of the social worker with the incorrect level of licensure and notify her of the requirement to obtain licensure at the independent (non-supervised) level.
Concur with comment: Recommendation complete. Employee no longer works for AFRH.
Observation A.6: Involvement of the Office of the Deputy Director, Defense Healthcare Policy and the Under Secretary of Defense for Personnel and Readiness
Discussion: **IG** – "In that same time period, the AFRH COO decided to designate a Medical Director at the Agency level. The SMA and DHA staff advised the COO not to promote the AFRH-W CMO to this position because of his role in allowing the unlicensed psychiatrist to work and his reported inability to grasp the concepts of quality management and peer review (for which he would be responsible at the Agency level.) However, the COO did not to follow the SMA's recommendations." **AFRH** – The AFRH COO was not advised by SMA or DHA not to promote the AFRH-W Chief Medical Officer to the position of Agency Medical Director. **IG** – "Extensive discussion of peer review and on-going monitoring of performance ensued." **AFRH** – The DoD IG medical team leader provided a briefing on credentialing while as consultant for the SMA. The discussion of peer review that they thought was extensive was not perceived as such by the credentialing team that attended that meeting. In fact the only individual that remembered the peer review discussion was the current Credentialing Manager who has asked the question and who had credentialing experience prior to coming to AFRH.
Recommendation(s)
A.6.a. Under Secretary of Defense for Personnel and Readiness, strengthen the oversight role of the Senior Medical Advisor by improving his/her authority over medical, budgetary, and personnel issues at the Armed Forces Retirement Home.
Non-concur - Statutory language establishes the SMA requirements and states: The SMA shall provide advice to the Secretary of Defense, the USD(P&R), the Chief Operating Officer (COO), and the Advisory Council regarding the direction and oversight of medical administrative matters at each facility of the Retirement Home; and the provision of medical care, preventive mental health, and dental care services at each facility of the Retirement Home. The SMA responsibilities do not include budgetary or personnel issues. Statutory language states the role is advisory to the leadership of AFRH and does not infer the SMA has authority over AFRH as stated in the recommendation.

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A.6.b. Under Secretary of Defense for Personnel and Readiness, establish routine communication and reporting requirements to the USD (P&R) from the Armed Forces Retirement Home Chief Operating Officer and the Deputy Director of Defense Health Agency, including periodic reports on Defense Health Agency interactions with the Armed Forces Retirement Home.

Concur with comment: Recommendation complete. In the fifteen months since the onsite inspection, the SMA developed an oversight plan that was approved by the USD(P&R). The plan includes communication and reporting requirements.

A.6.c. Under Secretary of Defense for Personnel and Readiness ensure that records of these reports are formalized and maintained.

Concur with comment: Recommendation complete. The SMA oversight plan includes documentation requirements

A.6.d. Deputy Director of Defense Health Agency, advise the Under Secretary of Defense for Personnel and Readiness on which Department of Defense medical Instructions, Regulations, and Directives are appropriate for the Armed Forces Retirement Home to follow/implement.

Non-concur – Statutory language establishes the SMA requirements and states: The SMA shall provide advice to the Secretary of Defense, the Under Secretary of Defense, Personnel and Readiness, the AFRH Chief Operating Officer (COO), and the AFRH Advisory Council regarding the direction and oversight of medical administrative matters at each facility of the Retirement Home; and the provision of medical care, preventive mental health, and dental care services at each facility of the Retirement Home. Statutory language also states the role is advisory to the leadership of AFRH and does not infer the SMA has authority over AFRH as stated in the recommendation.

Requiring AFRH to follow Department of Veterans Affairs and/or the DoD medical standards for which they have no input to the content and which are written for organizations with different structure, systems, and processes would add unnecessary risk for noncompliance with nationally recognized medical standards focused on the population and organization of AFRH.

AFRH should follow national standards as does the Department of Veterans Affairs and DoD when developing medical policies. AFRH should consider incorporating relevant information from the Department of Veterans Affairs/DoD Clinical Practice Guidelines during their policy development/ review process.

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Observation A.7: Medical Leadership
Discussion: More insight regarding the purpose of the Medical leads observation and their impact on the inspection is needed. During the inspection process the DoD IG Medical Team leader openly stated that they knew why things were not going according their perception at AFRH and the Medical Director was named. The descriptive passages in the discussion have little merit. The familiarity with VA/DoD clinical practice guidelines has no bearing on objectives of the inspection. There are many different sources of clinical practice guidelines depending upon the organization and the discipline. The treatment philosophies of the physicians at AFRH have been sound and there have never been any malpractice actions against either of them. The geriatric clinical expertise of the Medical Director is unparalleled having provided care without any negative citation for more than 30 years.
Recommendation(s)
A.7.a. Under Secretary of Defense for Personnel and Readiness, require the Armed Forces Retirement Home Chief Operating Officer to open available Agency-level and facility-level leadership position hiring actions to external applicants and authorize the Senior Medical Advisor to participate in the selection process.
Concur with comment: Recommendation complete. This issue has been addressed and resolved. The Chief of Healthcare Services and Director of Nursing position for AFRH-W as well as the Director of Nursing position for AFRH-W were posted on USA Jobs and SMA representative included on the selection panel.
A.7.b. AFRH COO set hiring criteria and performance objectives which require that the current and future Agency Medical Directors and Armed Forces Retirement Home –Washington, D.C. Chief Medical Officers be or become clinically and administratively competent.
Concur with comment: Recommendation complete. Hiring criteria and performance objectives are determined by the position description. The current AFRH medical director has certification as a medical director and meets all criteria set by their position description. Chief medical officer meets all criteria of their position descriptions.
A.7.c. AFRH COO convert the Armed Forces Retirement Home – Gulfport contract physician position to full-time civil service position.
Concur with comment: Recommendation in progress. Physician position's conversion to a full-time civil service position is being handled by AFRH Human Resources.
Observation A.8: Human Resources Practices and Impact on Morale
Discussion:
IG – "AFRH-W had altered position descriptions, in at least one case, to allow the selection of internal candidates who did not meet prior

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qualification requirements."

AFRH - See response 8.2.b. from Chief Human Capital Officer on candidate selection.

IG "Supervisors at AFRH had not been trained to serve as supervisors in the federal system."

AFRH Contractor trains each supervisor as they enter the position, giving each a minimum of 8 hours of federal supervisory training. In addition CHCO trains each supervisor on the support that they received from Bureau of Fiscal Services (BFS). Whenever BFS is not available CHCO will provide training.

IG "AFRH leadership failed to follow AFRH regulations or guidance in their HR practices."

AFRH Observation did not cite example of AFRH failure to follow AFRH guidelines in their HR practices.

IG "AFRH had not been required to, and did not follow DoD regulations in their HR practices."

AFRH AFRH is compliant with OPM hiring guidelines. The AFRH hiring process is supported by HR specialists at the BFS.

IG – "Supervisory nursing personnel believed that they were unsupported when disciplinary actions concerning their staff needed to be taken."

AFRH - AFRH provides HR support through BFS. CHCO is available at all times for questions and support. Each facility's Administrative Officer is a source of HR support.

IG -- "Inability of agency medical leadership to set appropriate medical standards for the care of residents, increasing the risk of inadequate and inappropriate care and poor performance by some nursing personnel."

AFRH -- The report confuses performance issues by nursing with the ability of medical leadership to set standards. Performance issues occur when the individual fails to meet the standard of care for their level of training as well as non-adherence to organizational policy.

IG "The DoD IG Inspection Team also found that the Agency PI Integrator had little experience in QM and PI outside of her exposure to the PI program at the AFRH."

AFRH Agency PI Integrator applied and was selected for the GS position. Agency PI made the Certificate of Eligibility compiled by the BFS personnel. As a retired Colonel in the US Army, the Agency Performance Improvement Integrator has participated and led quality initiatives in the past, including Chairing the Dental Credentials committee for the Dental Activity for 4 years in Germany and for 4 years for the Walter Reed Dental National Capital Region. The incumbent completed classes leading to certification as a Government Performance Manager and Lean Six Sigma for Green Belt level. The Agency PI's role is broad and covers AFRH accreditation initiatives, risk management, management of credentialing of practitioners and working directly with the SMA's representatives to ensure reporting of the oversight requirement. For further clarification a copy of the PI Integrator's CV is attached (attachment 11).

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Recommendations
A.8.a. Under Secretary of Defense for Personnel and Readiness, when disciplinary action is taken against nursing personnel, require the Armed Forces Retirement Home to report that disciplinary action to appropriate state licensing/certifying boards.
Concur with Comment: USD(P&R) require the Armed Forces Retirement Home to establish and implement a disciplinary action policy based on the state/district law for reporting disciplinary action and report to the appropriate state/district licensing/certifying boards accordingly.
A.8.b. AFRH COO ensure that supervisors receive appropriate Federal supervisory training.
Concur with comment: Recommendation complete. All supervisors receive a minimum of eight (8) hours of federal supervisory training.
A.8.c. AFRH COO establish procedures to ensure that medical personnel hired are appropriately qualified for their positions, in accordance with Office of Personnel Management guidelines.
Concur complete: Recommendation complete. All applicants provided to AFRH hiring managers are screened according to OPM guidelines at the Bureau of Fiscal Services (BFS) then placed on a certificate of eligibility. When a position was limited to internal applicants the same process was followed for qualification. Hiring managers choose selectees from the certifications that are prepared by BFS.
Discussion of Management Comments
Discussion: AFRH acknowledges that the Agency Directive 4-9 "Medical Qualification Determinations" had not been fully implemented in that the SOP was not developed on the Campus level. The processes that would have been included in the SOP such as contracting or location a source for occupational health services have been executed and used. The development of processes at Gulfport was in the nascent stage as services and staffing were being transitioned from contract to federal employees. SOPs at both campuses will be developed and complete the implementation of the Directive. AFRH-W employees that have had questionable fitness for duty are handled through the Human Capital Officers' resources. The initial documentation comes from the employee's personal provider and when needed a second opinion is obtained from the contracted services for occupational health. Physical requirements for all positions are posted in the job announcements and position descriptions. The pre-employment examinations forms especially in the case of the nursing staff have very specific questions that are completed by the physician to ensure that the demands of the position can be met.

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Recommendation(s)
A.9.a. AFRH COO update and clarify Agency medical directives, including processes for determination of fitness for duty of nursing personnel, and clarification of the Medical Director role in that process.
Concur with comment: The role of the Medical Director will be added to the current Agency directive.
A.9.b. AFRH COO develop policies to update and implement Agency Directive 4-9 concerning qualifications of medical personnel.
Concur with comment: Agency Directive 4-9 will be fully implemented by the establishment of campus level SOPs.
A.9.c. AFRH COO ensure that physical requirements are established for every position.
Concur with comment: Recommendation complete. Physical requirement for every position are clearly identified during the hiring process in the job announcement or the performance work statement.
A.9.d. AFRH COO assess the capacity of all nursing staff to perform their duties and take appropriate personnel action if they are unable to perform their duties.
Concur with comment: Recommendation complete. Upon initial employment each of the nursing staff received a pre-employment physical and was evaluated specifically for their ability to perform their duties. The current Fitness for Duty program is operating as planned and is appropriate for AFRH.
Observation 10: Quality Management and Performance Improvement
Discussion: As was the case during the 2009 inspection by DoD IG Medical Team, the 2012 Medical Team did not provide or use a checklist that, if used, would have helped to maintain standards, consistency, objectivity, and transparency in the inspection process. This resulted in the AFRH staff perception that this was not a balanced, structured review, but rather biased and subjective in nature. **IG** - "Agency Directive 1-11A, "AFRH Internal Controls," June 28, 2012, established an Agency-level "AFRH Internal Control Senior Assessment Team." The directive required PI Committees at the facility level, which reported to the Senior Assessment Team. The facility administrators were required to chair the facility PI Committee. The membership of the facility PI committees was established in a separate document, the Agency Notice 12-10, "Person-Centered Care Manual," July 20, 2012. The membership list used titles which did

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not exist at the facilities, including "Medical-Pharmacy Component Leader" and "Nursing Component Leader." Because the Agency guidance describing the membership of the PI Committee did not include the CHS in the Committee, there was confusion about the role of the CHS in the PI program." **AFRH** - DoD IG Medical Lead did not address any of the points highlighted in this discussion with the Acting PI Integrator nor COO. It appears that a review of documents after the inspection lead to many conclusions which could not be addressed. For instance, the inference that PI at AFRH has to be like Army MEDCOM QM limited the DoD IG team from objectively evaluating AFRH. The difference between the policy documents reflected the multiple areas in which the PI, a campus wide improvement program versus a healthcare quality improvement program will impact AFRH. In this discussion the DoD IG Medical lead is incorrect in stating names of the PI component leaders as written in Agency Notice 12-10 did not exist. In fact this document was accurate at that time. Concern that the CHS was not included in the PI program was unfounded in that the lead of the Medical-Pharmacy Component was the Chief, Healthcare Services at its inception. As a point of clarification, both components lost their CHS leads soon after the program began so other individuals took charge until this position could be filled. There are several events that impacted these changes but since it appears that a retroactive investigation to the PI program occurred after the DoD IG team left, their conclusion were never address with AFRH. Any discussion that was held with the AFRH-G DON and CHS would not have been fruitful or insightful as they were very recent members of the AFRH-G staff and could not provide answers to questions that they had not addressed with senior leadership.
[redacted]
A.10.a. AFRH COO ensure the facility personnel and Agency Performance Improvement Integrator obtains the necessary training to perform their duties to enable improvements in these programs.
Concur with comment: Recommendation in-progress. Campus Level Performance Integrators have taken formal training in the development of performance measures. Entire culture for performance improvement for AFRH is maturing.
A.10.b. AFRH COO obtain qualified personnel as medical advisors for the Quality Management and Performance Improvement programs.
Concur with comment: Recommendation complete. SMA advisor and members of Advisory Council provide medical expertise as needed at AFRH
A.10.c. AFRH COO revise the policies of the Performance Improvement program, including clarification of the membership of the Performance Improvement committees at the Agency and facility level. Include the Medical Director, Chief Medical Officer, Chief of Healthcare Services, and Director of Nursing on the committee.
Concur with comment: Recommendation in progress. The AFRH performance improvement culture and procedures include an annual evaluation that allows re-alignment of priorities and procedures.

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A.10.d. AFRH COO ensure appropriate metrics, incorporating specific inclusion and exclusion criteria, are adopted to measure the effectiveness of the Quality Management and Performance Improvement programs.
Concur with comment: Recommendation in progress. AFRH is working with SMA to ensure appropriate healthcare metrics are developed. The current heath care operational assessment conducted by The Joint Commission Resources, Inc. provided a report that was used in conjunction with P&R recommendations to dictate metric development.
Observation A.11: Medical Record Documentation
Discussion: AFRH is transitioning to an electronic medical record which will eliminate the identified short coming of the medical documentation. Resident medication education will be documented more clearly.
Recommendation(s):
A.11.a. AFRH COO ensure that appropriate standards for outpatient records documentation and nursing documentation in Long Term Care/Assisted Living are established.
Concur with comment: Recommendation in progress. Outpatient records are being transferred to a customized electronic medical record (EMR) system. Documentation required by Joint Commission standards for Nursing care and Ambulatory care is being incorporated in the EMR.
A.11.b. AFRH COO ensure that peer review is performed based on those standards and peer review results track quality improvement and privileging.
Concur with comment: Recommendation in progress. Existing peer review information and data will be packaged in a manner that demonstrates a direct link to privileging.
A.11.c. AFRH COO ensure Agency-wide adoption of the Department of Veterans Affairs/Department of Defense Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain Working Group.
Concur with comment: Recommendation in progress. AFRH is using The Joint Commission standards to update existing pain management policies. Will also utilize clinical practice guideline from most appropriate source for the geriatric population. Critical processes will be worked with SMA.

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A.11.d. AFRH COO consider the addition of a clinical pharmacist to the staff at Armed Forces Retirement Home – Gulfport. Alternatively, an available physician who is knowledgeable regarding medication use and risks in the elderly should review outpatient medications.
Concur with comment: Recommendation complete; AFRH-G will coordinate pharmacy medication reconciliation for residents with Keesler AFB.
[redacted]
Discussion: Many of the personnel issues discussed in this observation have been eliminated by the exiting of the senior nursing staff, as well as the previous DON and CHS. These positions have now been filled with new individuals with key positions selected with the participation of the SMA. Another major change was the moving of all Assisted Living and Long Term Care/Memory Support residents from the old LaGarde Building to the upgraded portions of the Sheridan Building and New Scott Building respectively. Completion of this move has resulted in reduced stress on the nursing staff. As the healthcare staff prepares for The Joint Commission accreditation survey in the fall of 2014, policy documents will be reviewed, revised as needed and implemented.
[redacted]
A.12.a. AFRH COO clarify the roles of Chief of Healthcare Services and the Director of Nursing at the Armed Forces Retirement Home - Washington, D.C. to ensure there is no overlap in responsibilities.
Concur with comment: Recommendation complete. The roles of the Chief of Healthcare services and the Director of Nursing are separate and clearly defined in their position description.
A.12.b. AFRH COO support the Chief of Healthcare Services in supervising the multiple sections for which she is responsible. Provide education and training to improve her knowledge in management of specialty areas other than nursing.
Concur with comment: Recommendation complete. The CHS at the time of the DoD IG inspection is no longer with the organization so comments in the discussion related to educational background and or ability to manage non-nursing personnel are no longer an issue. In the fifteen months since the inspection a new CHS has been selected with the participation of the SMA. AFRH promotes continued education and training to enhance the performance of all personnel.
A.12.c. AFRH COO ensure that Agency policies and facility standard operating procedures are revised to reflect the scope and services of the Armed Forces Retirement Home and that staff of the Armed Forces Retirement Home - Washington, D.C., implement those policies.
Non-concur: We are unable to respond as there are not sufficient details provided by the DoD IG report where scope and services were exceeded. If the DoD IG will identify, we will respond.

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A.12.d. AFRH COO support and assist supervisory personnel, especially the Director of Nursing, when disciplinary actions are required.
Concur: Recommendation complete.
A.12.e. AFRH COO ensure that all staff members are focusing on patient (resident) centered care and provide the staff appropriate training. If staff is unwilling to comply, support termination.
Concur with comment: Recommendation in progress. Person-centered care (PCC) is a strategic goal at AFRH and will be strengthened as preparation for The Joint Commission accreditation includes developing performance measures for PCC. The P&R review and DEOMI survey that were conducted since the DoD IG inspection did not reveal that PCC was insufficient at AFRH. The recent Operational Assessment by the Joint Commission Resources commended the AFRH staff for the level of person-centered care. Training of staff members will continue as a part of mandatory training as it has been for the past three years.
[redacted]
Discussion: Major changes have occurred in the AFRH-G healthcare staff. Most positions have been transitioned to federal employees and replaced the contract staff. This includes the Nurse Educator. Nurse practitioners positions have been filled at the GS-12 grade level that is acceptable in the local market as reflected in the attached USAJOB Announcements for Nurse Practitioners. AFRH continues to require standardization in SOP where appropriate with modifications as are relative to the location as is common in military facilities.
[redacted]
A.13.a. AFRH COO support the Armed Forces Retirement Home – Gulfport Healthcare Services leadership in tailoring standard operating procedures to fit the facility. Utilize the expertise of these leaders to improve policies and procedures at the Agency and Armed Forces Retirement Home – Washington, D.C.
Concur with comment: Recommendation is in progress. Standard operating procedures (SOP) are being reviewed as a part of preparation for the Joint Commission accreditation. SOPs at AFRH are developed to be standardized in areas that requirement documentation and measurement for performance or reporting. Where there are differences in operations due to the uniqueness of each campus the SOP will reflect it.
A.13.b. AFRH COO support the conversion of the contract nursing education position to a General Services position and ensure that nursing orientation and education programs are fully implemented.
Concur with comment: Recommendation complete. The educator position was converted to a GS position with appropriate duties in execution.

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A.13.c. AFRH COO re-evaluate the General Service grading decision regarding the Government employee grade level for Nurse Practitioners. Consult the Senior Medical Advisor to assist with such decisions in the future.
Concur with comment: Recommendation complete. The General Schedule grade for Nurse Practitioners was evaluated and determined be appropriate for the locale. Please see attachments regarding NP vacancy announcements posted in USAJOBs (Attachment 10). Examples were taken from Health and Human Services and MEDCOM.
Observation A14 Accreditation and Prior Inspections
Discussion: None
Recommendation A14
A.14.a. Under Secretary of Defense for Personnel and Readiness, require the Chief Operating Officer to meet the requirements of section 411(g), title 24 United States Code to have all services of the Armed Forces Retirement Home accredited by a nationally recognized civilian accrediting organization.
Concur with comment: Process to include all services (medical, dental, pharmacy, independent living, assisted living, and nursing care) of AFRH not currently accredited is underway.
A.14.b. AFRH COO improve policies addressing data collection, analysis, performance improvement, and staff education. Implement the improved policies and evaluate the implementation.
Concur with comment: Recommendation in progress. AFRH Agency provides oversight in the performance improvement and risk management in a continuous improvement manner. Staff education regarding performance improvement will continue to be promoted to enhance efficiency and effectiveness in services rendered as well as to control operational costs.
A.14.c. AFRH COO establish metrics to determine and measure progress made on implementation of person-centered care.
Concur with comment: Recommendation in progress. As part of the preparation for Joint Commission accreditation these metrics are being established.
A.14.d. AFRH COO add accreditation from The Joint Commission for Long Term Care and Ambulatory Care.

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Concur with comment: Recommendation in progress. Joint Commission accreditation in Ambulatory and Nursing Care preparations are underway for a survey in Sept 2014.
A.14.e. AFRH COO continue Commission on Accreditation of Rehabilitation Facilities Accreditation as a Continuing Care Retirement Community.
Concur with comment: Recommendation complete. Working with ASD (R&FM) and DHA, AFRH will maintain necessary accreditations to meet legislative accreditation requirements.
[redacted]
Discussion: AFRH Directive 4-3, AFRH Career Transition Assistance Plan (CTAP) clearly establishes that AFRH has adopted the Department of Treasury, Administrative Resource Center's (ARC) Career Transition Assistance Program (CTAP) policies and procedures. See attached document: Treasury Directive (Attachment 2). During the period reviewed, the ARC was in the process of re-engineering operations with a view toward identifying and implementing lean efficiencies and process improvements. Multiple training tools, work logs, check-sheets were developed; standard operating procedures (SOPs) examined and updated; a formalized staffing training program developed and implemented; and a Quality Control Program was implemented in FY13.
[redacted]
B.1. AFRH COO coordinate with the Bureau of Public Debt to develop a process for documenting the requisition number and the dates that the Career Transition Assistance Plan was cleared.
Concur with comment: Recommendation complete. During the period reviewed, the ARC was in the process of re-engineering operations with a view toward identifying and implementing lean efficiencies and process improvements. Multiple training tools, work logs, check-sheets were developed; SOPs examined and updated; a formalized staffing training program developed and implemented; and a Quality Control Program was implemented in FY 13. ARC is continuing to identify, develop, and standardize procedures. This entails conducting process mapping efforts which are expected to identify additional areas for improvement. See attached documents: The Staffing Quality Control Program (Attachment 3) and Staffing Peer Review Procedures (Attachment 4).

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Observation B.2: Lack of Transparency in Armed Forces Retirement Home Hiring Practices

Discussion: The Office of Personnel Management (OPM) conducted an audit of AFRH's Human Resources programs and hiring practices and did not find any indication that AFRH was not following required procedures or OPM guidelines. All Human Resources Directives are emailed to all employees at the time of publication and are posted on our internal website. Directives are reviewed periodically with staff at each facility.

The CHS vacancy announcement was cancelled each time to refine the position description. Review of the certificates of eligible candidates resulting from each recruit action proved that we were not reaching the talent deemed necessary to fulfill the duties of the position. The final position description was reviewed by staff members at the Defense Health Agency. That recruiting action was successful and an applicant was selected for the position.

The Agency Medical Director position was an urgent need in 2012. Both facilities required leadership at the Agency level for continuity of operations. At the Washington facility the medical providers are federal employees and at the Gulfport facility they are contract.

The Electronic Official Personnel Folder (EOPF) for the Chief Medical Officer does include the OPM required medical education credentials that deem his education is equivalent to education gained in an accredited U.S. education program. The copy attached was printed directly from the EOPF. OPM's General Schedule Qualification Policies Handbook under General Policies "4. Educational and Training Provisions or Requirements" accepts the medical license. See attached documents: Agency Medical Director License (Attachment 5) and Chief Medical Director transcript (Attachment 6).

Recommendations:

B.2.a. AFRH COO ensure that hiring managers provide documentation with justification for cancelling position announcements and document reasons for non-selection.

Concur with comment: Recommendation complete. Selecting officials prepare and retain documentation and justification for cancelling position announcements and reasons for non-selection.

B.2.b AFRH COO ensure that position descriptions are finalized before a job is announced and employees come on duty. Review all position descriptions when positions are vacant before they are announced.

Concur with comment: Recommendation complete. All position descriptions are reviewed prior to beginning the recruiting process.

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B.2.c AFRH COO ensure that the Human Resource Office sends e-mails out to employees informing them of all Armed Forces Retirement Home open positions. Additionally, ensure all positions are posted in the Armed Forces Retirement Home intranet.
Concur with comment: Recommendation complete. During 2012 our servicing Personnel office discontinued providing the Agency with final copies of the vacancy announcements. In 2013 that was corrected. All job announcements are provided to employees via email and copies are posted on bulletin boards in employee common areas.
B.2.d. AFRH COO coordinate with the Bureau of Public Debt to ensure staffing case files and electronic Official Personnel Files contain all necessary information (for example resume, transcripts, veterans preference documents, and clearance of Career Transition Assistance Plan).
Concur with comment: Recommendation complete: During the period reviewed, the ARC was in the process of re-engineering operations with a view toward identifying process improvements. Multiple training tools, work logs, check-sheets were developed; SOPs were updated and a Quality Control Program was implemented in FY 13.
B.2.e. AFRH COO ensure that all vacancies are posted on external locations such as USAJobs and that the vacancies' area of consideration is sufficiently broad to ensure availability of highly qualified candidates.
Concur with comment: Recommendation complete. All vacancy announcements are posted on USAJobs, Monster.com and Indeed.com. In addition announcements are posted on trade websites and provided to other Agencies with similar missions for broadcast.
[redacted]
Discussion: The AFRH CFO held Convenience Check Retraining for AFRH-W CORs, Purchase Card Holders, and Convenience Check requestors as well as met with the Acting AFRH-W Administrator to discuss discrepancies and provided recommendations to tighten controls. No discrepancies were found at AFRH-G. The use of a Convenience Check for Piano Tuning Services, referenced in the observation, was an appropriate use of Convenience Checks. This was a player piano and through market research conducted by the AFRH-G staff, they used the only vendor in the area that performed services for the make and model of the AFRH-G player piano.

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Recommendation(s)
C.1.a. AFRH COO develop policies that ensure that the Armed Forces Retirement Home Agency Chief Financial Officer directs the Purchase Card Program Coordinator to require all approving officials and cardholders that use or approve convenience checks to attend refresher training on convenience checks that stresses the restrictions on their use.
Concur
C.1.b. AFRH COO develop policies that ensure the Armed Forces Retirement Home Agency Chief Financial Officer direct the Purchase Card Program Coordinator to require approving officials to closely monitor use of all convenience checks to confirm compliance with guidance by preapproving all convenience check purchases.
Concur with comment: AFRH Directive 3-1 will be updated to require preapproval by the Campus Administrator and/or Corporate Resource Approver only.
Observation Title: Assessment of Funds are not being Audited
Discussion: None.
Recommendation(s)
C.2.a. AFRH COO develop policies to require the Agency Chief Financial Officer to ensure that the Armed Forces Retirement Home – Washington, D.C., Support Services personnel initiate cash counts of all cash funds at the Armed Forces Retirement Home – Washington, D.C., facility, as required by standard operating procedures W-OA-ADM-1-06, "Fund and Gift Accountability," July 6, 2012, and W-OA-BUS-2-04, "Miscellaneous," June 21, 2012.
Concur with comment: AFRH will update Directive 3-4 to require Campus Business Centers to provide results and certify cash audits have been completed annually.
C.2.b. AFRH COO develop policies to ensure that the Armed Forces Retirement Home – Washington, D.C., Financial Management Officer facilitate an annual outside audit of the Chaplain's Funds, as required by standard operating procedure, W-OA-ADM-1-06.
Concur with comment: AFRH IG will perform an annual audit of the Chaplain's fund. In addition, when Directive 3-4 is updated, the IG audit responsibility will be included.

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C.2.e. AFRH COO ensure the education and training of all Armed Forces Retirement Home – Washington, D.C., Business Center staff on the requirements of W-OA-ADM-1-06, "Fund and Gift Accountability," July 6, 2012, and W-OA-BUS-2-04, "Miscellaneous," June 21, 2012, and the procedures for conducting audit/cash counts.

Concur

Observation 11: Conflict of Interest in Dual Hatted Armed Forces Retirement Home Inspector General Position

Discussion: Since the creation of the AFRH IG position in 2002 the AFRH IG position has always been dual-hatted. Prior to the dual hat noted in this observation the AFRH IG position was dual-hatted with the duties of the AFRH Chief Information Officer/Safety Officer/Security Officer position – which was viewed by the COO as a conflict of interest. Prior to that it was dual-hatted with the Chief Support Services – which was not viewed as a conflict of interest by the COO nor DoD IG Team inspection of 2009. However in 2011 the Chief Support Services position was converted to the Chief Information Officer when the responsibilities for the CIO moved from the Deputy COO/CFO to this new position. Prior to that it was dual-hatted with the Chief Financial Officer, which was viewed by the DoD IG Team inspection of 2005 as a conflict of interest.

On September 21, 2012 AFRH requested USAFMSA conduct a Manpower and Organizational analysis of the AFRH COO/CRO office and Business Centers at both Campuses. On September 26 the Manpower and Organizational analysis was approved by USAFMSA. Study/survey was conduct in October – November 2012. Survey results were brief to AFRH COO/CRO staff and Campus Administrators on November 27, 2012 with no objections. On December 5, 2012 survey results were briefed to DASD (MC&FP), who concurred with survey. On December 6, 2012 copies of request for survey, survey approval, and survey outbrief were emailed to DoD IG Inspection Team Lead, who acknowledged receipt on December 12, 2012. A member of the DoD IG Team meet with the USAFMSA analyst to discuss the survey and AFRH IG position. As a result at the request of the AFRH COO, USAFMSA produced an addendum to the report that specifically addressed the AFRH IG position. This addendum was provided to the DoD IG Team Lead and Acting Deputy Inspector General for Special Plans and Operations via email on January 30, 2013.

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Recommendation 1:
D.1.a. AFRH COO convert the Armed Forces Retirement Home Inspector General position to a full-time position, without any additional responsibilities that could cause a conflict of interest in the performance of Inspector General duties.
Concur with comment: Since the DoD IG Inspection in August/September 2012 the AFRH Inspector General position has been advertised and the first round of interviews have been completed. See attached document: US Army Manpower Study (Attachment 7).
Observation D.2: Lack of Quality Standards for the Armed Forces Retirement Home Inspector General Investigation and Audits
Discussion: Under 24 U.S.C. *§411* AFRH has the authority to set policy and guidance to meet credible standards for audits and investigations within the Federal Government and will develop policy in this area.
Recommendations:
D.2.a. Under Secretary of Defense for Personnel and Readiness update Department of Defense Instruction 1000.28, "Armed Forces Retirement Home, and "February 1, 2010, to make the following Department of Defense Instruction applicable to the Armed Forces Retirement Home Department of Defense Instruction 7050.01, "Defense Hotline Program."
Non-Concur - As an independent agency, and in accordance with 24 USC, section 411(a), AFRH has legislative authority to set policy and guidance to meet credible standards for audits and investigations within the federal government and will develop policy in this area.
D.2.b. AFRH COO revise Agency Directive 1-9, "AFRH Inspector General Program," June 2, 2009, to include quality standards for Armed Forces Retirement Home Inspector General audits and investigations. Audits should comply with the Generally Accepted Government Auditing Standards published by the Government Accountability Office. Investigative standards should be modeled after the Council of Inspectors General for Integrity and Efficiency Quality Standards for Investigations, November 15, 2011.
Concur with comment: AFRH will establish standards within the AFRH Agency Directive-Inspection General Program for audits and investigations that meet Federal Government standards.

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Tab E – Admission/Eligibility
Observation E.1: Noncompliance with Armed Forces Retirement Home Directive 8-13 in Determining Applicant Eligibility
Discussion: AFRH Directive 8-13 is used in determining applicant eligibility regarding "Incapable of Earning a Livelihood". AFRH Directive 8-13 was reviewed not only by agency legal counsel, but was also vetted by the DoD General Counsel's office. Legal reviews that predate said directive are no longer applicable.
Recommendation(s)
E.1. AFRH COO modify Agency Directive 8-13, "Incapable of Earning a Livelihood Designation," July 3, 2012, to reflect the established Armed Forces Retirement Home practice and the Armed Forces Retirement Home Legal Team opinion, with respect to determining eligibility of those deemed incapable of earning a livelihood.
Concur with comment: Recommendation complete. AFRH Agency Directive 8-13 does not require modification. Agency 8-9D dated September 26, 2013 covers the legal reviews for each applicant applying under the incapable of earning a livelihood category.
Observation E.2 Inadequate Eligibility Verification Process to Exclude Applicants Who Have Drug Abuse Problems
Discussion: AFRH Medical Examination must be completed by the Medical Provider and not the applicant. The Medical Examination form clearly requires the medical provider and not the applicant to disclose drug and/or alcohol history, misuse and addictions.
Recommendation(s)
E.2. AFRH COO establish drug testing as a requirement of the admissions process and random drug testing during the probationary period.
Concur with comment: If the prospective applicant's medical provider makes the determination the applicant has a drug problem then additional drug testing will be required by AFRH.

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Observation E.3: Noncompliance with Agency Directive and Standard Operating Procedure Requirement for the Pre-admission Process

Discussion: The Agency Public Affairs Officer and Medical Director were following the guidance set forth in the AFRH Agency Directive 8-5C (draft). The SOP for Transitions (W-OA-ADM-1-14 and G-OA-ADM-15) at the facility was not following the guidelines set forth in AFRH Directive 8-5B Admissions Program nor 8-5C (draft).

Recommendation(s)

E.3. AFRH COO in coordination with Armed Forces Retirement Home – Gulfport and Armed Forces Retirement Home – Washington, D.C. facility Administrators, review and revise the standard operating procedures and directives to resolve any contradictions.

Concur with comment: The Admissions Program Directive update is in progress. The Directive will provide the correct guidance for the Administrators to update the Standard Operating Procedures for the Transition Program at the facility level.

Table F – Facilities Improvement and Safety

Observation F.1: Armed Forces Retirement Home Occupational Health and Safety Manual and Emergency Operations Plan Not Issued

Discussion: None

Recommendation(s)

F.1. AFRH COO issue the pending directives related to the Armed Forces Retirement Home Occupational Health and Safety Manual, and the Armed Forces Retirement Home Emergency Operations program, as required by Armed Forces Retirement Home Agency policy.

Concur with comment: AFRH will review the pending draft directives 7.1 and 7.2 to determine if both are still required or if a single directive will suffice.

Observation F.2: Defective "HomeFree Emergency Call and Wander Alert System" ("HomeFree" System)

Discussion: At the time of this inspection and for some time before this inspection, Residents, which were at risk for flight, were not allowed to wander freely in the above mentioned area of LaGarde. At-flight-risk Residents, residents with the personal watches, were only allowed to

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free in the monitored and secure Dementia Ward on the Second floor of LaGarde and in the monitored and secured Day Room on the Ground floor. The HomeFree system was an obsolete system that has currently gone out of business. Obtaining service and parts to repair the system were difficult at best at the time of this inspection; therefore, AFRH did not attempt to repair equipment that was not in resident utilized areas. If the IG team had reported this issue to the AFRH Facility personnel at the time of this inspection, AFRH would have described the situation above to the DoD IG Team, and demonstrated how the areas the Residents where housed were safe, secured, and monitored. Since the closing of LaGarde in March of 2013, AFRH has installed a completely new Patient Monitoring System called Tektone throughout much of the Campus and all of the occupied buildings. We are currently testing and monitoring new system.

Recommendations:

F.2.a. AFRH COO calibrate the failed device in the "HomeFree" system.

Concur with comment: HomeFree is being phased out; the new Tektone System is up and running. We are currently working the kinks out of the new system.

F.2.b. AFRH COO follow operating procedure to test the monitoring devices periodically.

Concur with comment: Recommendation in progress; new Directive has been developed on how to test and monitor the new Tektone System.

F.2.c. AFRH COO notify the "HomeFree" system vendor about identified defects and failures, and ensure that routine tests cover all system checkups.

Concur with comment: Recommendation in progress; the HomeFree Company is no longer in business; the facility maintenance contractor has the preventative maintenance requirement in their contract for the new Tektone System that has been installed. They are required to follow the Tektone manufacturer guidelines and recommendations for all maintenance work and inspections.

[illegible]

Discussion: The above issue was the result of a wind storm that had recently occurred. The pole had been reported by the grounds keeper contractor to the maintenance contractor, and the maintenance staff had alerted the Security Chief that the device on that pole had been by-passed until the new Tektone Monitoring System was installed. This by-pass was necessary since the HomeFree Company was going out of business and did not have replacement parts for service. All involved personnel believed that this by-passing did not constitute an immediate safety issue since multiple monitoring poles were installed in the area, and the area being covered by the malfunctioning pole device did not seem to be affected due to the overlapping monitoring coverage of the other surrounding devices on poles. If the IG team had reported this issue to the AFRH Facility

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personnel at the time of this inspection, AFRH would have described the situation above to the DoD IG Team, and demonstrated how the area in question was monitored and safe for Residents.

While Security does perform regular patrols of all utilized areas of the campus, it is true that without actual activation it is impossible to be 100% sure that a device will perform as designed. It is also true that even after activating a device to test; it may malfunction within seconds of that test, which results in a defective device until the next scheduled test. Therefore, it is necessary to rely on the patient monitoring systems self-diagnostic capabilities and the manufactures recommended manual testing procedures for the nearly 1000 devices on campus to achieve the best results for ensuring a fully functional system. The New Patient Monitoring System installed to replace HomeFree, since support from HomeFree can no longer be procured, was created by Tektone, who is an UL Registered Firm. AFRH has taken steps to develop a directive and testing SOPs that follow the guidelines and recommendations of the manufacture within the next 4 months. Currently, the system is being monitored and tested by the Tektone staff during the warranty period while AFRH learns and trains on the capabilities and requirements of the system.

[illegible]

F.3. AFRH COO ensure that the fallen utility pole is fixed, and work with the "HomeFree" contractor to ensure that notifications are generated when a wireless monitoring unit is non-functional.

Concur with comment: Recommendation in progress; HomeFree is being phased out. The new Tektone System has been installed. The new Tektone exterior repeater system automatically notifies the main monitoring panel when an issue arises with monitoring devices.

[illegible]

Discussion: LaGarde Building was shuttered in March 2013.

[illegible]

F.4.a. AFRH COO ensure that safety inspections at the Armed Forces Retirement Home – Washington, D.C., LaGarde Building are performed and documented periodically, as required by the Armed Forces Retirement Home standard operating procedures.

Concur with comment: Recommendation complete.

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F.4.b. AFRH COO ensure that the Armed Forces Retirement Home – Washington, D.C., supervisors conduct daily inspections of conditions in the Assisted Living rooms, and that the Safety Officer(s) conducts/coordinates follow-up inspections to verify that corrections have been made to identified deficiencies.

Concur with comment: Recommendation complete. Since the completion of the DoD IG Inspection in September 2012 the LaGarde Building was shuttered (March 2013). Assisted Living rooms have since been relocated to the Sheridan building. Supervisors and staff monitor conditions daily with periodic inspections conducted by the Safety Officer to identify deficiencies and verify corrections.

[redacted]

Discussion: Cameras are mounted that monitor the openings. The gaps in the fence are over the entry and exit points of the huge drainage canal on the campus that services a good portion of the Gulfport community. An attempt to enclose the sections of fences that are over the canal could result in major drainage issues for AFRH and the community due to debris buildup on any enclosure. This issue was discussed with the DoD OIG Safety team during the inspection, which concurred with the AFRH approach to monitor the openings with CCTV cameras. AFRH does not believe the benefit of such a fence in light of the cameras out ways the liability of installing fences to the AFRH. This issue was discussed with the DoD OIG Safety team during the inspection, who concurred with the AFRH approach to monitor the openings with CCTV cameras.

[redacted]

F.5. AFRH COO ensure that the two security fence gaps are securely closed at the Armed Forces Retirement Home – Gulfport.

Non-concur: Department of Homeland Security conducted a threat assessment of D.C. and Gulfport facilities. Use of cameras in Gulfport to monitor two security fence gaps provides adequate security consistent with Department of Homeland Security's threat assessment. Cameras are mounted that monitor the openings. The gaps in the fence are over the entry and exit points of the huge drainage canal on the campus that services the Gulfport community. Enclosing the sections of fences could result in major drainage issues for AFRH and the community due to debris buildup on any enclosure. This issue was discussed with the DoD OIG Safety team during the inspection, which concurred with the AFRH approach to monitor the openings with CCTV cameras.

[redacted]

Discussion: AFRH agrees that there was a major issue with the system during the inspection. An intermittent technical malfunction had made it difficult for the system to continuously stay online and monitor devices, and being intermittent, the malfunction was difficult to diagnose and correct by the manufacture repair service personnel. Within 2 months of this inspection, the technical issue had been resolved. The system is currently running as designed with no outages. Random device activation(s) are performed by Security each day to ensure the system is up and running per

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manufacture guidelines. The results of the activations are published in the Security Blotter for all management to review.

Recommendation(s)

F.6. AFRH COO ensure that the Armed Forces Retirement Home – Gulfport Resident Monitoring System is fully functioning and maintained, and provides the sustained and reliable service intended.

Concur with comment: Recommendation complete. Each day the resident monitoring system is tested through various monitoring system devices. The results are included in the daily blotter. Any malfunctions are reported to maintenance for corrective action.

[redacted]

Discussion: The DoD IG Information Assurance Inspection Team makes various statements in its discussion. The bullets below are the areas in which the DoD IG Information Assurance Team makes reference to specific weaknesses, followed by the AFRH comment in response to the weakness…

IG: Access Control – "This control was intended to protect the systems and network from unauthorized access. This control also required the information system to enforce approved authorization for controlling the flow of information within the system and between interconnected systems, in accordance with the applicable policy. The DoD IG Inspection Team reviewed the DOI NBC-AFRH POA&M and found two weaknesses in this security control family area that were not corrected. AFRH did not have a remote access area procedure that included AT&T remote support. AFRH also lacked tools to monitor unauthorized connections and/or to interrogate the information system prior to establishing a connection to the system".

AFRH: The DOI NBC-AFRH POA&M identified access control referenced in this observation as an issue at the DOI-NBC data center. The weaknesses found during the DoD OIG inspection have since been corrected and closed in the POA&M. Remote access tools for AT&T remote support were limited in scope. AFRH is currently in the process of moving its ISP support under the DOI-NBC MTIPS service on or before 2-24-14. All connections (authorized and unauthorized) to the AFRH network will be monitored through the MTIPS connection. This change was discussed with the Inspection Team during the inspection.

IG: Audit and Accountability – "This control required the AFRH to identify events which needed to be auditable as significant and relevant to the

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security of the information system. The DoD IG Inspection Team reviewed the DOI NBC-AFRH POA&M and found that the security violations and auditable events were logged; however, there was no formal process established for an audit to facilitate the review or evidence that the review was consistently completed."

AFRH: The AFRH initiated the Certification & Accreditation process as a formal means of auditing and documenting security and controlled weaknesses. This particular weakness was found to be an action for the DOI-NBC to correct in POA&M and not the AFRH. The AFRH believes that the DoD Inspection Team assigned this weakness in error.

IG: Security Assessment and Authorization – "This control required AFRH to assess all security controls in the information system to determine the extent to which the controls were implemented correctly, operating as intended, and producing the desired outcome with respect to meeting the security requirements for the system. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed that a process between NBC and AFRH to track and remediate deficiencies through a POA&M process had not been implemented. The DoD IG Inspection Team also observed other control weaknesses listed in the DOI NBC-AFRH POA&M that were not implemented nor executed".

AFRH: The AFRH and DOI-NBC had established a process to review, track and remediate control weaknesses found in its 2012 POA&M. The process included bi-weekly meetings between the AFRH and DOI-NBC to review & open weaknesses found in the POA&M. The process also required the DOI-NBC Security Team to routinely review any deficiency found in the AFRH DOI-NBC enterprise and notify the responsible parties at each agency where weaknesses were found or had not been corrected. This process was discussed with the Inspection Team with both the AFRH and DOI-NBC

IG: Configuration Management – "This control was intended for controlling modifications to hardware, firmware, software, and documentation to protect the information system against improper modifications before, during, and after system implementation. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed the following controls still had not been implemented as required"

- Information on how AT&T monitors internal network baselines was not documented.
- A formal configuration management process had not been developed or implemented.
- The standards and hardening principles for configuration settings had not been identified.
- The AFRH had not identified the information deemed necessary for effective IT property accountability
- The AFRH had not developed or implemented a configuration management plan.
- The AFRH Windows systems were missing security patches.
- AFRH had not implemented permission controls that limited the ability to install or run application software to authorized users. With the ability to run arbitrarily, the AFRH system may be used maliciously to introduce additional risks into the system network. The permission controls to install or run application software must be limited to authorized personnel only.
- The access to onto network shares may have presented unauthorized information to unauthorized users.
- Domain Name Servers (DNS) were provided with the remote access protocols. Remote access protocols were not supposed to include

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DNS.

- The Adobe software was not updated to mitigate vulnerability. The security patches were not updated for Adobe software, exposing the system and network to undue risks.
- The Socket Security Layer certificate was expired and needed to be updated.
- The system revealed too much data during information gathering activities, relaying system functions, ports, programs, etc.
- The AFRH information system was not configured in accordance with baseline configuration documents.
- The AFRH changes to the information system were not tested and approved prior to implementation, nor were these changes documented.
- The standards and network hardening principles for baseline configuration had not been established.

AFRH: The AFRH baseline/configuration management plan was developed and executed by the DOI-NBC. A formal baseline configuration and management plan does exist and is available from the DOI-NBC. DOI-NBC states that the Inspection Team did not request this information during the inspection. The AFRH annually provides information to its Facilities Office for the collection of information for IT assets (DC & Gallipoli). DOI-NBC provides automated security patches for the AFRH-W Windows desktops and manual patches for the AFRH-G Windows desktops. Automated Windows security patches for the AFRH-G desktops will commence in Feb 2014. Permission controls are and have always been in place for AFRH desktop computers. AFRH is unsure why this was found as a weakness. Network shares can only be removed by the AFRH IT or DOI-NBC IT departments. Remote access protocols have been corrected to not include Domain Name Servers (DNS). Adobe software has been updated on the servers at the AFRH-W and AFRH-G. The SSL certificate has now been updated. The AFRH information system meets the requirements of its established baseline configuration. All changes to the AFRH information system are tested on development servers prior to going into production. The AFRH is unclear as to what the Inspection Team is referring to in its observation that the standards and network hardening principles for baseline configuration had not been established.

IG:

- Physical and Environmental Protection – "This control required AFRH to have formal, documented procedures to facilitate the implementation of the associated physical and environmental protection controls, such as the fire protection system, the temperature and humidity controls, water damage protection, emergency lighting, emergency power shutoff system, etc. A review of the AFRH SSP and NBC-AFRH POA&M revealed that":
  - Neither server room at the AFRH-W and AFRH-G facilities had an emergency power off switch to cut off the power to the information systems in an emergency situation.
  - The computer room for AFRH-W did not employ a sprinkler system or dry pipes. At the time of the inspection, the computer room did not have fire protection.
  - The AFRH-W computer room did not employ temperature and humidity controls.
  - The AFRH did not develop a formal physical access authorization and review process.
  - The emergency lights and emergency exit lighting were missing at AFRH-G.
  - The fire suppression system was not installed in AFRH-W.

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AFRH: The AFRH-W server room has main power switch that cuts off power to the entire room. The AFRH-G server room now has a main power switch that will cut off power to the server, if necessary during an emergency situation. The AFRH-W server room does in fact have a sprinkler system. Fire protection has also been added to the AFRH-W server room. The AFRH-W server does have temperature and humidity controls, which were in place during the DoD IG inspection. The AFRH does have a formal physical access authorization and review process, which was made available for review to the DoD IG Inspection Team during their inspection. The emergency lights and emergency exit lighting at the AFRH-G was reviewed by the DoD IG Safety Inspection Team as well and this was not reported as an issue. Fire suppression was being scheduled for insertion into the AFRH-W server room during the inspection, and has now been completed.

IG: Program Management - "This control required AFRH to develop and disseminate an organization-wide information security program plan. The information security program plan could have been represented in a single document or compilation of documents, at the discretion of the organization. The plan documented the organization-wide management controls and organization-defined common controls".

AFRH: AFRH issued AFRH Directive 6-2.A, Information Security (dated July 2012) to all agency staff. It was also posted on the AFRH Intranet website in July 2012. This document provides the AFRH Information Security Program Plan.

IG: Risk Assessment - "This control required AFRH to conduct an assessment of risk. This control also required AFRH to employ vulnerability scanning tools and techniques, to scan for vulnerabilities in the information system, and to analyze vulnerability scan reports and results from security control assessments. A review of the AFRH SSP and DOI-NBC-AFRH POA&M revealed that the AFRH did not periodically scan the systems for vulnerability".

AFRH: This weakness was identified in the AFRH DOI-NBC POA&M as a weakness for DOI-NBC and not the AFRH. The weakness has since been remedied by DOI-NBC.

IG: System and Services Acquisition - "This control required AFRH to determine, document, and allocate the resources required to protect the information system. It also required the AFRH to manage the information system using system development life cycle methodology. A review of the AFRH SSP revealed that the AFRH did not have the IT life cycle in place".

AFRH: Life Cycle Management of the AFRH network and any associated equipment is provided by the DOI-NBC. The DOI-NBC furnished the AFRH network equipment and any associated equipment that make-up of the infrastructure, which would be included in the DOI-NBC life cycle documentation. The AFRH has developed an Information Strategic Plan that provides details on AFRH owned and furnished equipment (desktop & laptop computers, Cell Phones, Black Berry's, Printers, Copiers), and the life cycle management of these devices.

IG: System and Communications Protection - "This control required AFRH system to monitor and control communications at the external boundary of the system and at key internal boundaries within the system. This control also required the AFRH system to implement required cryptographic protections using cryptographic modules that complied with applicable Federal policies and standards. A review of the AFRH SSP and DOI-NBC-AFRH POA&M revealed that".

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- A Voice over Internet Protocol (VoIP) was not implemented in the AFRH's LAN GSS.
  - The AFRH servers, workstations, and laptops were not encrypted.
  - An agreement between AFRH and AT&T to provide adequate system and communication control had not been established.

AFRH: The AFRH LAN GSS will be monitored through the DOI-NBC Managed Telecommunications Internet Protocol Service (MTIPS), which will negate the need for VOIP connection. The AFRH users do not store any sensitive, PII or classified data on their desktops or laptops. Given this scenario the AFRH does not feel that encrypting the desktops or laptops is needed. The AT&T agreement will be replaced by the DOI-NBC MTIPS agreement in February 2014, which will provide the necessary communication controls to ensure adequate system protection and integrity. This information was discussed with the DoD Inspection Team during the inspection.

IG: System and Information Integrity – "This control required AFRH to develop, review, and update formal, documented procedures to facilitate the implementation of the system and information integrity policy and associated system information controls. A review of the AFRH SSP revealed that information system weaknesses were not identified, documented, and corrected".

AFRH: AFRH would like to preface this response by stating that the DoD Inspection Team which reviewed the AFRH Information Assurance areas were not well versed nor seem to be very familiar with the difference between an Inter-Agency Agreement (IAA) and a contract. There are many references to providing contract oversight, which actually do not apply in the environment that has been established through the IAA. IBC is a federal agency - which provides shared services to other federal agencies. In many instances, the DoD Inspection Team applied controls that were not applicable to the AFRH given the unique setup of its IT infrastructure. In many cases the controls identified as an AFRH weakness by the DoD Inspection Team actually should have been associated with the DOI-NBC. AFRH believes that the information required in this observation is included in the AFRH DOI-NBC POA&M AFRH Certification and Accreditation (C&A) documentation maintained separately from the AFRH SSP. The C&A was provided to the Inspection Team during their visit.

IG: Contingency Planning: "This control required the AFRH to establish an alternate storage site, including necessary agreements to permit the storage and recovery of AFRH backup information. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed the following weaknesses still remained":

- The AFRH did not elect to have an alternate processing site. Thus, an alternate processing site service had not been established. AFRH reportedly had no plan to search for an alternate site, because they planned to move their enterprises to the cloud.
- The organization will not be able to recover the system in a reasonable time when alternate sites have not been established.
- The AFRH did not utilize NBC disaster recovery services nor did the AFRH have a process in place to recover the system after a disaster. In the event of a system/hardware failure, the AFRH system could not have been recovered and reconstituted by backup tapes.
- The backup processes had not been developed to periodically backup the systems, and the AFRH may not have been able to recover the system from backup.
- The AFRH contingency activities were not tested annually.

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AFRH: The DoD OIG Inspection Team states in its observation above that the AFRH should develop a process to recover systems after a disaster. The AFRH has since created a "cloud" environment for its operation. Over 90% of the software applications used daily by the AFRH can be accessed by any computer outside of the AFRH. The AFRH network drives are backed up by the IBC data center. Hard drives of the desktop computers are not backed up. The AFRH will modify its current agreement with the IBC to include disaster recovery coverage for its network hardware and offsite data storage.

IG: Identification and Authentication – "This control required the AFRH system to have the capabilities to uniquely identify and authenticate information before establishing a connection. It also required AFRH to comply with the Homeland Security Presidential Directive 12 (HSPD- 12), "Policy for a Common Identification Standard for Federal Employees and Contractors," dated August 27, 2004, which required the AFRH system to use multifactor authentication for both network-access and local-access to privileged and non-privileged accounts. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed the multifactor authentication was not in use at the AFRH-W local area network (LAN)".

AFRH: This weakness was identified during the 2012 AFRH C&A and recorded in the 2012 POA&M. The weakness was assigned to the DOI-NBC and the AFRH. However, the AFRH has geared up to implement multifactor authentication. All AFRH staff and contractors (Gulfport and Washington, DC facilities) have been processed through the HSPD-12 system and have received Personal Identification Verification (PIV) cards. Workstations at both facilities are currently being upgraded with PIV card readers for additional end-user authentication. DOI-NBC plans to implement the PIV card authentication process on the AFRH local area network on or before the 3rd quarter of 2014. This plan was discussed with the DoD IG Inspection Team during the inspection process.

IG: Maintenance – "This control required AFRH to audit and document non-local maintenance and diagnostic sessions. The AFRH also required designated personnel to review the maintenance records. A review of the AFRH SSP and DOI NBC-AFRH POA&M revealed that":

- The AFRH did not handle the maintenance of the servers, desktops, and laptops as part of the AFRH system. The DOI NBC was responsible for providing security patch management. However, external maintenance was not conducted on the Windows operating environment.
- The maintenance and repairs made to the information system at AFRH were not consistently documented.

AFRH: As stated in the DoD IG observation above, the AFRH does not handle the maintenance of its servers, desktops and laptops. DOI-NBC provides maintenance and support for the aforementioned devices. Maintenance records are maintained by the DOI-NBC. This control weakness was a DOI-NBC issue that was remedied in the POA&M.

[redacted]

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G.1.a. Undersecretary of Defense for Personnel and Readiness, ensure that the Armed Forces Retirement Home takes aggressive information technology security actions specified in Observation G.1.b.

Concur with comment: AFRH has taken and will continue to take aggressive Information Technology security actions as specified in Observation G.1.b.

G.1.b. AFRH COO improve contractor oversight and take immediate steps to correct security control weaknesses as described in the Plan of Actions and Milestones including:

G.1.b. (1) AFRH COO applying updates to security control documentation as required by National Institute of Standards and Technology standards.

Concur with comment: Recommendation complete. The corrective actions for weakness identified in the AFRH 2012 POA&M was well underway during the DoD OIG Inspection and has been completed since the conclusion of the DoD IG Inspection of the AFRH in 2012. AFRH Security Control documentation has been updated to reflect the remedies and corrective actions from the POA&M. Additionally, the AFRH is establishing a support contract on or before July 2014 with an IT vendor to provide continued support for its FISMA, Web Development & Hosting, and to provide periodic updates to its security control documentation, and POA&M to ensure compliance with NIST standards.

G.1.b. (2) AFRH COO developing a formal physical access authorization and review process.

Concur with comment: Recommendation complete. AFRH has an established formal physical access authorization form and review process. This process was outlined in the AFRH Information Security Manual that was available during the DoD IG Inspection. See attached documents: Physical Authorization Form (Attachment 8) and Plan of Action and Milestones (Attachment 9).

G.1.b. (3) AFRH COO developing and implementing a process between the Department of the Interior National Business Center and the Armed Forces Retirement Home to track and remediate deficiencies through a plan of actions and milestones.

Concur with comment: Through the 2013 C&A Process conducted by the Interior Business Center (IBC), a Plan of Actions and Milestones (POA&M) was developed and closed. This POA&M will be used on a continuous basis by the AFRH to monitor deficiencies and remediate them

G.1.b. (4) AFRH COO implementing security patches for Armed Forces Retirement Home Windows 8 systems.

Concur with comment: Recommendation complete. Security Patching is done routinely by the IBC for AFRH desktops in DC. There was an issue with the Gulfport desktops. Manual updates were applied. Automated updates commenced for Gulfport desktops beginning Feb 1, 2014

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G.1.b. (5) AFRH COO developing a process to recover systems after a disaster,
Concur with comment: AFRH will develop a disaster recovery plan for its Information Technology systems.
G.1.b. (6) AFRH COO developing a process to backup systems periodically.
Concur with comment: Recommendation complete. AFRH systems are backed up by the vendor, IBC. Desktop and Laptop computers are not backed up; however, staff have been instructed to save their files to the AFRH network drives to ensure that data is securely backed-up at both campuses (AFRH-G & AFRH-W). Backup policies for the AFRH staff are outlined in the AFRH Information Security Manual.
G.1.b. (7) AFRH COO developing a procedure to periodically scan the systems for vulnerabilities.
Concur with comment: Periodic scans have been conducted by the IBC since 2010 for all systems used by the AFRH. Any discrepancies found are reported to the AFRH along with a corrective plan of action.
Tab H – Resident Recreation Services
Observation H.1: Lack of Adherence to Standard Operating Procedures at the Armed Forces Retirement Home Washington DC –
Discussion: We are currently updating all Resident Services SOP's Completion date is estimated 30 June 2014.
Recommendation(s)
H.1. AFRH COO develop internal controls to ensure the current Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services review standard operating procedures, monitor implementation, and make corrective actions, where warranted.
Concur
Observation H.2: Armed Forces Retirement Home-Washington DC Walk-through Inspections Lacked Consistency in Procedures and Documentation

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Discussion: Daily walk through inspections are documented by the Resident Volunteer Shop Manager/Attendant on days the Shop is open. The documents are filed in the Shop during the week, at week's end the Recreational Specialist picks them up and files them in her office. The Recreation Specialist also does a written inspection twice a week which are filed in her office. The Team leader or Recreation Supervisor will conduct a quarterly inspection with the Safety Officer. The Safety Officer will file the original copy in her office and a copy will be filed in the Arts Specialist's office with the other files.

Recommendation(s)

H.2. AFRH COO develop procedures to ensure the Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services implements a quality control plan to guarantee daily walk-through inspections are conducted, documented, and confirmed.

Concur

Observation H.3.a: Easy Access to Potentially Dangerous Heavy Equipment within the Armed Forces Retirement Home-Washington, DC

Discussion: The Arts Specialist and/or the Shop Manager conduct certifications as needed to meet the needs of those interested. A list is posted in the shop of those qualified to use the machinery. A certification card is given to the residents after completion of their training. The certification is effective for one year.

Recommendation(s)

H.3.a. AFRH COO develop procedures to ensure the Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services and Safety Officers conduct a safety assessment of the Auto Hobby Shop, Wood Shop, and Arts and Crafts Shop and take corrective actions to comply with Armed Forces Retirement Home Resident Services Standard Operating Procedures.

Concur

Observation H.3.b: No Ventilation System in the Armed Forces Retirement Home-Washington, DC Arts and Crafts Shop

Discussion: Regarding the entrance/exit of the Arts and Crafts Shop, there are two doors for egress. The Arts and Crafts shop has two working spray booths/exhaust systems which vent to the outside. This is the only area that cleaning greenware and spraying is authorized. A sign has been

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posted in the room near the booths.
Recommendation(s)
H.3.b. AFRH COO develop procedures to ensure the Armed Forces Retirement Home – Washington, D.C. Chief of Resident Services and Safety Officers conduct a safety assessment of the Auto Hobby Shop, Wood Shop, and Arts and Crafts Shop and take corrective actions to comply with Armed Forces Retirement Home Resident Services Standard Operating Procedures.
Concur
Observation H.4: Lack of Adherence to Standard Operating Procedures at the Armed Forces Retirement Home, Gulfport
Discussion: All GP SOP's have been revised in Feb 2013 and Dec 2013 to reflect Gulfport procedures. All SOP's are updated on an as needed basis as procedures change and annually reviewed.
Recommendation(s)
H.4. AFRH COO develop internal controls to ensure the current Armed Forces Retirement Home – Gulfport Chief of Resident Services.
Concur
H.4.a. AFRH COO reviews and revises standard operating procedures so that they capture the appropriate characteristics of activities that take place at the Armed Forces Retirement Home – Gulfport.
Concur
H.4.b. AFRH COO implements the procedures developed in response to recommendation H.4.a.
Concur

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Observation H.5: Armed Forces Retirement Home-Gulfport Walk-through Inspections Lack Consistency in Occurrence and Documentation
Discussion: All walk through inspections are conducted daily (Monday-Friday with exceptions of Holidays) and documentation of walk through inspections is completed daily. Daily walk through forms have been revised for all areas to be consistent with the SOP. The Recreation Supervisor will sign inspection logs weekly to verify compliance. All associated files are maintained in one location.
Recommendation(s)
H.5. AFRH COO develop procedures to ensure the Armed Forces Retirement Home – Gulfport Chief of Resident Services implements a quality control plan to guarantee daily walk-through inspections are conducted and documented.
Concur
Topic: Contract Management Observation I.1: Failure to Maintain Independent Government Cost Estimates and Other Supporting Documentation for Contract Estimates
Discussion: Since the IG did not highlight these observations during their BPD or AFRH Out briefs or provide a list of contract files referenced in the observation and IGCEs vary greatly depending on the size, scope and type of contract; AFRH was unable to determine what standard the IG was measuring IGCE clarity against. To verify AFRH and BPD were following IGCE standards and evaluate whether a deficiency needed to be remediated, AFRH CFO requested BPD sample AFRH current contracts. After reviewing 20% of current contract files, BPD concluded the IGCE contained in the files was appropriate for the size, scope and type of award and adhered to current AFRH/Treasury Fund Interagency Agreement, AFRH COR Handbook, Treasury Regulations, and Federal Acquisition Regulations.
Recommendation(s)
I.1. AFRH COO ensure that the Bureau of Public Debt's Contracting Officers enforce standards within the Interagency Agreement #1213-0026, the Armed Forces Retirement Home Contracting Officer Technical Representative Handbook, and the Federal Acquisition Regulation for developing Independent Government Cost Estimates and that this documentation is consistently provided by Armed Forces Retirement Home Contracting Officer Technical Representatives as part of the acquisition packages.

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Concur with comment: Recommendation complete. Since the IG didn't provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if IGCEs were complete and appropriate for the award size and scope. The BPD review determined IGCE's were included for each contract, were appropriate for the size and scope of the contacts and were within the standards set by the AFRH COR Manual and Federal Acquisition Regulation.
[redacted]
Discussion: Since the IG did not highlight these observations during the BPD or AFRH Out briefs or provide a list of contract files referenced in the observation, AFRH was unable to review the specific files identified in this observation. To verify whether market research was provided by CORs and signed by the Contracting Officer, AFRH CFO requested BPD sample AFRH current contract files. After reviewing 20% of current contract files, BPD found files contained signed collective market research outcomes and adhered to current BPD/Treasury Fund Interagency Agreement, AFRH COR Handbook, and Federal Acquisition Regulations. BPD did not sample files for collective market research standards set by: --CLC 004 since this reference is a training class which does not establish standards, or --Federal Acquisition Certification COR since this reference is the COR Certification process as set by FAR.
[redacted]
1.2. AFRH COO ensure that Bureau of Public Debt's Contracting Officers enforce standards within Interagency Agreement 1213-0026, the "Armed Forces Retirement Home Contracting Officer Technical Representative Handbook," and the Federal Acquisition Regulation and Department of Treasury Acquisition Regulation for conducting market research to ascertain a suitable approach to acquire, distribute, and support supplies and services.
Concur with comment: Recommendation complete. Since the IG didn't provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if market research was completed and appropriate for the size and scope of the award. BPD determined market research was included for all awards, was prepared appropriately for the contract size and scope and market research met the standards set by the AFRH COR Handbook, Federal Acquisition Regulation and Treasury Acquisition Regulation.
[redacted]

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Discussion: Since the IG did not highlight these observations during the BPD or AFRH Out briefs or provide a list of contract files referenced in this observation, AFRH was unable to review the specific files referenced in this observation.

To verify BPD was preparing award memoranda and evaluate whether a deficiency needed to be remediated, AFRH CFO requested BPD sample AFRH current contracts. After reviewing 20% of current contract files, BPD concluded an award memorandum was present for all contract files, was signed, appropriate for the size, scope and type of award and adhered to current AFRH/Treasury Fund Handbook, AFRH COR Handbook, Treasury Regulations, and Federal Acquisition Regulations.

[illegible]

I.3. AFRH COO ensure that the Bureau of Public Debt Contracting Officers place increased emphasis on making the determination and recommendation for award using procedures and requirements, as prescribed by the Federal Acquisition Regulation and Department of Treasury Acquisition Regulation.

Concur with comment: Recommendation complete. Since the IG didn't provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if award memoranda for contracts was completed and appropriately prepared for the award size and scope. The BPD review determined award recommendations were appropriately completed for the size and scope of the contract, were signed by both the Contracting Specialist and Contracting Officer, and were available in the contract file as required by Federal Acquisition Regulation and Treasury Acquisition Regulation.

[illegible]

Discussion: Since the IG did not highlight these observations during the BPD or AFRH Out briefs or provide a list of contract files reviewed, AFRH was unable to review the specific files referenced in this observation.

To verify AFRH CORs were preparing award modifications accurately prior to BPD processing modifications and evaluate whether a deficiency needed to be remediated, AFRH CFO requested BPD sample AFRH current contracts. After reviewing 20% of current contract files, BPD concluded the award modifications documentation was appropriate for the type of modification being processed and adhered to current AFRH/Treasury Fund Interagency Agreement, AFRH COR Handbook, Treasury Regulations, and Federal Acquisition Regulations. The observation "approval of a purchase request was insufficient by itself" doesn't recognize administrative modifications (i.e. change in accounting lines, COR changes) where the request itself is sufficient documentation.

[illegible]

I.4. AFRH COO ensure that Contracting Officers focus on obtaining all appropriate documentation from Contracting Officer Technical Representatives, as prescribed by Armed Forces Retirement Home and Bureau of Public Debt policies, to support contract transactions and the

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contract file.

Concur with comment: Recommendation complete. Since the IG didn't provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if contract modifications were sufficiently documented for the complexity of the individual contract action. BPD determined the files contained sufficient documentation for the complexity of the contract action being undertaken as prescribed by AFRH and Bureau of Public Debt policies. The specific observation "approval of a purchase request was insufficient by itself and has the potential to create problems during future audits and can create the perception of a lack of contract oversight" does not recognize the various types of administrative modifications.

Discussion: This observation doesn't recognize the scope of the AFRH/BPD Interagency Agreement (IA) which indicates BPD provides contract services. IA's, as well as other types of agreements between Federal Government Agencies (Reimbursable Work Agreements (RWA) or MIPERS) are not a type of contract and oversight is performed by the AFRH Agency. BPD does not have a role in IA oversight. AFRH uses the BPD provided PRISM system to establish and automatically feed the obligation to Oracle Financials. The AFRH CFO reviewed currently AFRH IAs and validated each IA is being monitored by AFRH and regular oversight is being performed.

1.5. AFRH COO work with Bureau of Public Debt's Administrative Resource Center to clarify their respective roles and responsibilities, as well as to define consistent methodology for surveillance and monitoring of interagency agreements performance.

Concur with comment: The AFRH Agency Directive 3-1, pages 42-44 provide guidance for managing IA's, in addition, AFRH assigns a POC who is responsible for oversight and management of the interagency agreement. AFRH will review the Directive and provide additional clarity on the roles.

Discussion: Since the IG did not highlight these observations during the BPD or AFRH Out briefs or provide specific observations, AFRH was unable to evaluate specific observations.

Over 90% of AFRH contracts have a full-time assigned COR vice collateral COR duties. These positions are advertised, evaluated and selected based on these duties, and each COR completes training as required by AFRH COR Handbook, Treasury Regulations and FAR.

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Recommendation 1.6
1.6. AFRH COO ensure that the Armed Forces Retirement Home Contracting Office analyzes Contracting Officer Technical Representative's workload and seeks to align Contracting Officer Technical Representative experience with contracts to improve surveillance and monitoring of contractor performance.
Concur with comment: Recommendation complete. Per AFRH COR Handbook (July 2012), each AFRH COR has met the mandatory training requirements, been nominated by their management team based on their technical experience and been designated in writing. In addition, BPD completes annual AFRH contract file reviews to identify file and responsibility improvements needed to assist AFRH CORs in performing their responsibilities. Although CORs may temporarily be requested to assume additional duties due to separations/retirements, COR responsibilities are reviewed and adjusted appropriately.
Observation [illegible] Requirement Summary
Discussion: Since the IG did not highlight these observations during the BPD or AFRH Out briefs or provide a list of contract files reviewed, AFRH was unable to review the specific files referenced in this observation. To verify QASP were included in contract awards and evaluate whether a deficiency needed to be remediated, AFRH CFO requested BPD sample AFRH current contracts. After reviewing 20% of current contract files, BPD concluded all contracts included QASP which adhered to current AFRH/Treasury Fund Interagency Agreement, AFRH COR Handbook, Treasury Regulations, and Federal Acquisition Regulations. In addition, BPD found all Contractor Annual AFRH requests a list of the contract referenced and the specific deficiencies identified for this observation to perform a review of COR files to determine if oversight was appropriately being performed and documented.
Recommendation 1.7.a
1.7.a. AFRH COO ensure that Contracting Officer Technical Representatives develop Quality Assurance Surveillance Plans for surveillance in accordance with the prescribed Armed Forces Retirement Home and Federal Acquisition Regulation policies.
Concur with comment: Recommendation complete. Since the IG did not provide a list of contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if QASP or Performance Requirement Summary (PRS) were adequate to evaluate contract performance

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based on contract type. BPD determined QASP or PRS were included for all awards, were prepared appropriately for the contract size, scope and type and met the standards set by the AFRH COR Handbook and Federal Acquisition Regulation.

I.7.b. AFRH COO ensure that Bureau of Public Debt Contracting Officers document and implement surveillance methodologies to effectively manage contractor performance.

Concur with comment: Recommendation complete. Since the IG didn't provide a list of the contracts they reviewed, AFRH requested BPD sample a portion of our current contracts to determine if surveillance methodologies were adequate to assess contractor performance. The BPD review determined QASP or PRS were adequate to measure contractor performance based on the contract size, type and scope.

[redacted]

Discussion: Charge of the Scale was officially transferred to the VA Police Force on or about Nov 2013. Barricades were strategically placed in locations that prohibit Scale Gate traffic from entering the AFRH main grounds. The AFRH is establishing a written agreement to ensure that the VA Police abide by AFRH Security SOP No. W-OA-SEC-5-27.

[redacted]

J.1.a. AFRH COO complete a written agreement with the Department of Veterans Affairs to ensure that Veterans Affairs Police Officers on Scale Gate facility entrance security duty are in full compliance with Armed Forces Retirement Home security policies and standards for access control.

Concur: Recommendation in progress.

J.1.b. AFRH COO assign Armed Forces Retirement Home – Washington, D.C. security guards to attend to the Scale Gate facility entrance until Department of Veterans Affairs Police Officers begin providing security in full compliance with required policies.

Concur with comment: Charge of the Scale was officially transferred to the VA Police Force on or about Nov 2013. Barricades were strategically placed in locations that prohibit Scale Gate traffic from entering the AFRH main grounds.

[redacted]

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Discussion: The AFRH will explore various federal training programs for security officers and secure a training program that meets minimum training requirements of the DHS Federal protective Service guards. AFRH Security has implemented an active shooter program and provided training to staff and residents.

[redacted]

J.2. AFRH COO establish a security guard program that meets the minimum qualification and training requirements of Department of Defense or Department of Homeland Security Federal Protective Service guards, including a plan to respond to an active shooter incident.

Concur with comment: The AFRH will explore various federal training programs for security officers and secure a training program that meets minimum training requirements of the DHS Federal protective Service guards. AFRH Security has implemented an active shooter program and provided training to staff and residents.

[redacted]

Discussion: Wills are disposed of in accordance with 24 USC §420. The IG Inspection team did not find any Resident's original will in any file that was identified to AFRH. Probate Courts in both jurisdictions require original wills, not copies or references to a will for admission to Probate for the fulfillment of the testamentary wishes. Furthermore, there is no authority or requirement that AFRH be in possession or that they constantly update information relating to Residents wills. This observation is not feasible as many of our elderly Residents do not wish to have a will or talk about it as it is a cause of anxiety to many of them.

[redacted]

K.1.a. AFRH COO update Armed Forces Retirement Home Directive 8-8, "Estate Matters," September 2, 2008, to include amendments from the Public Law 112-81 and to reflect current practices of the Armed Forces Retirement Home.

Concur with comment: AFRH Directive 8-8 is currently under revision. AFRH is not in the practice of keeping original wills. Original wills found among Residents' personal effects are disposed of IAC 24 USC§ 420.

K.1.b. AFRH COO establish a written policy covering the handling, tracking and recording of all actions related to the disposition of last will and testaments that are given to or found by AFRH staff, before or after the death of a resident, with special emphasis on whether the will was provided to the court or given to the next of kin, executor, or other entity.

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Concur with comment: Requirements related to the handling of wills are also covered in 24 USC§420. AFRH is required to AFRH is not in the practice of keeping original wills. Original wills found among Residents' personal effects are disposed of IAC 24 USC§ 420.
K.1.c. AFRH COO ensure that Armed Forces Retirement Home Administrators adequately account for all wills executed by residents in their possession.
Concur with comment: Recommendation complete. This recommendation, with respect, is ambiguous. The pronoun "their" can be read to refer to AFRH or residents. AFRH is nonetheless not in the practice of keeping original wills. Copies of wills serve only as references for AFRH Administrators in identifying next of kin or nominated fiduciaries. Original wills found among residents' personal effects after they have died are accounted for, the AFRH/GC is notified, and the wills are disposed of IAC 24 USC §420. Residents are also under no requirement to make a will, and may revoke or alter a will at any time without providing notice to any interested party. The task of creating, updating, and securing a will is the resident's responsibility.
Observation K-2 Concur/Compliance with Established Policies and Procedures
Discussion: Since 2005, it has been the established policy of AFRH to not keep original wills. When entitlement to the deceased's property is established to the satisfaction of the AFRH Administrators, distribution of said property occurs pursuant to 24 USC §420(a)(2). AFRH Directive 8-8, *AFRH Estate Matters*, 2 September 2008, is currently being revised.
Recommendations
K.2.a. AFRH COO develop policies that ensure that each facility Administrator implements a standardized centralized record keeping process and policy specific to estate matters.
Concur
K.2.b.(1) AFRH COO update directives and standard operating procedures regarding the disposition of decedent's effects and estates to ensure: (1) they are complete and do not contradict each other, and

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Concur
K.2.b. (2) AFRH COO update directives and standard operating procedures regarding the disposition of decedent's effects and estates to ensure: they expand on the documentation requirements needed to verify conduct of all employees in these matters.
Concur with comment: AFRH Directive 8-8 is currently under revision and will incorporate by reference the Estate Fiduciary Codes of each facilities jurisdiction.
K.2.c. AFRH COO develop policies that require each facility Administrator to arrange for training and implement other measures to ensure that Armed Forces Retirement Home staff involved in the disposition of decedents' effects and the administration of estates are knowledgeable about their roles.
Concur with comment: Recommendation complete. The AFRH General Counsel has been tasked by the COO with the responsibility to provide training in estate matters to relevant AFRH employees by the AFRH/COO. This requirement has been occurring since 2011.
K.2.d. AFRH COO develop policies to ensure that each facility Administrator enforces policies, develops specific performance indicators, and develops a system for tracking compliance with directives and standard operating procedures, to include documentation of all required actions related to the disposition of decedents' effects and estates.
Concur with comment: AFRH Directive 8-8 addresses this recommendation and is currently under revision. Policies developed relating to decedents' effects and estates will be drafted to ensure compliance with 24 USC 420 and the Fiduciary codes of the respective jurisdictions of each facility.
K.2.e. AFRH COO ensure that each facility Ombudsman conduct continuous review of all actions taken and confirms that all records are on file.
Concur with comment: Current policy requires the Ombudsman maintain an overview of all actions and conduct a quarterly review of actions taken.
[redacted]

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Discussion: The AFRH legal team is prepared to advise AFRH Employees on compliance with the statutory requirements of 24 USC §420- DISPOSITION OF EFFECTS OF DECEASED PERSONS; UNCLAIMED PROPERTY. The AFRH legal team is also capable of assisting AFRH with probate matters should they arise. AFRH-Washington has a designated attorney to assist with estate and probate issues which arise in the District of Columbia. AFRH-Gulfport has identified a designated attorney from the Harrison County Bar Association to assist with estate issues which arise in Gulfport, Mississippi.
[redacted]
K.3.a. AFRH COO create policies that direct employee conduct in probate matters to ensure the highest level of transparency and protection.
Concur with comment: Employee conduct in probate matters is addressed in AFRH Directive 8-8. AFRH Directive 8-8 is currently under revision. Employee conduct is also addressed in 24 USC §420.
K.3.b. AFRH COO develop policies that ensure that the Armed Forces Retirement Home - Gulfport Administrator arranges for training of the Armed Forces Retirement Home - Gulfport employees in areas related to estate matters in probate cases.
Concur with comment: Recommendation complete. The AFRH General Counsel is tasked with the responsibility to provide training in estate matters to relevant AFRH-G and AFRH-W employees by the AFRH/COO. The AFRH/GC delivered training to senior management and two (2) social workers in February 2011 at a specific meeting regarding estates and wills. Training was recently conducted at AFRH-G in February 2014.
K.3.c. AFRH COO ensure that the Armed Forces Retirement Home - Gulfport Administrator adopt the Armed Forces Retirement Home – Washington, D.C. designated attorney as its own or select an attorney who meets the specifications dictated in section 420, title 24, United States Code.
Concur with comment: AFRH/GC has recently settled on a designated attorney to assist with Wills and Estates for AFRH-G. Prior to this selection, the AFRH-W designated attorney for wills and estates was ready to assist with and/or advise on Estate matters. Furthermore, a short-list of attorneys was provided to AFRH-G prior to this selection.
[redacted]

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Observation 1.1: Lack of AFRH Inspector General Hotline Implementing Guidance
Discussion: Under 24 U.S.C. *§411* §411(*a*)AFRH has the legislative authority to set policy and guidance to meet credible standards for the IG Hotline within the Federal Government and will develop policy in this area. As a matter of administrative law, as an independent agency of the executive branch, AFRH creates, promulgates and enforces its own directives and policy mandates.
Recommendation(s)
L.1.a. AFRH COO ensure the Armed Forces Retirement Home Inspector General issues implementing guidance that specifies: quality standards for the Armed Forces Retirement Home Hotline Program.
Concur
L.1.b. AFRH COO ensure the Armed Forces Retirement Home Inspector General issues implementing guidance that specifies: procedures to ensure appropriate evaluation and action on all allegations of fraud, waste, abuse, and mismanagement.
Concur
L.1.c. AFRH COO ensure the Armed Forces Retirement Home Inspector General issues implementing guidance that specifies: methods to ensure appropriate protection of the identity of sources requesting anonymity or confidentiality.
Concur
Exhibit Senior Management

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Observation O.1: DoD Instruction 1000.28 is Out of Date
Recommendation(s)
O.1. Under Secretary of Defense for Personnel and Readiness, update the Department of Defense Instruction 1000.28 to incorporate the Public Law 112-81 amendments to the Armed Forces Retirement Home Act.
Concur with comment: DoDI 1000.28 has been revised, coordinated within USD(P&R) and is in the issuance process for final edits and formal coordination.
Observation O.2: Hiring of Institutional Competent Personnel
Discussion: During the onsite visit and out brief there was no mention of this "Observation." As part of the Advisory Council meeting in November 2012 each Administrator was asked to highlight the DoD IG exit briefs at the Facility. The following was taken from the minutes of the Advisory Council meeting: **Washington Administrator (Dave Watkins):** Healthcare a. Medical documentation was generally good. b. Link more closely Agency bylaws and campus credentialing procedures. c. Metrics in PI needs to grow. Nursing a. "Supervisory Staff is great." b. There is some room to improve in metrics. **Gulfport Administrator (Charles Dickerson):** Medical a. Many employees are new. b. Credentialing issues have been addressed; contract Podiatrist replaced. c. One social worker is working under a license that requires supervision. The issue is being resolved. d. Nurses need continued training in emergency response.

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IG: "In addition, during the inspection the DoD IG Inspection Team found that two key supervisory nursing positions at the AFRH-W facility were vacant." In the first sentence of the second paragraph it states: "This happened because the AFRH management had been hiring internal candidates instead of hiring more qualified external candidates. Also the salary offered by AFRH management was not sufficient to attract the candidates with the required qualifications and competency."

AFRH: There is no evidence that supports any of this discussion by the IG Medical Team. We were unable to find the two supervisory positions that were stated as vacant. If the DoD IG team can identify what specific positions and time they were vacant, please advise. Also because internal candidates are hired instead of external candidates it does not indicate these hired were less qualified. During a discussion between the DoD IG Medical Team and the COO during a visit in November 2012 the Nurse Practitioner of the team addressed the grade levels of nurse practitioners in the AFRH. The COO indicated they were GS-12 grades. The DoD IG member did not agree with the grade level and cited her grade of GS-13 as rational. The Position Descriptions for AFRH Nurse Practitioners are graded at GS 12 level. Specific grades and salary are established under OPM guidelines as part of hiring/filling positions. See attached documents for two examples of job announcements for GS-12 Nurse Practitioners from USAJOBS (Attachment-10 USAJOB announcements). One is from Health and Human Services and the other from MEDCOM. AFRH is governed by Title 5 and OPM. As such all salaries are set by the General Schedule Pay Tables published annually by OPM. Nurse/Nurse Practitioners are a good example.

IG: Based on the observation of the DoD IG Inspection Team's medical inspectors, a number of senior medical personnel were determined to be insufficiently competent for their positions. (See Observation A.7. in Medical section.) Marginally competent senior medical leadership and nursing staff were contributing to low quality of overall medical care. The situation observed at the AFRH-W facility after the DoD IG Inspection Team's August 2012 field work as a result of disciplinary action recommended by BPD for a number of nursing staff and medical officer for "patient neglect (failure to meet standards of care)." The Report states: "If these disciplinary actions are implemented, AFRH-W facility will have even fewer nursing staff to provide the necessary care to the residents."

AFRH: It should be noted that these disciplinary actions have occurred without impacting resident care. There is no evidence that supports any of the discussion in the report or rubric used to justify the tone or demeaning allegations. As seen in the IG discussion above the report makes references that the competencies of the four AFRH professionals in GS positions (Agency Medical Director, AFRH-W Chief Medical Officer, AFRH Performance Improvement Integrator, and AFRH-W Chief of Healthcare Services) are "insufficient" or "marginally competent" and thus were the catalyst for many "Observations" and "Recommendations" cited in the report. The report makes allegations that are demeaning to the professional qualifications and integrity of these professionals. The onsite out briefs by the DoD IG Team made no mention about the qualifications of these four professionals. Over the course of the 15 months to produce this report, the DOD IG Team Lead never addressed, discussed, nor raised any concerns with the COO about the incompetency of these four AFRH professionals. The AFRH Medical Director was first certified as a medical director by the American Medical Director's Association (AMDA) in 2006 and his current certification is from 2010 to 2016. The AMDA Certified Medical Director (CMD) in Long Term Care Program was developed by AMDA in 1991 to define the core skills and knowledge necessary for effective medical direction. The Certified Medical Director program recognizes the equal clinical and managerial roles of the medical director.

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Certification requires indicators of competence in clinical medicine and medical management in long term care. The certification process is based on an experiential model that incorporates existing mechanisms such as fellowship programs, board certification, continuing medical education, CMD-approved and AMDA-sponsored courses in medical direction, and other continuing education programs to fulfill certification requirements. The CMO is also certified as a Medical Director. Both the AFRH's Medical Director and CMO resume/CV are attached (attachments 5 and 6). The AFRH PI Integrator was a part of the introduction of the DOD Centralized Credentials Quality Assurance System while serving as active Army credentialing Chair. In addition, as a retired United States Army Colonel, the AFRH PI Integrator has participated in and led quality initiatives in the past. While serving as Acting AFRH PI Integrator, the incumbent attended classes in Government Performance Management and Lead Six Sigma that were filled with incumbents as well as new selectees from many Government Agencies that were honing their skills, learning new techniques as all Government Agencies are coming on board with current Office of Management's new Government Performance Requirements.

[redacted]

O.2.a. AFRH COO offer market salary to attract highly qualified healthcare personnel, from both internal and external sources, to create competent senior medical leadership at the Agency and Armed Forces Retirement Home-Washington and to fill vacant nursing supervisory positions.

Concur with comment: Recommendation complete. AFRH is governed by Title 5 and OPM. As such all salaries are set by the General Schedule Pay Tables published annually by OPM. The AFRH will continue to hire competent senior medical leadership within Title 5 OPM guidelines and dictated salaries. As supervisory positions become vacant AFRH will place priority on hiring these positions within Title 5 OPM guidelines and salaries.

O.2.b. AFRH COO implement effective professional development programs for the current senior medical personnel to rapidly improve their medical knowledge and administrative competency. Replace those who fail to meet the required knowledge and competency after the completion of these programs.

Concur with comment: Recommendation complete. Please see discussion of competencies of senior medical AFRH professionals in "Discussion" of "Observation" 2. The AFRH will continue to conduct professional development programs and promote growth for employees. The dedicated senior medical professionals of AFRH are considered competent and qualified to perform the duties of their position.

[redacted]

Discussion: - None

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Recommendation(s)
O.3. Under Secretary of Defense for Personnel and Readiness, under the authority given to the Secretary of Defense in section 411(d)(3), title 24, United States Code, issue a directive-type memorandum for immediate action, followed by a revision of Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," dated February 1, 2010, to provide the Senior Medical Advisor appropriate authority and responsibility for the continuous oversight of medical operations of the Armed Forces Retirement Home to ensure appropriate medical care is provided to the residents.
Non-Concur - Statutory language establishes the SMA requirements and states: The SMA shall provide **advice** to the Secretary of Defense, the USD(P&R) the Chief Operating Officer (COO), and the Advisory Council regarding the direction and oversight of medical administrative matters at each facility of the Retirement Home; and the provision of medical care, preventive mental health, and dental care services at each facility of the Retirement Home. Statutory language states the role is advisory to the leadership of AFRH and does not infer the SMA has authority over AFRH as stated in the recommendation. Moreover, there is no need for the recommended additional guidance for a revision of DoDI 1000.28 since 24 U.S.C. § 413a(2) states that the SMA shall "ensure compliance by the facilities of the Retirement Home with accreditation standards, applicable health care standards of the Department of Veterans Affairs, or any other applicable health care standards and requirements (including requirements identified in applicable reports of the Inspector General of the Department of Defense)."
Observation O.4: Lack of Detailed Guidance from Under Secretary of Defense for Personnel and Readiness Regarding Applicable Department of Defense Policies and Standards
Recommendation(s)
O.4.a. Under Secretary of Defense for Personnel and Readiness, under the authority given to the Secretary of Defense in section 411(d)(3), title 24, United States Code, issue a directive-type memorandum for immediate action, (followed by a revision of Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010) to: Identify Department of Defense instructions, directives, and regulations that could be applicable to the Armed Forces Retirement Home, in all areas of operation, and direct the Armed Forces Retirement Home Chief Operating Officer to follow implement them.
Non-concur - Requiring AFRH to follow DoD instructions, directives, and regulations for which they have no input to the content and which are written for organizations with different structure, systems, and processes would add unnecessary risk for noncompliance with nationally recognized standards focused on the population and organization of the AFRH.
O.4.b. Under Secretary of Defense for Personnel and Readiness, under the authority given to the Secretary of Defense in section 411(d)(3), title 24, United States Code, issue a directive-type memorandum for immediate action, (followed by a revision of Department of Defense Instruction 1000.28, "Armed Forces Retirement Home," February 1, 2010) to: Identify other guidance (such as applicable Department of Veterans Affairs or Military Service guidelines and standards) where Department of Defense policy is not specific enough or not appropriate for the Armed Forces

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Assistant Secretary of Defense (cont'd)

Retirement Home. Require the Armed Forces Retirement Home to follow/implement such guidance.
Non-concur - Requiring AFRH to follow DoD instructions, directives, and regulations for which they have no input to the content and which are written for organizations with different structure, systems, and processes would add unnecessary risk for noncompliance with nationally recognized standards focused on the population and organization of the AFRH.
Observation O.5: Organizational Climate Free of Reprisal
Discussion: None.
Recommendation(s)
O.5.a. AFRH COO establish an open door policy and host town hall meetings to learn about the concerns of employees. Acknowledge, record, and respond to grievances and suggestions from the employees.
Concur
O.5.b. AFRH COO keep the employees informed of all the corrective actions taken as a result of investigations into past cases of reprisal, unless privacy laws prohibit such communications.
Concur
O.5.c. AFRH COO share with all the employees, particularly the lower-level staff, the FedView survey results and subsequent actions taken to improve the working conditions and organizational climate.
Concur

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Observation 0.6: Current Chief Operating Officer also Effectively Holding the Continuous Position of Deputy Chief Operating Officer/Chief Financial Officer
Discussion: On September 21, 2012 AFRH requested USAFMSA conduct a Manpower and Organizational analysis of the AFRH COO/CRO office and Business Centers at both Campuses. On September 26 the Manpower and Organizational analysis was approved by USAFMSA. Study/survey was conduct in October – November 2012. Survey results were brief to AFRH COO/CRO staff and Campus Administrators on November 27, 2012 with no objections. On December 5, 2012 survey results were briefed to DASD (MC&FP), who concurred with survey. On December 6, 2012 copies of request for survey, survey approval, and survey out brief were emailed to DoD IG Inspection Team Lead, who acknowledged receipt on December 12, 2012. The Survey recommended deleting Deputy COO/CFO position and hiring a CFO position. CFO has been hired.
Recommendation(s)
O.6. AFRH COO expeditiously fill the vacant position of the Deputy Chief Operating Officer/Chief Financial Officer (combined position) with a highly qualified and competent candidate.
Concur with comment: Recommendation complete. Per the results of USAFMSA Manpower and Organizational analysis the Deputy COO/CFO position has been deleted and a highly qualified and competent CFO has been hired.
Observation 0.7: Lack of Support for Employee Renewal Program
Discussion: AFRH has a comprehensive Incentive Awards program in place. The CHCO has consistently reminded managers of the Incentive Awards program and stressed implementation of that plan. A tuition assistance program is in development now. Employee person-centered growth is a Strategic Goal of AFRH. We will continue to grow in this important, strategic effort.
Recommendation(s)
O.7. AFRH COO expedite the development and implementation of an effective professional development/employee recognition program and an employee morale and welfare program (including the items identified above), with a priority on lower-level employees.

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Concur with comment: AFRH has established a team to review education and tuition assistance programs for all employees. Subsidizing of Toastmasters classes has been offered to employees who wish to attend on the campus. The Toastmasters Program was a joint program with employees and residents. The current Incentive Awards program has been implemented at both Campuses. Employee of the Quarter and Employee of the Year awards have been established and implemented. Planning for Guest Speakers on topics of interest to staff is in development.
Observation O.8: Creation of the Agency-Level Ombudsman Position
Discussion: On September 21, 2012 AFRH requested USAFMSA conduct a Manpower and Organizational analysis of the AFRH COO/CRO office and Business Centers at both Campuses. The position was support by the USAFMSA Manpower and Organizational Review of the COO/CRO Office.
Recommendation(s)
O.8. AFRH COO cancel and do not fill the proposed Agency-level Ombudsman position and utilize the funds towards improving the quality of the medical and nursing care by offering market salary to competent external candidates.
Non-Concur: The Ombudsman position was validated by the USAFMSA Manpower and Organizational Review. AFRH is governed by Title 5 and OPM. As such, all salaries are set by the General Schedule Pay Tables published annually by OPM. AFRH will continue to manage within OPM guidelines.

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Acronyms and Abbreviations

ACLS	Advanced Cardiac Life Support
AFB	Air Force Base
AFIA	Air Force Inspection Agency
AFRH	Armed Forces Retirement Home
AFRH-G	Armed Forces Retirement Home – Gulfport, MS
AFRH-W	Armed Forces Retirement Home – Washington, D.C.
AHLTA	Armed Forces Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AL	Assisted Living
AR	Army Regulation
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BDP	Bureau of Public Debt
C&A	Certification and Accreditation
CARF/CCAC	Commission on Accreditation of Rehabilitation Facilities/Continuing Care Accreditation Commission
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHCS	Center for Healthcare Services
CHS	Chief of Healthcare Services
CIGIE	Council of Inspectors General on Integrity and Efficiency
CMO	Chief Medical Officer
CNA	Certified Nursing Assistant
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COR	Contracting Officer's Representative
COTR	Contracting Officer's Technical Representative
CPG	Clinical Practice Guidelines
CQA	Clinical Quality Assurance
CTAP	Career Transition Assistance Plan
DA	Department of the Army
DEOMI	Defense Equal Opportunity Management Institute
DFE	Designated Federal Entity
DHA	Defense Health Agency
DME	Durable Medical Equipment
DNS	Domain Name Servers
DOI	Department of Interior
DON	Director of Nursing
DTAR	Department of the Treasury Acquisition Regulation
DUSD(MC&FP)	Deputy Under Secretary for Military Community and Family Policy
ECIE	Executive Council on Integrity and Efficiency
FAR	Federal Acquisition Regulation
FIPS	Federal Information Processing Standards

Acronyms and Abbreviations (cont'd)

FISMA	Federal Information Security Management Act
FLRB	Franchise Labor and Relations Branch
GAO	Government Accountability Office
GSA	General Services Administration
GSS	General Support System
HR	Human Resources
HSPD	Homeland Security Presidential Directive
IA	Information Assurance
IAW	In Accordance With
IBC	Interior Business Center
IDT	Interdisciplinary Team
IGCE	Independent Government Cost Estimate
IG	Inspector General
IL	Independent Living
ILP	Independent Living Plus
INR	International Normalized Ratio
IT	Information Technology
LAN	Local Area Network
LE	Law Enforcement
LPN	Licensed Practical Nurse
LTC	Long Term Care
LTC/AL	Long Term Care/Assisted Living
MEDCOM	Army Medical Command
MHS	Military Healthcare System
MOU	Memorandum of Understanding
NAT	Needs Assessment Team
NBC	National Business Center
NFPA	National Fire Protection Association
NIST	National Institute of Standards and Technology
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OUSD (P&R)	Office of Under Secretary of Defense for Personnel and Readiness
PAR	Performance and Accountability Report
PCC	Person-Centered Care
PCIE	President's Council on Integrity and Efficiency
PD	Position Description
PDUSD (P&R)	Principal Deputy Under Secretary of Defense, Personnel and Readiness
PI	Performance Improvement
POA&M	Plan of Actions and Milestones

Acronyms and Abbreviations (cont'd)

POC	Point of Contact
PRS	Performance Requirement Summary
PWS	Performance Work Statement
QAR	Quality Assurance Review
QASP	Quality Assurance Surveillance Plans
QM	Quality Management
RAC	Resident Advisory Committee
RMS	Resident Monitoring System
RN	Registered Nurse
RSVP	Resident Stipend Volunteer Program
SBAR	Situation, Background, Assessment, Recommendation
SMA	Senior Medical Advisor
SME	Subject Matter Expert
SOP	Standard Operating Procedure
SPO	Special Plans and Operations
SSP	System Security Plan
TAD	Technical Assessment Division
TB	Tuberculosis
USAFMSA	United States Army Force Management Support Agency
U.S.C.	United States Code
USD (P&R)	Under Secretary of Defense for Personnel and Readiness
VA	Department of Veterans Affairs
VoIP	Voice over Internet Protocol
WRNMMC	Walter Reed National Military Medical Center


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