





INSPECTOR GENERAL  
DEPARTMENT OF DEFENSE  
400 ARMY NAVY DRIVE  
ARLINGTON, VIRGINIA 22202-4704

January 17, 2008

MEMORANDUM FOR PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE  
FOR PERSONNEL AND READINESS

SUBJECT: Inquiry of GAO-Forwarded Allegations Related to the Armed Forces  
Retirement Home – Washington D.C. (Report No. D-2008-0001-PO/FO)

This final report provides the results of our inquiry into allegations related to the care for residents at the Armed Forces Retirement Home (AFRH)–Washington DC (AFRH-W) forwarded by the Government Accountability Office (GAO) in their March 19, 2007, letter to the Secretary of Defense. We have considered management’s comments to a draft of this report in preparing the final report. The comments are attached.

**BACKGROUND.** The AFRH is an independent executive branch entity that provides three levels of continuing care for former military members – independent living, assisted living, and long-term care. It also operates a health and dental clinic for residents. The AFRH has more than 1,100 residents with an average age of 80. The AFRH is managed by a Chief Operating Officer (COO) who is appointed by and reports to the Secretary of Defense. The Secretary has delegated responsibility for the Armed Forces Retirement Home to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)).

The National Defense Authorization Act of Fiscal Year 2002 changed the former managing board of directors to an advisory board and established the position of COO. The establishment and operation of the AFRH is codified in Chapter 10, Title 24, Hospitals and Asylums, United States Code.

In the past several years there have been other significant changes at the AFRH, many resulting from the need to address financing issues, including selling or leasing some of the AFRH property, contracting out services resulting in a perceived change in services provided, and the influx of residents from the Gulfport facility when it was destroyed during Hurricane Katrina.

**OBJECTIVE.** At the request of the Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD(P&R)), we initiated an inquiry to determine whether the allegations provided by the GAO in its March 19 letter had merit and what actions would be appropriate and needed to address them. The allegations are:

- a rising number of resident deaths, despite the fact that AFRH is now limiting admissions to relatively healthy retirees;

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- increases in the rates of admission to Walter Reed Army Medical Center (WRAMC) from AFRH and in the proportion of residents admitted directly to the intensive care unit;
- residents admitted to Walter Reed Army Medical Center with the most serious type of pressure sores and one admission with maggots in the wound;<sup>1</sup>
- failure of AFRH to ensure that a resident with a kidney transplant received appropriate care, resulting in hospitalization; and
- observation of blood-, urine-, and feces-spattered rooms among residents living independently, suggesting that they were inappropriately placed and should reside in either the assisted living or nursing home setting.

The scope and methodology of our inquiry is at the attachment.

**CONCLUSIONS FROM INQUIRY.** Regarding the allegations forwarded by GAO, we found the following.

- Based on an analysis of 3 years of data, we found no evidence that the death rate at the AFRH was increasing.
- Those making the allegations were unable to provide specific results of patient case reviews to support the allegation of increases in admissions to the ICU due to quality of care issues. [REDACTED]
- In fall of 2006, eight employees were terminated and three others disciplined when one person was found with maggots in a wound. The AFRH participates in a national quality of care program for pressure ulcers, and the AFRH data that we looked at was not significantly different from the national average.
- A kidney transplant patient was receiving regular and close follow-up by the providers at the AFRH and tertiary treatment facilities. [REDACTED]<sup>2</sup>

<sup>1</sup> Pressure sores are areas of skin and tissue damage resulting from a lack of blood flow due to sustained pressure. They commonly form where bones are close to the skin, such as ankles, back, elbows, heels, buttocks and hips. The risk of developing a pressure sore is increased for individuals who are bedridden, use a wheelchair, or are unable to change position.

<sup>2</sup> This section contains confidential medical quality assurance information exempt from discovery and restricted from release under 10 U.S.C. 1102. Information contained in this correspondence may be used only by authorized persons in the conduct of official business. Any unauthorized disclosure or misuse of information may result in civil penalties. If you are not the intended recipient of this correspondence, please destroy all copies of the correspondence after notifying the sender of your receipt of it.

- A Norovirus outbreak in February 2007 had residents confined to their rooms. The AFRH staff received a Certificate of Appreciation from the Commander, WRAMC Health Care, for their rapid response in halting transmission of the highly contagious virus.

Although we noted areas where improvements could be made, employees interviewed were committed to providing quality care to residents and generally displayed satisfaction with their employment at AFRH. The Medical Director is a highly qualified geriatrics specialist with expertise in elder care, and the credentials of the medical professionals raised no major concerns. Also, a majority of the residents interviewed were satisfied living at the AFRH. Most concerns expressed by the residents centered on changes such as sale of a portion of the 272 acres of AFRH property, and the long-term lease of property and buildings. They also feel that changes, such as no longer having military doctors on staff and fewer military staff, are taking away the “military” culture of the AFRH. According to the Chief Operating Officer most of these changes are to improve the financial ability of the home to continue to provide existing and to enhance services to the Home’s residents. We have not addressed these specific concerns, but we identified issues that need to be addressed related to effective communications between medical facilities, wait times, maintenance, and personnel vacancies.

**A. GAO FORWARDED ALLEGATIONS.** In its March 19 letter, GAO forwarded five concerns from health care professionals, which they had received in the course of their statutorily required study of the AFRH. As a result of our inquiry into the allegations, we have made recommendations that we believe will improve the operations at the AFRH and the communication between the AFRH and the medical facilities that support it.

**Allegation 1. Rising Number of Deaths at the AFRH.** According to the allegations, the number of deaths at the Home is rising, despite the fact that AFRH is now limiting admissions to relatively healthy retirees. We did not find a rising death rate at the AFRH.

The rate of deaths at the AFRH based on total population was 9.65 per 1000 residents for 2004, 9.67 per 1000 for 2005, and 9.22 per 1000 for 2006. The AFRH Medical Director reported that the AFRH medical staff reviews all resident deaths on a regular basis through the morbidity and mortality review<sup>3</sup> process. However, the number of deaths per year is tracked as a simple count per month instead of a rate relative to the resident population. Using a rate instead of a simple count would take into account the increase or decrease in number of residents and provide a basis for determining whether there is in fact a real change in death rate. For example, in September 2005, 249 residents were added to the AFRH Washington facility as a result of Hurricane Katrina. More sophisticated methods could also be used to analyze the information based on risk adjustment factors such as chronic disease, acute conditions, and age. According to the Chief Operating Officer, the staff also compares their statistics to the total population in their demographic area.

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<sup>3</sup> A morbidity and mortality (M&M) review is a specific analysis of medical or surgical care that focuses on unexpected or unintended negative outcome or death.

**Allegation 2. Increasing Admissions to Emergency Room and to Intensive Care Unit.**

According to the GAO letter, the rates of admission to the hospitals from AFRH and the proportion of residents admitted directly to the intensive care unit (ICU) were increasing. Those making the allegations were unable to provide patient case reviews for the admissions to the ICU at the hospital that included analysis or longitudinal data that supported the perceived increase in admissions of AFRH patients to the ICU due to quality of care issues. Without a thorough review of the health status and acuity of a patient; the plan of care prior to admission; the care during hospitalization; and the plan of care implemented post hospitalization, it is impossible to determine whether continuum-of-care quality issues exist.

No information provided to the review team indicated that an ongoing mechanism for timely communication and review of quality concerns exist between the medical facility and AFRH. A collaborative review has not been conducted by medical staff representatives from AFRH, WRAMC, the VA hospital, and any other hospital which provides medical services of a sample of the AFRH residents admitted to the ICU. Inter-facility participation in the performance improvement/morbidity and mortality committees and processes at the AFRH would be advantageous. The process of sharing concerns in care for these complex patients<sup>4</sup> should be facilitated by a regular and open exchange of appropriate information and concerns between the facilities at a senior clinician level. A senior clinician from WRAMC and from the VA should be appointed as part of the performance improvement and morbidity and mortality committees at AFRH and should be prepared to receive concerns from the AFRH as well as to be conduits to express quality concerns on AFRH residents from their respective facilities.

**Allegation 3. Pressure Sores and Infestation of Wound.** According to those expressing concerns, residents were admitted to a medical facility with the most serious type of pressure sores and one admission with maggots in the wound. We found that in the fall of 2006, eight employees were fired when a patient was found with maggots in a wound. In general, the incidence of AFRH pressure sores tracks with a national group statistics.

According to information provided by the AFRH staff, in August 2006 a patient with a pressure ulcer was found to have maggots in the wound. The resident had refused to cooperate with dressing changes for several days, and the nursing staff did not insist on changing the dressing. When clinical leadership became aware of the incident, they took immediate corrective action. Education was provided to all the nursing staff on the importance of dressing changes. The event was thoroughly investigated and eight employees were terminated as a result of the investigation, with three others disciplined but not terminated.

AFRH has policies and procedures for the care and treatment of pressure ulcers that were most recently reviewed by clinical staff in 2007. They also participate in a national quality of care program for pressure ulcers and submit data for national comparison. Based on our medical team's assessment, the report data that the team reviewed was not significantly different from the national average.

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<sup>4</sup> These patients are complex in that they often have multiple medical conditions requiring multiple medications, have psychological-social and physical issues, and in some cases have diminished or diminishing mental faculties.

[REDACTED]. Therefore, medical members of the review team provided information on pressure ulcer prevention. Based on our discussions with the AFRH staff, they were receptive to identifying opportunities to enhance their program for the care and treatment of pressure ulcers. We will ensure that the upcoming inspection of the AFRH includes an assessment of the AFRH implementation of pressure ulcer prevention program.

**Allegation 4. Inappropriate Care for a Patient with a Kidney Transplant.**<sup>5</sup> The GAO letter alleged that AFRH staff failed to ensure that a resident with a kidney transplant some years ago receive appropriate care, resulting in hospitalization. A detailed chart review was conducted by the medical team and included notes from the AFRH nursing home and clinic, as well as notes from visits to tertiary care facilities. [REDACTED]

[REDACTED] We will ensure that the information related to the case review is provided to the appropriate Medical Staff at the facilities.

**Allegation 5. Unsanitary Conditions in Independent Living Rooms.** The GAO letter stated that blood-, urine-, and feces-spattered rooms were observed among residents living independently, suggesting that they were inappropriately placed and should reside in either the assisted living or nursing home setting.

AFRH staff believes that the allegation as described occurred during a Norovirus outbreak in February 2007, infecting more than 100 residents. We obtained no other specific information from those who had expressed concerns. The AFRH, working with the WRAMC Health Inspector controlled the spread of the virus. The Commander, WRAMC Health Care, presented a Certificate of Appreciation to the AFRH for its staff efforts to halt transmission of the highly contagious virus.

The AFRH-W Resident Guide, dated September 21, 2005, requires domiciliary rooms to be maintained in a clean, neat manner, and free of all fire hazards and combustible materials, including cooking equipment. There is a system in place that regularly monitors the needs of residents and evaluates the appropriate level of care resulting in recommendations for transition to a higher level of care when indicated. Additionally, level of care reviews are conducted based on observations and recommendations from staff and other residents. It should be pointed out that the resident population is characterized by a high level of need with complex medical and social concerns. This challenge has led the AFRH to recently increase staffing in this area and to recognize that it may have to invest further to meet the needs of this population. There is also a balance that has to be made between the need for professional staff members to have access to the private spaces and the privacy of the individuals in their private living space. We will see that the upcoming inspection prioritizes an assessment of this area.

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**Conclusion:** Although some of the allegations had a basis in fact and others did not, we believe that improving communication between the medical service providers and the AFRH can improve the services provided to the residents and help prevent misunderstandings between all parties. Hospital staff participation on AFRH committees is critical for improvement in the timeliness and consistency of resident medical information.

An ARFH resident can go to any one of three medical facilities – Walter Reed Army Medical Center, the Veterans Administration hospital, and the Washington Medical Center. The extent that resident takes or returns the medical record, or other information for the medical file, impacts the completeness and accuracy of the resident’s medical records. Thus, it is extremely important that the AFRH expend sufficient resources to be able to regularly and thoroughly evaluate and manage the complex needs of their residents. The expeditious implementation of electronic medical records can facilitate this greatly. The electronic medical record (AHLTA) should be fully deployed and the data used to track the care and status of the residents when possible. Participation in other population health systems, such as the Military Health System Portal (MHS Portal) should be explored and implemented if feasible. Various electronic case management systems can be considered as well. We also believe that better availability of updated records for the medical service providers at the AFRH and the various hospitals that provide medical services for the residents will greatly facilitate the care of the residents for all and will also help ensure effective communication between all medical providers. We have the following recommendations to improve communication.

**Recommendation A:** We recommend the Principal Deputy Under Secretary of Defense for Personnel and Readiness direct and provide appropriate support to the Chief Operating Officer, Armed Forces Retirement Home:

1. to expeditiously establish medical records that are up-to-date and available to the multiple medical providers for the residents of the Armed Forces Retirement Home and proceed with setting up a clear process that ensures a thorough tracking and follow-up of its complex patients, particularly those who frequently transition between the Armed Forces Retirement Home and its referral centers.
2. to revise the resident death tracking methodology to a rate based calculation based on resident population instead of the current simple count; and
3. to establish new or revise existing Memorandums of Understanding or Agreement, as appropriate, to have a senior clinician from Walter Reed Army Medical Center and from the Veterans Affairs Hospital be assigned as regular clinical liaisons with the Armed Forces Retirement Home Medical Director and to participate in its Morbidity and Mortality Committee and other relevant Armed Forces Retirement Home committees.

**B. OTHER CONCERNS AND ISSUES.** In the process of our inquiry medical professions and residents expressed the following concerns.

**Clinic Staffing and Wait Times.** As a result of our interviews, residents expressed concern and frustration that the clinic at AFRH is understaffed; residents wait for long periods to be seen and no medical staff is available on weekends at AFRH. The team found no evidence of understaffing but believes an appointment-based system for same-day concerns can alleviate long wait times.

With a staffing of 4 primary care physicians and 3 nurse practitioners for a resident population of approximately 1,100, there is no evidence of “understaffing” in medical primary care provider personnel. All residents are assigned a PCM (primary care provider) and are scheduled for a wellness evaluation visit yearly. There appears to be consistent and ready access to PCMs for both acute and chronic routine care. It should be pointed out; however, that same-day concerns, and some routine ones, are often handled by a sick call and walk-in model, which at peak times may lead to longer wait times for residents.

Medical staff coverage for after hours and weekends includes coverage for all residents and is an on-call system. A physician or nurse practitioner from the medical staff is available at all times by telephone for after hours and weekend coverage. If a nurse practitioner is the primary call person, a physician is assigned as back-up and available as needed for consultation.

**Recommendation B1.** We recommend that the Principal Deputy Under Secretary of Defense for Personnel and Readiness direct the Chief Operating Officer, Armed Forces Retirement Home, to evolve to an appointment-based system for same day concerns that can be staggered throughout the day or increase the number of same day appointments when necessary during peak utilization times.

**Maintenance at AFRH.** In the course of our inquiry, residents and employees that we interviewed expressed concerns about maintenance at the AFRH. Specific problems identified included:

- restroom fixtures out of order (15 months and longer),
- safety barrier on Scott building loading dock constructed after death,
- safety latches/springs on fire doors not operational (Sep 03 violation - continues).
- hot water/heat/AC – significant outages and lapses continue.

Those interviewed indicated that the shift from permanent maintenance staff to contract maintenance staff as a result of downsizing has created the maintenance problems. Some of the maintenance issues identified by the residents and employees were observed by team members during our visits to AFRH.

The Bureau of Public Debt provides contracting services for the AFRH. On the largest facility maintenance contract, TPD-AFRW-05-K-00024, the contracting officer at the Bureau of Public Debt (BPD) established a quality assurance surveillance plan (QASP) and regularly evaluates contractor performance in the Contractor Performance System (CPS). Despite

concerns reported to us at various AFRH buildings, the contractor continues to receive good performance grades and has not received a single negative contractor deficiency report during the contract period of performance. No formal Contracting Officer Technical Representative (COTR) surveillance execution plan was noted and quality assurance documentation consisted only of a series of e-mail exchanges addressing various on-site problems.

Quality assurance documentation of facility maintenance contracts at AFRH needs to be improved. Per the Federal Acquisition Regulation, the government is required to maintain suitable records reflecting the nature of Government quality assurance actions, number of observations, and number/type of defects in procured goods and services. This documentation is not being accomplished in an adequate manner. The specific maintenance concerns noted above should be addressed and monitored by the Contracting Officer and COTR.

The facilities at the AFRH are aging. The Scott building for example was built in 1957. There is a high volume of maintenance actions on the aging facilities. In FYs 2006 and 2007, respectively, there were 8083 and 7917 service calls - 4560 and 4020 related to the Scott building, 1210 and 1559 related to the LaGarde building, and 1898 and 1800 related to the Sheridan building. These service calls average more than 650 per month, 94 percent of which are in the buildings housing residents. During our inquiry, the AFRH Chief Financial Officer informed us that they had identified more than 250 backlogged work orders. Based on information provided by the AFRH managers, they have a full-time COTR and two other individuals who provide part-time COTR services. These individuals now assess the completion of each service order.

According to the COO, because of the financial constraints with the Home, many actions to make improvements to the aging facilities have been deferred. There is a capital improvement plan which addresses these investment needs. For example, in his FY 2009 budget request, the COO stated that the 2006 estimate for the repair of all deficiencies was more than \$134 million, with the Scott building being the largest at more than \$81 million. The Scott building houses the majority of the independent living residents and the assisted living residents. In addition it has a dining facility, Wellness Center, Dental and Eye clinics, barbershop, Army and Air Force Exchange Service lounge, library with computer stations, religious activities, theater, and billiards room.

They also have prioritized the requirements for maintenance to identify those which must be dealt with in what time frame and revisit that priority periodically. Although such capital improvements should reduce the incidents of required maintenance, the AFRH must in the interim ensure timely upkeep and maintenance. For example, if something is left unfixed for more than a year then maybe the question should be whether it is needed as opposed to deferring having it fixed. But it should not be left as is for that period of time.

The 2005 Triennial Inspection by the Air Force Inspector General made recommendations for the AFRH to strengthen its oversight of contractor service quality. According to its March 2006 response to those recommendations and its October 2006 follow-up status report on the recommendations, the AFRH had taken actions to correct deficiencies noted. However, as noted above, maintenance problems still exist.

We will ensure that this area receives priority attention by the upcoming inspection, but in the meantime, we believe that the budget and contracts for the maintenance at the AFRH should be reevaluated toward reducing and maintaining a reduced backlog of maintenance actions.

**Recommendation B2.** We recommend that the Principal Deputy Under Secretary of Defense for Personnel and Readiness ensure and support the Chief Operating Officer, Armed Forces Retirement Home to:

- a. reassess the current and future maintenance budget and contract requirements for the Armed Forces Retirement Home to address current backlog and to maintain a reduced backlog until completion of the planned capital improvements, and
- b. work with the Bureau of Public Debt contracting officer to improve documentation of contract files.

**Vacant Key Positions.** The Director position at the AFRH-Washington has been vacant since May 2007. The Deputy Director position has been vacant for more than a year. These key positions need to be filled promptly.

The COO is in the process of filling these positions and has incumbent senior managers filling the positions on an interim basis. However, for a senior level position, such as the Deputy Director position to remain vacant for more than a year puts an unnecessary strain on the overall management of the AFRH, if in fact the position is needed. Although the senior managers who fill in on an interim basis are provided outstanding development opportunities, it can, after a time, also impact their ability to most effectively perform their own functions. Also, since the deputy position was left vacant for so long, when the Director position was vacated in May, two key positions became vacant and put more responsibility on acting senior managers. Understandably, the COO focus has been on finding someone with experience in retirement/nursing home management. We also realize that the current impact on OP TEMPO in the DoD has impacted the ability of the Department to provide military personnel to support the AFRH. Although we understand the need for retirement/nursing home management experience, we also believe that filling the positions is equally important and a compromise may be needed to get the positions filled.

**Recommendation B3.** We recommend that the Principal Deputy Under Secretary of Defense for Personnel and Readiness ensure the Chief Operating Officer, Armed Forces Retirement Home, expeditiously fill the Director and Deputy Director positions with a combination of military management experience and experience with retirement or nursing home management or other relevant experience.

We greatly appreciate the outstanding support provided to us by management, employees, and residents of the AFRH. The team's requests for information and documentation were responded to promptly, and the employees and residents were courteous and willing to provide information as requested. We would also like to thank the representatives of the

TRICARE Management Agency who participated as members of our team to review the specific quality of medical care issues that appear in this report.

Please provide me planned actions and milestones for implementing recommendations in this report. If you have any questions or would like to discuss these issues further, please contact me at (703) 602-1017 or at [patricia.brannin@dodig.mil](mailto:patricia.brannin@dodig.mil).



Patricia A. Brannin  
Acting Deputy Inspector General  
for Policy and Oversight

Attachments:

As stated

cc:

Inspector General of the Army  
Naval Inspector General  
Inspector General of the Air Force  
Director, TRICARE Management Agency  
Director, Armed Forces Retirement Home

## **SCOPE AND METHODOLOGY.**

Our inquiry was conducted between April and September 2007. Medical professionals from TRICARE Management Agency supported the DoD IG team to address medical specific issues. When the report refers to the review team it is referring the medical members as well as the DoD IG members.

In addition to gathering and reviewing relevant documentation, including maintenance contracts and clinical charts and other medical-information, the team conducted interviews with:

- 8 professional medical professionals from WRAMC and VA who treat or have contact with the residents at the AFRH;
- a volunteer worker at AFRH;
- 21 randomly identified employees from the 200+ AFRH government employees;
- 48 residents of ARFH, who voluntarily spoke with DoD IG representatives at prescheduled opportunities; and
- AFRH clinical leadership and supervisory staff.

We selected a random sample of 21, about 10 percent, from the more than 200 AFRH government employees. We did not include contractor staff in our sample. We randomly selected the employees in order to overcome a perceived concern by some of potential retribution. A previous reduction in force (RIF) from 800+ employees to 240, along with fears that another RIF was possible, made some leery of appearing to complain.

We considered as appropriate relevant information from prior reviews, assessments, or visits.

- 2005 Triennial Inspection Report of the Armed Forces Retirement Home, 25-29 July 2005 conducted by the Air Force Inspection Agency, Office of the Inspector General US Air Force.
- GAO Report Armed Forces Retirement Home: Health Care Oversight should Be Strengthened, GAO-07-790R, May 30, 2007.
- Office of Secretary of Defense (OSD) and Congressional visits in response to GAO March 19 letter:
  - On March 20, an experienced medical team sent by the Assistant Secretary of Defense for Health Affairs conducted an unannounced inspection.

- On March 21, the Joint Commission, a nationally recognized accrediting body for healthcare organization, arrived unannounced at the request of the Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD(P&R)), to conduct an independent review.
- On March 23, senior Department of Defense leadership and congressional staff members from the House and Senate Armed Services Committees and House Veterans Affairs Committee personally toured the facility.
- On May 2, 2007, members of Senator John Warner's staff made an unannounced visit to the AFRH in response to correspondence and phone calls from both a volunteer and the Chairman of AFRH Resident Advisory Council.

# **Report Distribution**

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## **Other Defense Organizations**

Director, Tricare Management Activity

## **Non-Defense Federal Organizations**

Chief Operating Officer, Armed Forces Retirement Home  
General Accounting Office

## **Congressional Committees and Subcommittees, Chairman and Ranking Minority Member**

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House Subcommittee on National Security and Foreign Affairs,  
Committee on Oversight and Government Reform

# Office of the Under Secretary of Defense Comments

Final Report  
Reference



PERSONNEL AND  
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE  
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NOV 30 2007

## MEMORANDUM FOR THE ACTING DEPUTY INSEPECTOR GENERAL (POLICY AND OVERSIGHT)

**SUBJECT:** Inquiry of GAO-Forwarded Allegations Related to the Armed Forces Retirement Home – Washington D.C. (Report No. TBD)

Thank you for the opportunity to comment on your draft report dated November 19, 2007. The Department has only two comments, which are related to the report's reference to the Norovirus outbreak; the possibility that "the rooms were not policed as quickly as desired" (page 2) and "which may have resulted in a less-than-preferred clean up of rooms" (page 5). AFRH staff worked in concert with the Walter Reed Army Medical Center Health Inspector to quickly control the spread of the virus and was presented a Department of Army Certificate of Appreciation for their "rapid response in halting transmission of a highly contagious infection." To infer they did not respond as quickly as desired or that there was a less-than-preferred clean-up does not correlate with their recognition by WRAMC. A copy of their certificate is attached.

Thank you and your staff's continued support for the residents and staff at AFRH.

Sincerely,

Leslye A. Arshitt

Deputy Under Secretary Defense  
(Military Community and Family Policy)

Attachment:  
As stated



Corrected



# DEPARTMENT OF THE ARMY

## **CERTIFICATE OF APPRECIATION**

AWARDED TO

### **ARMED FORCES RETIREMENT HOME**

To the staff of the Armed Forces Retirement Home for your rapid response in halting transmission of a highly contagious Norovirus infection among residents of this retirement home. The staff's response reflect great credit upon the Armed Forces Retirement Home's corporate culture and collective professionalism and excellence of each staff member.

Walter Reed Army Medical Center

  
VIRGIL T. DEAL  
Colonel, MC  
Commanding

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Inspector General  
Department of Defense

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