TAMMY BALDWIN
WISCONSIN

COMMITTEES:
APPROPRIATIONS
BUDGET
HEALTH, EDUCATION, LABOR, AND PENSIONS
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

United States Senate
WASHINGTON, DC 20510

January 4, 2017

Mr. Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary McDonald:

Over the past months there has been frequent media reports concerning the Wisconsin Veterans Home at King. Accounts of neglect, staffing shortages and crumbling facilities is alarming, and recent reports of systematic attempts to cover-up and obscure incidents of concern from state and federal oversight demands action.

In April 2016 I wrote to your office to share concerning allegations involving conditions at King that my office received from constituents and a Wisconsin State Senator. I requested that the VA review these allegations and provide a response as to the Department's plan to address any instances of substandard care at King. The VA's June 2016 response affirmed that while VA has no legal authority to manage or intervene in State Veterans Homes (SVH) like King, VA does provide oversight by conducting annual surveys at all SVHs to ensure they meet VA standards in 38 Code of Federal Regulations Part 51. The last annual VA survey of the King SVH was completed on June 16, 2016 and the report indicated all standards were met.

However, since June 2016, there have been ongoing reports of incidents of concern at King that demand additional attention. My office has been in contact with the U.S. Department of Health and Human Services to raise concern that an Immediate Jeopardy citation that was issued to King's Olson Hall this past March 2016 was not posted to the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare site until November, a delay of eight months. In that interim time, the King facility received an apparent erroneous five-star rating under the CMS Nursing Home Quality Rating System.

In September 2016, the Wisconsin State Legislature approved an audit of King to investigate allegations of mistreatment of residents and improper use, or non-use, of state and federal funds.

And most recently it has been brought to my attention that what could have been a catastrophic and potentially deadly event related to the mishandling of liquid oxygen at King went unreported. Employees with information about this event have been told not to discuss the incident and were formally directed not to write a security incident report. Attached please find the written account of this incident provided by a concerned citizen with close ties to King staff who has worked to improve the safety of King's liquid oxygen protocol with little support from King leadership.

Veterans and their spouses who receive care at the Wisconsin Veterans Home at King expect and deserve the highest quality of care. While King is owned and operated by the State of Wisconsin Department of Veterans Affairs, it receives millions of dollars in federal construction grants and per diem payments. A full review of the allegations of reporting obstruction and substandard care at King is warranted. I request that your office order a for-cause survey of the King SVH based on these series of incidents and take all action available within your authority to provide meaningful recommendations to ensure the safety and effectiveness of operations at King.

Thank you for your prompt consideration of this request.

Sincerely,

Tammy Baldwin
United States Senator

Enclosures