Big Spring Texas State Veterans Home

Following are detailed responses to allegations of abuse highlighted by the *Dallas Morning News*:

- *[Dallas Morning News 4/5/10] A resident, unattended in his wheelchair, left the veterans home building. The resident was found in the cold darkness, lying on the cement about 80 feet from the front door, with swelling to his left eye and cheekbone. He spent two days in the hospital.*

ISSUE: This was an elopement incident reported to state regulators by home staff. The resident exited the building around 7:30 a.m. while the staff was preparing other residents for breakfast.

SOLUTION: To address this issue they put a "wander guard" bracelet on him in January 2007, which lets the staff know when he is close to an exit. To help monitor the front exit during the busy morning hours, the RN Supervisor now sits at the front receptionist desk from 6:00 a.m. until 8:00 a.m. when additional administrative staff arrive.

- *[Dallas Morning News 4/5/10] A man choking to death on a radish, although his physician earlier had ordered a soft diet for him. The man had Alzheimer's disease, schizophrenia and dementia.*

ISSUE: This incident was reported to DADS and a full investigation was conducted. The investigation determined that the serving attendant misread the menu for this resident and had added the radish as a garnish.

SOLUTION: In February 2004 new procedures for menus were implemented and employees retrained.

- *[Dallas Morning News 4/5/10] A resident with Parkinson's disease who was not offered timely counseling or psychiatric help last year after he talked three times about death and suicide, and then wrapped his feeding tube around his neck twice in one day.*

ISSUE: The operator believes that this is a fraudulent allegation and is under appeal by the operator.

SOLUTION: The home's operator appealed this finding in August 2009. It is pending review.

- Lack of a system for ensuring that beds were in locked positions after a man fell when his bed rolled. The home also did not properly supervise another resident who had been found on the floor at least four times in less than two months.

ISSUE: The bed wheel lock system was reviewed and found to be defective.
SOLUTION: In November 2008 the VLB made the bed manufacture replace all wheel lock systems on all beds.