'Horrific' veteran deaths covered up in Oklahoma state-run nursing home, insiders say

Andrea Eger Mar 5, 2017

Kevin Kimbrough survived 13 months of combat in Vietnam and the related post-traumatic stress disorder that plunged him into a dozen years of self-medicating with alcohol and drugs.

Between 2013 and early 2015, he even survived a major stroke and the amputations of both of his legs.

But two years at the Oklahoma Veterans Center in Talihina has left him battered and bruised, and two months ago, on the brink of death.

His sister, who moved halfway across the country to see to his care, has had enough. She's transferring him to a state veterans home in Fayetteville, Arkansas, where the patient-to-aide ratio is a fourth of what it is at Talihina.

"We're all gonna die. Kevin's gonna die. But it's gonna be on God's time – not because you neglected him or failed to do your job!" said Molly Kimbrough.

One state lawmaker is assisting top executives at the Oklahoma Department of Veterans Affairs with legislation to relocate the vets' nursing home at Talihina to a larger city nearby because of two high-profile, questionable deaths in the last five months.

Those state officials have focused their public comments and concerns on local staffing challenges and the age and design of the converted, 1921 tuberculosis sanitorium on the outskirts of a remote, tiny town in the Ouachita Mountains.

But health-care workers from the highest to lowest levels of patient care at multiple ODVA-run nursing homes for veterans say the problems are in no way limited to Talihina – they're systemic.

In a Tulsa World investigation, sources provided detailed accounts and documentation of systemwide reductions in medical and nursing staff, outsourcing of lab work and one-size-fits-all, top-down medical directives and policy changes. All the corners being cut and administrative decisions are driving out staff dedicated to the mission of veteran care and are compromising patient care and safety, sources say.

The Tulsa World verified the identities and clean state license histories of the workers and agreed to protect their identities because they fear retaliation by superiors.

Consistently, those who work directly with patients cited as the root of their concerns the centralized decision-making by ODVA's top, new leadership — career military leaders without nursing home or long-term-care experience — and cover-ups and patient-blaming when mistakes, injuries and unnatural deaths occur.

"I don't think it's a Talihina problem," said a high-ranking staffer. "The system is sick and it starts from the top down."

The individual added: "There are deaths the public isn't even aware of and there have been a lot more near-misses — lab work not done in a timely fashion or not at all; one nurse having to pass meds to 50 people within one hour of a meal; three aides to feed, toilet and clean 50 patients on a unit. When you spread people that thin, bad things are going to happen. And it's veterans who are suffering."

Died a 'horrific' death

The Tulsa World began its investigation after the Oct. 3 death of Vietnam veteran Owen Reese Peterson, who was found with maggots in his body and later died from sepsis.

State officials have said Peterson needed a morphine pump for pain management but couldn't get one because the center didn't have a medical doctor on staff at the time. Insiders say he died a slow, "horrific" death over the course of two months.

"His room was on the second floor, where there's a time clock. You could get off that elevator to clock in or out and there was a terrible smell, a terrible odor. And it was him," a worker said.

That worker, who has many years of experience in long-term care, said Peterson should have been moved into hospice care to receive the kind of medication needed to make proper wound care possible for nurses. The worker didn't attend to Peterson personally but has spoken to those who did and has seen photos.

"By the time he left that facility, he didn't have any skin down his shoulders, all the way down his backside and the back of his legs. He had decubitus ulcers (pressure sores or bedsores) — that's from not turning or repositioning a patient. Those that are not treated spread and tunnel and spread throughout the body, causing sepsis and infection throughout the body," the worker said. "He didn't have many baths. They would just sponge off his front. And they couldn't change the dressings or his sheets, so they would just reinforce the dressings with new on top of old and then slip pads in between him and the bed."

Before the funeral home or outside investigators arrived, staffers disposed of his mattress and cleaned his body in a shower room to eliminate evidence of his true condition, the worker said.

ODVA stalled for weeks the release of its completed, internal investigative report into Peterson's death despite the Oklahoma Open Record Act's requirement to provide "prompt, reasonable access" to public records. Provided Thursday, the heavily redacted, six-page document states that Peterson had "open wounds with gnats about him constantly" and concludes that a nurse practitioner and assistant administrator "should have submitted" their resignations. Both are still top-ranking employees at the home.

Another questionable death occurred in January when 70-year-old Leonard Smith of Sapulpa, an advanced dementia patient, choked to death and then was found with a plastic bag lodged in his throat. He was living in the locked-down special needs unit at the Talihina center.

Residents and health-care workers provided the Tulsa World accounts of other deaths at Talihina during the past two years they say were non-natural.

Those include the drowning of a resident in a motorized wheelchair in one of the property's ponds; a man who fell, cracked his head open and bled out in front of fellow patients after being induced to dance with a visiting group of line dancers; an unattended man who died after falling out of his wheelchair and cracking his head on the pavement on one of the center's patios; and the sudden death from a burst abscess of a man whose symptoms had been misdiagnosed by medical staff onsite.

'She played God'

The Tulsa World requested a list of clinical care staff at the Talihina center, which has the capacity for 175 patients. ODVA provided a database with 152 names. But local workers say that 24 of the names are individuals who no longer work at the facility and another nine haven't shown up for work in weeks but still have their names listed on schedules, falsely inflating staffing levels.

Numerous veterans and their family members say the lack of adequate staffing has had serious consequences for those living there.

Kimbrough, the double amputee and Vietnam vet, suffered a broken arm in the facility on New Year's Eve, when nurses and patient aides were especially scarce, his sister said.

"Because they were so short, someone from another floor had to help him, and he was not put in his wheelchair properly. When that happens, he tends to slide and that left arm, which he cannot move at all, dangles. He ran into a door jamb," Molly Kimbrough said. "This never would have happened if they had let me take him home for the holiday weekend, but they have a rule that says you can't be gone overnight more than 12 nights a year. So he had to wait for his 12 days to start over on Jan. 1."

She said doctors at the local hospital where her brother was first taken misdiagnosed the location of the break in his arm as being in the lower half. He was left to languish at the veterans center in agony, unable to drink much or eat because of pain.

After a nurse noticed Kimbrough had stopped breathing, he was transported to the Jack Montgomery VA Hospital in Muskogee, and his sister was called.

“They got him stabilized enough and that night, they brought in a portable X-ray and determined that the break in his arm is actually about an inch and a half below his shoulder — in his upper arm — in the humerus,” she said. “Two days later, the nurse practitioner at the hospital tells me if I have family to call them because this is end of life. He is in complete kidney failure because he only had 20 ounces of fluids in six days.

“They gave me the name of a mortuary.”

After out-of-state family gathered in Muskogee, another doctor determined that Kimbrough had been prescribed too much pain medication and also treated him with IV antibiotics.

“In three days, you would not believe the difference,” she said.

Seeing her brother so close to death was the final straw for Molly – she and other family members immediately began looking for another nursing home for Kimbrough. But two recent mishaps during van transports are also high atop her list of reasons.

Last summer, Kimbrough suffered serious pressure wounds after being left in the same position in his wheelchair in the back of an ODVA van on an all-day round trip to Claremore and Tulsa. In a separate ODVA van ride, he was transported in a wheelchair with no safety belt.

“They had taken him to Jack Montgomery hospital for a post-surgical checkup,” his sister said. “On the way back to Talihina, when they are in Eufaula, he tells the two drivers, ‘Please slow down. I’m slipping out of the chair.’ They told him, ‘Oh, you’ll be fine.’ He fell out of the chair. Instead of stopping, they turn around and go back 40 minutes to Jack Montgomery for help with him on the floor of the van,” she said.

Other patients’ cases raise questions, too.

Tom Crowson, 60, was a U.S. Army special operations paratrooper from 1979 to 1982 and came to live at Talihina just over two years ago. He, like Kimbrough, is considered 100 percent service-connected disabled.

In late 2015, he was diagnosed with Charcot foot syndrome, a complication of diabetic neuropathy that can have destructive effects on the foot and ankle. Then late last summer, his specialist told him he needed a cast and boot to help prepare for surgery.

“My foot was shifting and turning. All of the bones were out of position,” Crowson said.

He needed a referral to a specialized clinic to outfit him with the cast and boot, but the doctor at the center departed abruptly. The only staff person remaining who could provide him the referral was a nurse practitioner.

After Crowson was told the nurse practitioner had received notes from his attending nurses, asking about the status of his referral, he sought answers.

“I asked her twice when I saw her in the hall, I said, ‘Where’s the referral for my foot? I’m in a lot of pain.’ ” Crowson said. “I told her she had signed off on the (nurses’) notes, and she said, ‘I sign a lot of things, I don’t read everything.’ ”

Finally, when a new doctor was hired to serve as medical director at Talihina, Crowson finally got the referral, but the months-long delay had serious consequences.

“When the new doctor got here on Dec. 7, he put in the referral and I had it the next day. But from September to December, my foot deteriorated to the point that when I went back to see (the specialist) he recommended amputation and said, ‘It just went too long without being supported enough to be rebuilt,’ Crowson said. “I was angry about the fact that she was the only person here and she played God, and I’m not the only one she has played God with. She made a decision – she intentionally did not pick up the telephone to get my foot worked on with the boot and cast.”

Crowson said he filed an official grievance, and the state’s investigator found in his favor. He was told the investigative report was being sent to the ODVA’s central office and the Oklahoma Medical Board, but he has no way of knowing whether that’s true.

As for his foot, Crowson got a second opinion from a Tulsa specialist who thinks there is still a chance it can be saved through surgery. But everything is on hold again, for a new reason.

“After a series of calamities, I finally got to Tulsa and a doctor there said he could operate on it as long as I didn’t have foot ulcers. Now I’ve got two ulcers. He won’t operate on it,” Crowson said.

‘As veterans, they were promised so much more’

Honorably discharged veterans with at least one day of active-duty service are eligible to reside in one of Oklahoma’s seven state-run veterans homes. Applicants are admitted by priority of earliest wartime service, with World War II-era vets given the highest priority.

Currently, 1,363 of the 1,423 available beds are filled. Of those, 295 served during WWII, 283 during the Korean War, 599 during Vietnam and 42 during the Gulf War.

Kimbrough, now 67, was drafted into the Army when he was 18 years old. He was sent to Germany but soon volunteered to serve in Vietnam. He ended up in the 1st Battalion, 11th Infantry, delivering ammunition by truck to U.S. troops in Quang Tri province — sometimes over the South Vietnamese border into North Vietnam.

He was exposed to Agent Orange and suffered shrapnel wounds after his convoy took on friendly fire from a 155-millimeter cannon.

“For 10 years, I was picking shrapnel out of my inner legs,” he said. “I think about it every day — just being over there. I never got any mental health, and I never wanted to talk about it. It hurts to remember it. It hurts my mind.”

Kimbrough returned from war a totally different person than the Catholic school kid with a happy, secure home life. His sister said he got healthy and “came back to his family” in 1984, and the whole clan has been tight-knit ever since.

“I had lived in California and Arizona for decades, but when he lost his first leg, I moved here to take care of him,” she said. “After the stroke and the second leg was amputated, it was too much. If I could take care of him at home, I would, but I have multiple sclerosis. Some days, I feel like I’ve had a stroke, and my legs don’t work.”

The siblings remember Peterson from smoking together on a patio at the Talihina home. His death haunts them.

“Everybody called him Pete. He was a nice man,” Molly said. “That didn’t happen overnight! As veterans, they were promised so much more – and they deserve it.”

Kimbrough said the bottom line is the state needs “to close this place down or get more staff.”

“I like all the nurses and aides I have, but there is not enough help,” he said. “I’d be dead if I didn’t have Molly. She’s very outspoken and she comes at least every other day. She looks out for me, she loves me. Not everybody has a Molly.”

New cuts, new policies

A Tulsa World analysis coming Monday will show high employee turnover during the last two years and a rapid crackdown on overtime pay in the last half of 2016 across the state’s veterans nursing home system.

And, internal documents provided by sources show ODVA just reduced the number of medical providers – doctors, physician assistants and nurse practitioners – by a net of three or four, effective Jan. 1.

ODVA spokesman Shane Faulkner confirmed the cuts and explained the changes in response to the World’s request.

“The staffing levels were decreased based upon a decision to prospectively operate in accordance with long-term-care regulations rather than those of an acute-care facility,” Faulkner said. ”In accordance with these regulations, a physician is required to see a resident at least once every 60 days after admission. There has not been a fiscal analysis performed on what the cost savings are due to the new staffing levels.”

He also revealed ODVA leaders contemplated eliminating staff medical providers from the veterans homes altogether.

“Due to the doctor shortage in Talihina, we were considering going with a consortium of doctors who provide services to long-term-care facilities on a contract basis across the agency,” Faulkner said “If we had incorporated this, it would have been an approximate $2 million savings. However, upon discussing this with other states that do not have on-site providers, we came to the conclusion that our doctors should have greater familiarity with the residents rather than merely a brief monthly visit.”

Multiple health-care workers spoke of the central administration’s new medical directives to the homes, including a new 1,200-page policy and procedure manual that took effect the same day it arrived in September.

Workers said it appears to be an unlicensed, generic policy manual borrowed from a private company, with a host of items in direct conflict to state laws and federal nursing home statutes and guidelines.

“One of the policies is about IV dopamine infusions, which are only done in ICUs in hospitals. Another policy said patients have a right to smoke in their rooms, which could be extremely dangerous around oxygen and could possibly get us shut down by federal inspectors,” a staffer said.

“It says we will not discriminate on the basis of race, etc., and veteran status – and we have to discriminate on the basis of veteran status. It has a generic wound care policy. Two or three steps, not definitive nursing home policy. There’s also no chest pain protocol. Every nursing home has to have one.”

In late November, the ODVA’s clinical care director, whose background is in nursing, sent an email forbidding the use of routine doctors’ orders. These are commonly used in long-term-care settings to ensure patients promptly receive things like oxygen, breathing treatments, Tylenol, over-the-counter cough medicine and laxatives, workers said.

“She overrode every doctor’s medical orders in all seven homes. That’s practicing medicine without a license,” one worker said. “And patients can wait hours and hours, sometimes overnight, to get something simple – even for a headache.”

A Tulsa World analysis found 62 percent of ODVA staffers in 2014 no longer work there. Every worker interviewed for this story said what keeps them from joining the legions who have already quit is their commitment to serve this special patient population.

“I cry at the end of almost every shift,” one staffer said. “I want to quit, sometimes I think I must quit, but I feel I would be abandoning my patients.”

Veterans homes historically higher

in quality

Dr. William Martin worked at Talihina from 2006 until his retirement in 2016, and he had previously worked at the Ardmore and Sulphur veterans' homes.

He said ODVA's new leadership took a hands-off approach to patient-care providers from the get-go. Gov. Mary Fallin appointed retired Maj. Gen. Myles Deering as executive director of the ODVA and as state secretary of veterans affairs in February 2015. He soon brought on retired Col. Doug Elliott to oversee the seven veterans nursing homes and five claims offices.

Martin said the agency's previous director would attend the site medical directors' quarterly meetings to hear any issues or concerns, but Deering never had.

Then ODVA shut down the doctors' longstanding practice of holding those meetings, which included "mortality and morbidity" reviews of "adverse events" in the state veterans homes. Martin said peer reviews encourage transparency about mistakes and learning from those mistakes and making improvements moving forward.

"When they first took over, Deering was scheduled to speak to us for 90 minutes at our April 2015 meeting. He never showed up. He never called. No explanation was ever given for that. That was our introduction," Martin said.

"I'm only aware of him coming to Talihina one time (before Martin left), and that was upon the retirement of the center's administrator. He never came to me or any of the other doctors, and never talked to the nurses. He strictly talked to administration. That was a surprise and a change to me. If you really care about patient care, you might talk to the people who do it."

Deering is out of the office recovering from knee surgery and unable to comment. But his spokesman Shane Faulkner was asked to respond to claims that Deering is out of touch with doctors and nurses at the centers.

Faulkner said Deering meets quarterly with the center administrators, who are not medical personnel.

"He stays engaged with the centers constantly talking with administrators," Faulkner said. "To say he is out of touch is far from what is happening."

Martin said during his final year with ODVA, he never met Doug Elliott, and that during his two or three visits to Talihina, he only spoke with the site administrator.

"It seemed that they were more distant. My feeling is that the governor or the Legislature or both want to downgrade the centers and make them into private nursing homes that are contracted to care for the veterans," Martin said.

"The thing that made us different than a regular nursing home is that we have doctors on staff, we had labs, we had our own pharmacy and physical therapy right there. Not all of the state

centers do, but we had a 50-bed dementia unit. Many of the veterans we admitted would have died anywhere else because regular nursing homes don't have those things right there."

Martin said it is a farce for state leaders to suggest that Talihina's most recent difficulty in recruiting or retaining a doctor was unique or extraordinary in any way.

"All of the centers have had trouble over and over, especially in maintaining medical staff, and that is because of the wide gap in what you can earn in a private setting versus the state veterans centers," Martin said. "It's all being made out to be about Talihina, but how did we get such good inspections in 2014 and 2015 and all of a sudden we're so terrible?

"So many of the decisions are being made 200 miles away – and by folks who are very ready to criticize – when some of the decisions being made at the top are causing the patient care issues that are happening in the centers."

He added, "If it's all about money and the state is going bankrupt, then just be honest about it."

Lawmaker seeks whistleblowers, relocation of veterans home

Andrea Eger Mar 5, 2017 Updated Jan 27, 2021

State Sen. Frank Simpson, R-Ardmore, is the author of proposed legislation to close the Oklahoma Department of Veterans Affairs-run nursing home at Talihina and relocate it to a new facility in a bigger city in the same part of the state, possibly Poteau.

If he succeeds, he also wants to see the veterans home in Clinton be replaced because it, too, is in an old, converted tuberculosis hospital.

Simpson said those outdated, multi-story buildings are detrimental to resident safety, independence and general quality of life and they need to be replaced with modern facilities, designed as a series of small group homes.

Still, he said he is sympathetic to the economic impact the loss of the current facility would have on the area where it's located. He's drawn criticism from community leaders in Talihina organizing an effort to save the existing veterans home.

"This is not a personal vendetta against Talihina," Simpson. "I've been accused of making money off of this, which is outrageous. Since I came to the Legislature, I have really focused my time and efforts on making sure veterans get proper care. I feel this is my calling."

Mayor Donnie Faulkner said the loss of the vets center could bankrupt his town.

"From the utilities, to the number of jobs at the center. It's a tremendous domino effect it could have on the schools, county tax base, property values," Faulkner said. "Why Poteau? There's been no analysis of the labor pool there. So who's benefiting? We don't know."

Jerome White, a Vietnam veteran of the U.S. Navy and a member of the resident council at the Talihina center, said he knows well some of the challenges, including delays in staff responses to emergencies and an alarming number of staff terminations and departures in recent months.

He once went four or five days without pain medication while waiting for a doctor to approve a refill when the facility was in between staff doctors.

But, White said, he and other residents wonder why they are left to rely on rumors and speculation about the future of the place they call home.

"We wish the folks in Oklahoma City would take the time, trouble and effort to come down here and talk to the veterans," White said. "That has never come to pass."

As for would-be whistleblowers, Simpson encourages them to come to him personally and be assured their identities will be protected, and that he will act on their information. After questionable deaths occurred about five years ago in the Claremore veterans center, Simpson said, he met confidentially with about 40 staffers to help enact sweeping changes across the department as a result.

“I do not work for ODVA. I hold ODVA accountable for how they treat our veterans. I don’t mince words and I don’t sugarcoat it. If there’s a problem, I demand that they address the problem,” Simpson said.

Simpson has blasted ODVA over two recent vet deaths at Talihina, taking issue with a couple of statements made by officials at the Oklahoma Veterans Commission meeting in February.

He said Owen Reese Peterson’s death “should have been a sentinel event,” which is defined as an unanticipated event in a health-care setting resulting in death or serious injury to a patient, unrelated to the natural course of the patient’s illness.

Tina Williams, the clinical compliance director for ODVA, has said that despite the infestation of maggots and other conditions at the time Peterson died, his death no longer meets the definition of a sentinel event, so the agency would no longer be counting it as such.

Simpson said he was infuriated after learning that John Carter — chairman of the governor-appointed, oversight state Veterans Commission — made a public statement implying a family was at fault for failing to properly warn ODVA after their relative, an advanced dementia patient, choked to death in late January in the locked-down special needs unit at the Talihina center.

Carter said ODVA staff informed him that the man, Leonard Smith of Sapulpa, “had a long history of ingestions of things perhaps that were not edible and this was not passed onto admissions when he was admitted.”

Smith’s relatives have denied the allegation. They say in the three years he lived at the center, only once did ODVA staff tell them their loved one had choked or had trouble swallowing something — and in that case, it was food.

“It’s shameful we wanted to make it look like the family’s fault,” Simpson said. “That’s a cop-out. We can accelerate their death if we don’t care for them properly – and that’s not just at Talihina.”

Simpson said he hopes the state Veterans Affairs commissioners, all of whom are confirmed by a legislative committee on which he serves, “would be more aggressive. They need to be holding the agency accountable for how we treat veterans. I think we need to get out of the mindset of warehousing vets.”

Simpson also said he is aware of another recent, questionable death in a state veterans home that hasn’t been made public yet.

Vet Center Deaths investigation: Family speaks out about Tulsa-area man behind the headlines

Sapulpa man has been in the headlines after his death at Talihina Veterans center

Andrea Eger Mar 6, 2017

See the complete series: tulsaworld.com/veterans

Leonard Smith's shocking death in a state-run veterans home wasn't the end he deserved.

That's what the Sapulpa man's family wants both the public and the powers-that-be to know about their loved one.

"He didn't bring up his medals at all — he served the country and was a hero," said Smith's niece Missie Little, of Sand Springs. "He's in a facility with people who get paid to care for others. He deserved common, human decency."

Smith served as a radar technician in the U.S. Navy for five years during the Vietnam War, earning the Vietnam Service and Vietnam Campaign medals.

The 70-year-old advanced dementia patient choked to death Jan. 31 after being given food, fluids and medication and was then found with a plastic bag lodged in his throat. He had been a resident of the locked-down, special-needs unit of the Oklahoma Veterans Center at Talihina since January 2014.

His family is reeling from the way he died and his death's aftermath, but also clinging to memories of the Leonard Smith they knew and loved.

"He was so intelligent, and he would crack these jokes — a lot of them were just over people's heads," Little said. "When we were kids, he didn't really have the patience for us. He would kind of go his own way when kids were around, but as he got older and we got older, it got easier for him to relate to us and for us to know him."

Smith's aunt, Eunice Harger, cared for him in her home for the first few years after his diagnosis with dementia.

She said he loved to reminisce about family members who had passed away and to talk about presidential politics. He also liked to listen to Tammy Wynette, George Jones, Johnny Cash and Patsy Cline and loved old Westerns and war movies, especially those starring John Wayne and Clint Eastwood.

“He had no use for new movies, except about old subjects. He loved anything from his era, except ‘Hanoi Jane,’ ” Harger said, with a quick laugh at the memory of how Smith and other Vietnam-era vets have referred to Jane Fonda for posing for a photo on an enemy anti-aircraft gun during the war.

Smith’s nearest relatives said they first learned of his sudden death on the evening of Jan. 31, when a nurse practitioner called to inform them that he had died three hours earlier. They say they were told his death was “accidental” and as such, the state Medical Examiner’s Office would be investigating.

Then they picked up the Tulsa World a few days later and learned Smith’s death was being looked into by multiple state and federal agencies. And, they learned from the story that another medical professional from the facility described his death as “unnatural,” and the chain of events leading up to his death was very different from what the nurse practitioner had told them.

The same day the Tulsa World reported Smith’s death, Doug Elliott, deputy director at the Oklahoma Department of Veterans Affairs, reportedly called Smith’s relatives to tell them some of the initial details they had been given were wrong.

Harger said the family’s first red flag about the quality of his care occurred the first time she ever visited him.

“He’d lost 40 pounds, maybe 50, after the first few months he was in there. When I had him, I’d cook him three meals a day, and he liked everything. He *loved* ice cream,” she said. “I was concerned, and I talked to them about it. I never wanted to put him in there. It was very hard, but I was almost 80 years old.”

What haunts Smith’s family now is that he had almost died at Talihina once before, choking on something to which a dementia patient in a locked special-needs unit should never have had access.

Two years ago, the family received an urgent phone call that Smith had “choked on a piece of meat” and was being transported by ambulance to a hospital.

When relatives arrived, doctors showed them a whole, uncooked hamburger patty — like the readily available, prepared kind typically sold frozen — that EMTs had removed from Smith’s throat.

“I was told due to staffing levels and him walking around constantly, they could only guess he had gone into a kitchen and gotten it himself,” said Christine Cornwell, another of Smith’s

nieces, whom he had given power of attorney after dementia began to set in about five years ago.

A few weeks after Smith's death, the chairman of the governor-appointed, oversight Veterans Commission, made a public statement implying Smith's family had failed to properly warn ODVA about his habits when he was admitted at Talihina.

Chairman John Carter said ODVA staffers told him that Smith "had a long history of ingestions of things perhaps that were not edible and this was not passed on to admissions when he was admitted."

Harger said she and her family not only deny that ever happened when he lived at home, but they are disgusted by the accusation.

"He never, ever ate anything inedible. That was totally a made-up lie — no truth to that whatsoever," she said, shaking her head. "Where did he get the plastic bag? If they knew he had a problem with eating inedible things, why didn't they keep them out of his reach? Wouldn't that be the sensible thing to do?"

Little questions whether the special-needs unit at the Talihina veterans center is providing patients with such a progressive condition with adequate staff monitoring and safety restrictions.

"As parents, that's what we would do for our children. And, when somebody has dementia, that is basically, in a sense, where they're at. They can't help it," she said. "We have to protect them as if they were children."

She added, "The other thing is the misleading. We were originally told one story and then given another. It seems like they were intentionally trying to hide something."

Vet center deaths investigation: Public information on deaths in state-run nursing homes for veterans scarce

Andrea Eger Mar 7, 2017

Officials at the Oklahoma Department of Veterans Affairs are citing patient privacy laws for concealing nearly all of their investigation into the October death of a Vietnam veteran who became infested with maggots and later died from sepsis in a state-run nursing home.

In mid-February, Deputy Director Doug Elliott announced to the Oklahoma Veterans Commission in a public meeting the completion of ODVA's internal investigation into the Oct. 3 death of Owen Reese Peterson, 73, at the Talihina veterans center.

Public records obtained by the Tulsa World through a request under the Oklahoma Open Records Act reveal that ODVA compliance employees found that Peterson had "open wounds with gnats about him constantly," and that the immediate resignations of a physician's assistant and three nurses were requested, not volunteered.

More than half of the contents of the six pages released by ODVA were censored by the agency's attorney, but three complete statements under the heading "recommendations" appear to find fault or the need for additional training for three employees still working at Talihina.

"I feel the (nurse practitioner) should have submitted her resignation as well," and "I feel the Assistant Administrator should have submitted her resignation as well," are in bold print.

And the last sentence of the report reads: "Not sure how much experience the Administrator has but some extra training in management, investigation and reporting could be beneficial."

ODVA is a state agency that provides intermediate to skilled nursing care for about 1,365 veterans in seven nursing homes it operates with a combination of funding from the state and the U.S. Department of Veterans Affairs.

The Tulsa World first began investigating in December after ODVA officials revealed that in the wake of Peterson's death, a physician's assistant and three nurses, including the director of nursing, "resigned before the termination process began."

At the time, Executive Director Myles Deering, who also serves in Gov. Mary Fallin's Cabinet as secretary of veterans affairs, said Peterson "did not succumb as a result of the parasites. He succumbed as a result of the sepsis," referring to a potentially life-threatening complication of an infection.

And ODVA spokesman Shane Faulkner said, “All four (employees) chose to resign before the termination process began.”

But the World soon learned that the physician’s assistant was rehired a month after his resignation and is working at a state veterans center in Lawton.

Then, state officials pointed to “refusal by the resident for (wound) care” because of pain, his need for a morphine pump for pain management and their inability to treat him with one because of their lack of a medical doctor on staff at the time.

Insiders, who fear retaliation by superiors, told the Tulsa World that Peterson died a slow, “horrific” death over the course of two months.

“By the time he left that facility, he didn’t have any skin down his shoulders, all the way down his backside and the back of his legs. He had decubitus ulcers (pressure sores or bedsores) — that’s from not turning or repositioning a patient. Those that are not treated spread and tunnel and spread throughout the body, causing sepsis and infection throughout the body,” one worker said. “He didn’t have many baths. They would just sponge off his front. And they couldn’t change the dressings or his sheets, so they would just reinforce the dressings with new on top of old and then slip pads in between him and the bed.”

Before the funeral home or outside investigators arrived, staffers disposed of his mattress and cleaned his body in a shower room to eliminate evidence of his true condition, the worker said.

The Tulsa World requested the ODVA’s investigative report on Feb. 17, the day Deputy Director Elliott told his agency’s oversight board it was complete.

John Carter, chairman of the state Veterans Commission, which oversees ODVA, told the Tulsa World that day he had “received a verbal briefing,” but had not seen the document.

Elliott held up to journalists a report in plain sight, which appeared to be at least 20 pages thick and had Peterson’s name on the cover, and said they could have it but first needed to submit a formal request.

The Oklahoma Open Records Act requires “prompt, reasonable access” to public records. In response to the World’s formal request, ODVA officials first responded that the release of the report would be delayed while the state agency’s legal counsel reviewed it.

“An urgency or need for information on your behalf does not equate to an emergency in this agency,” wrote Elliott in an email to the Tulsa World. “My staff attorney deals with claims of class actions and request from the Attorney General’s office prior to responding to requests from reporters under the Open Records Act, and she is very proficient.”

More than two weeks later, ODVA released six pages with about half of the total content blacked out, and no date, or name or signature of the investigator who prepared it.

“Redactions have been made to remove protected health information as required by HIPAA,” wrote Faulkner, referring to the federal Health Insurance Portability and Accountability Act, or HIPAA, which safeguards the privacy of patients’ medical information.

Asked whether the six pages provided were the full document, Faulkner replied, “That is the document as it exists.”

Faulkner also said that Deering and Elliott were unavailable to answer questions about the internal investigation, but the World submitted questions in writing anyway and got some responses from Faulkner.

He said ODVA’s compliance department, directed by Tina Williams, conducted the investigation and wrote the report.

As for any disciplinary action against any ODVA employee, including referral to state licensing boards, resulting from the investigation, Faulkner said, “The findings have been filed with state licensing boards, any further employee action will be determined by their decisions.”

Asked for a list of everyone who received the results of this investigation, either by written copy or by verbal communication, Faulkner replied, “This is an internal report, ODVA leadership are the only ones to receive the unredacted report. We have supplied redacted copies for legislators who requested them.”

The Tulsa World is not naming the individual employees who resigned or whose resignations were recommended in the ODVA investigative report because no criminal charges have been filed in the case.

Jeff Smith, district attorney for LeFlore and Latimer counties, told the Tulsa World previously that ODVA had pledged to forward information from its investigation to his office.