

Mission Failure: Abuse, neglect prevalent at many state veterans homes

by M. Scott Carter and Bob Sands

Published: May 3rd, 2012



Allan Kraft, a veteran of World War II, sits slumped over in his wheelchair at the Claremore Veterans Center. Kraft, his daughter said, was chemically restrained by the center and left unattended and slumped in his wheelchair for several hours. (Photo courtesy Susan Kraft)

Editor's Note: Reporter M. Scott Carter has been investigating problems with the state's veterans centers for nearly a year. That effort was joined by OETA reporter Bob Sands, who contributed to this report. OETA ran Sands' version of this story during the May 4th, 2012 Oklahoma News Report. View the video [here](#).

TULSA - Allan Kraft survived three years as a soldier in World War II.

Drafted just two months after his 18th birthday, Kraft joined the 103rd Infantry and was sent to Marseilles, France, to fight the German army. He fought in Germany, France and Austria and, in the spring of 1945, after the 103rd joined with the 45th Infantry Division, was part of the group that helped liberate about 32,000 prisoners of war from the Dachau Concentration Camp.

After the war he was discharged, returned home, married and started a family and a series of successful businesses. Then, in 2008 Kraft began showing signs of dementia. Unable to provide around-the-clock care for their father, Kraft's children, Michael and Susan, placed him in the Claremore Veterans Center on March 17, 2011.

Living at the center almost killed him.

Pattern of mistreatment

Across the state, many veterans have suffered a similar fate.

And though state lawmakers, elected officials and veterans groups claim that Oklahoma offers high-quality long-term care for veterans, an investigation by *The Journal Record* and OETA News shows a pattern of mistreatment of patients, including abuse, theft, neglect, rape allegations and, in some cases, premature deaths at several of the state's seven veterans centers.

"I know of at least three veterans that were killed at our center because of negligent care," said Dr. Pamela Hiti, who served as the medical director at the Norman Veterans Center from 2006 to 2011.

Doc's story

John Gordon Rollins, a World War II veteran known by most as Doc, lived at the Norman Veterans Center.

Rollins quit medical school to join the Army, serving as a radio operator during the Battle of the Bulge. And, like Kraft, he received numerous medals.

After he returned to the states, he finished his medical degree and established a practice in Purcell. But, by 1990, health problems forced him to retire. Over the next decade, Rollins battled a series of ailments, including the loss of his right leg below the knee and Alzheimer's disease.

Rollins was admitted to the Norman Veterans Center in 2002, where he lived for about eight years

with few problems, his wife said.

In 2011 he was transferred to the center's E2 wing.

Frail and needing high-level medical care, Rollins declined rapidly. His wife said the downturn was caused by poor medical care at the center. She said Rollins was dropped while being moved on Sept. 7, when the staff ignored a doctor's order to use a lift.

The next day, he died.

Lawsuits pending

Cases similar to those of Kraft and Rollins are documented in court records, police reports, federal and state inspection reports, medical records and photographs. The documents show a pattern of substandard care. In other cases, residents had money and belongings taken by staff members or were verbally abused, those records show.

At least six lawsuits alleging negligent medical treatment are pending in state courts. Those lawsuits follow many others that, over the past several years, have been adjudicated, most in favor of the plaintiffs.

The problems go back at least a decade. Documents show:

- On June 8, 2000 Harold Nichwander, a quadriplegic resident of the Claremore Veterans Center, was admitted to Claremore Regional Hospital with a fractured femur and because he was vomiting fecal material. A police report, taken at the time Nichwander was admitted to the Claremore hospital, notes that "someone that cares for the patient" could have caused Nichwander's injuries.

Officials at the Claremore center were unable to account for Nichwander's injuries. And though the center denied abusing Nichwander, court records indicate the Oklahoma Department of Veterans Affairs settled the claim with Nichwander's family in 2005.

- On Dec. 19, 2006, 93-year-old David Shelton, who had suffered a stroke, was taken to the Norman Veterans Center. Three weeks later, on Jan. 5, Shelton died after losing more than 20 percent of his body weight. In 2007, Shelton's family sued the Norman center and the Oklahoma Department of Veterans Affairs over his death. Shelton's family won the case and the maximum allowable award - \$175,000.

A decision by the Oklahoma Court of Civil Appeals in March 2011 upheld the ruling.

- Roger Butts, who was being treated for grand mal seizures and Hepatitis C, was kicked out of the Norman center on Feb. 16, 2007. His sister, Beverly Channel, said Butts got the boot because he got into a shouting match with the center's director, Bob Weeks.

Weeks, now retired, did not respond to numerous calls seeking comment, but a letter Weeks sent to the patient said Butts was involuntarily discharged because his health had improved to the point he no longer needed their services.

Just two months later, Butts was found dead at the Range Motel in Tecumseh. A report from the state medical examiner's office lists Butts' cause of death as a seizure disorder, the same problem he was treated for at the Norman Veterans Center.

- In June 2008 Mike Simmons, paralyzed from multiple sclerosis, complained about the quality of care at the Norman center. In October of that year, Simmons received a letter from Weeks, who wrote that the veteran would be involuntarily discharged on Thanksgiving Day because the center was unable to meet Simmons' needs. Simmons has waged a four-year court battle to remain at the center, where he continues to live.

- In March 2011, 47-year-old Donald Demonbreum was charged with using excessive force while caring for four patients at the Ardmore Veterans Center. The charges allege Demonbreum had been abusing residents since 2010. He is awaiting trial.

During the police investigation, Sgt. Kevin Norris told the Ardmore Ardmoreite, staff members at the center had been aware of complaints against Demonbreum for months, but failed to report it to police. That revelation led to the June 2011 resignation of the center's administrator, Greg Robertson.

- On June 28, 2011, Jeremy Craig Lyday, a 27-year-old employee of the Norman Veterans Center, was charged with one count of rape and two counts of forcible oral sodomy against patients with advanced dementia. Lyday's case is pending in Cleveland County District Court.

In 2011, several high-level ODVA staff members and the Norman Veterans Center medical director resigned, citing concerns about veterans' treatment.

Hiti, the medical director who resigned, said she gave up the position because too many veterans were being hurt.

"It's absolutely disgraceful," she said.

Hiti said the problems have spread across the state because there is little oversight of center administrators and other staff.

"It's systemic," she said. "I used to be part of the medical directors group. We would get together and review each other's cases, and they are happening at every center. The administrators feel empowered to decide everything. The problems are not going to go away until they improve staffing, provide better training and stop the administrators from making medical decisions."

Vast differences

Federal officials have also raised concerns about conditions at several of the centers. Annual inspections by a Department of Veterans Affairs contractor show vast differences in the quality and performance of each center.

For example, at the Clinton Veterans Center, federal inspectors recorded no patient or medical care problems.

At Lawton, however, the 2011 inspection noted that medications were not administered according to recommendations. The inspection detailed how a patient's feeding tube wasn't turned off while receiving the anti-seizure medicine Dilantin.

According to the report, a nurse said she was not aware the feeding tube needed to be turned off for one hour before and one hour after the medication was given.

The Claremore center's 2010 inspection, the most recent available, revealed serious problems.

The problems were so severe that federal investigators informed the administrator, Cindy Adams, that her center's status would be reduced to provisionally certified until nine deficiencies were corrected.

The Norman center's 2011 inspection, conducted in September, gave the center a clean report despite the fact that a staff member had been charged with raping and sodomizing two residents just three months earlier.

Cleveland County sheriff's records show that deputies were dispatched to the center at least six times in 2011 for complaints including larceny, sexual battery and assault and battery.

Hiti questioned the quality of the federal inspections.

"People don't worry about them," she said. "They almost always know when they (the inspectors) are coming and they clean things up. I know I was part of that."

Little state oversight

Unlike jails and nursing homes, Oklahoma's veterans centers have little state oversight.

Prior to 2000, the centers were inspected by the nonprofit Joint Commission on Accreditation of Healthcare Organizations, the Department of Veterans Affairs and the state Department of Health. The Department of Veterans Affairs stopped using the Joint Commission and in 2003 the Oklahoma Legislature took the centers off the OSDH inspections list, leaving the VA's annual inspections as the only form of supervision.

Reports of patient abuse go to the state Department of Human Services, which confirmed more than 20 incidents of abuse, neglect, sexual abuse, exploitation and verbal abuse spread among

inadequate and negligent medical care and involuntarily discharged Kraft in violation of his due process rights.

Kraft is currently living at the Autumn Leaves Nursing Home in Tulsa, his daughter said.

"My father went to war when he was asked and he served honorably," Susan Kraft said. "But when he needed the state, the state didn't help. He didn't deserve this. I don't think it's too much to ask that someone who fought for us, a soldier who went to war, be allowed to live out the twilight of his life in peace and dignity."

ALSO SEE:

[Calls for veterans center reform not heeded](#)

Like 188

34

2

35

Complete URL: <http://journalrecord.com/2012/05/03/mission-failure-abuse-neglect-prevalent-at-many-state-veterans-homes-capitol/>

WVC chairman: Lack of oversight led to problems in veterans system

by M. Scott Carter

Published: August 22nd, 2012



War Veterans Commission Chairman Richard Putnam speaks to a legislative panel Tuesday. (Photo by Brent Fuchs)

OKLAHOMA CITY – Mired in problems, faced with more than a half-dozen negligence claims and wrongful-death lawsuits, the Oklahoma Department of Veterans Affairs and its governing body, the War Veterans Commission, lost the public's trust, the commission's new chairman told a legislative panel Tuesday.

Speaking at an interim meeting of the Oklahoma Senate's Veterans and Military Affairs Committee, new WVC Chairman Richard Putnam said the state's veterans system had suffered from a lack of oversight and direction.

"We lost your trust and we're trying to get it back," he said.

Putnam told lawmakers the new commission – which has been in office only since July – was charged by Gov. Mary Fallin with quickly replacing the ODVA's current leadership.

"I do believe there was inadequate oversight and that has led to current conditions," Putnam said. "This commission has been very carefully put together. One of the first things we have been tasked to do is replace the leadership in ODVA. We are moving to extend our own influence, authority – however you want to say that – more overtly into the ODVA processes."

Putnam's statement contradicts a letter distributed to the WVC by former ODVA Executive Director Martha Spear in July. In her letter, Spear wrote that she was retiring to take care of her husband.

Spear was forced out of her \$100,000-per-year position after reports were published that showed officials with the Claremore Veterans Center misled the state medical examiner's office about the causes for the death of World War II veteran Jay Minter.

Spear had worked for the ODVA for 46 years.

On Tuesday, state Secretary of Military and Veterans Affairs Rita Aragon told lawmakers that Spear and previous members of the WVC refused her requests for information about Minter's death.

"I contacted one member (of the old commission) and was told that information was outside of my scope of responsibility," she said. "So I did not get any information."

Aragon said Spear told her that Minter's death, while tragic, was not suspicious.

"The information I was given by the director was that it was tragic death but there had been no culpability and that the family was happy with the results," she said. "That was the story I was given. In other words, the death of Mr. Minter was a result of his age."

A report issued by the state medical examiner's office showed that Minter died as a result of thermal injuries to more than 50 percent of his body. Minter's widow, Frances, has filed a negligence claim with the state over her husband's death.

Aragon told lawmakers that she worried that previous deaths at the centers were caused by negligence.

"It's been one of my greatest fears," she said. "We have seven wrongful-death suits sitting right now. I wonder daily and nightly. I look at how many of those have occurred in the past when no one was watching."

Roy Griffith, the ODVA's acting deputy director and administrator of the Talihina Veterans Center, told lawmakers that veterans center staff members were obligated to report cases of suspected abuse. Griffith said at his center those incidents were investigated by a team he appointed.

"I appoint a team of three, and also inform the headquarters office and DHS adult protective services," he said. "Once the investigation is done, if there is any kind of discipline, we coordinate with headquarters about the disciplinary action."

The system works, Griffith said.

Griffith said the system is constantly being audited by state and federal officials. He said the VA regularly inspects each veterans center. Griffith said those inspections were performed by Ascellon, a private contractor hired by the VA.

Asked if center staff had prior notice of the inspections, Griffith told lawmakers the inspections were unannounced, adding that veterans center staff was only aware of the month the inspection would take place.

"Not prior notice but we do know the month," he said. "Like if I'm a December guy, I'm going to get it in December. You know the month but you don't know the day."

However, emails obtained by The Journal Record contradict Griffith's statement.

In a message from Nancy Gallup, administrator of the Sulphur Veterans Center, Gallup warned several other ODVA staff members of her center's upcoming inspection. Gallup's email included the exact day of the Ascellon inspection and the date when the inspection would be completed.

"I confirmed with Matthew Fox (an official with the Oklahoma City VA Medical Center) that the inspection team will be here next Tuesday, Jan. 11," Gallup wrote. "They will do a full survey and should complete it on the 13th. If there is anything that you know of that we need to do before they arrive, please let me know."

Emails from several ODVA and veterans center staff members also warn other centers and staff what the VA inspectors are looking for.

WVC chairman: Lack of oversight led to problems in veterans system

By [M. Scott Carter](#) <!-- By M. Scott Carter -->
Oklahoma City / Capitol bureau reporter. Contact: 405-278-2838,
scott.carter@journalrecord.com, @JRMScottCarter.
Posted: 10:35 PM Wednesday, August 22, 2012



Powered by [Bookmarkify™](#)



War Veterans Commission Chairman Richard Putnam speaks to a legislative panel Tuesday. (Photo by Brent Fuchs)

OKLAHOMA CITY – Mired in problems, faced with more than a half-dozen negligence claims and wrongful-death lawsuits, the Oklahoma Department of Veterans Affairs and its governing body, the War Veterans Commission, lost the public's trust, the commission's new chairman told a legislative panel Tuesday.

Speaking at an interim meeting of the Oklahoma Senate's Veterans and Military Affairs Committee, new WVC Chairman Richard Putnam said the state's veterans system had suffered from a lack of oversight and direction.

"We lost your trust and we're trying to get it back," he said.

Putnam told lawmakers the new commission – which has been in office only since July – was charged by Gov. Mary Fallin with quickly replacing the ODVA's current leadership.

"I do believe there was inadequate oversight and that has led to current conditions," Putnam said. "This commission has been very carefully put together. One of the first things we have been tasked to do is replace the leadership in ODVA. We are moving to extend our own influence, authority – however you want to say that – more overtly into the ODVA processes."

Putnam's statement contradicts a letter distributed to the WVC by former ODVA Executive Director Martha Spear in July. In her letter, Spear wrote that she was retiring to take care of her husband.

Spear was forced out of her \$100,000-per-year position after reports were published that showed officials with the Claremore Veterans Center misled the state medical examiner's office about the causes for the death of World War II veteran Jay Minter.

Spear had worked for the ODVA for 46 years.

On Tuesday, state Secretary of Military and Veterans Affairs Rita Aragon told lawmakers that Spear and previous members of the WVC refused her requests for information about Minter's death.

"I contacted one member (of the old commission) and was told that information was outside of my scope of responsibility," she said. "So I did not get any information."

Aragon said Spear told her that Minter's death, while tragic, was not suspicious.

"The information I was given by the director was that it was tragic death but there had been no culpability and that the family was happy with the results," she said. "That was the story I was given. In other words, the death of Mr. Minter was a result of his age."

A report issued by the state medical examiner's office showed that Minter died as a result of thermal injuries to more than 50 percent of his body. Minter's widow, Frances, has filed a negligence claim with the state over her husband's death.

Aragon told lawmakers that she worried that previous deaths at the centers were caused by negligence.

"It's been one of my greatest fears," she said. "We have seven wrongful-death suits sitting right now. I wonder daily and nightly. I look at how many of those have occurred in the past when no one was watching."

Roy Griffith, the ODVA's acting deputy director and administrator of the Talihina Veterans Center, told lawmakers that veterans center staff members were obligated to report cases of suspected abuse. Griffith said at his center those incidents were investigated by a team he appointed.

"I appoint a team of three, and also inform the headquarters office and DHS adult protective services," he said. "Once the investigation is done, if there is any kind of discipline, we coordinate with headquarters about the disciplinary action."

The system works, Griffith said.

Griffith said the system is constantly being audited by state and federal officials. He said the VA regularly inspects each veterans center. Griffith said those inspections were performed by Ascellon, a private contractor hired by the VA.

Asked if center staff had prior notice of the inspections, Griffith told lawmakers the inspections were unannounced, adding that veterans center staff was only aware of the month the inspection would take place.

"Not prior notice but we do know the month," he said. "Like if I'm a December guy, I'm going to get it in December. You know the month but you don't know the day."

However, emails obtained by The Journal Record contradict Griffith's statement.

In a message from Nancy Gallup, administrator of the Sulphur Veterans Center, Gallup warned several other ODVA staff members of her center's upcoming inspection. Gallup's email included the exact day of the Ascellon inspection and the date when the inspection would be completed.

"I confirmed with Matthew Fox (an official with the Oklahoma City VA Medical Center) that the inspection team will be here next Tuesday, Jan. 11," Gallup wrote. "They will do a full survey and should complete it on the 13th. If there is anything that you know of that we need to do before they arrive, please let me know."

Emails from several ODVA and veterans center staff members also warn other centers and staff what the VA inspectors are looking for.

"VA is here doing their inspection and will be back Wednesday," wrote Cheryl Strong, a nurse manager at the Norman Veterans Center.

"Please pass this on to the patient care attendant staff so we can assure all the microwaves, refrigerators, etc., are clean. We need to make sure the residents are dressed nicely in the AM. Make sure there are no expired meds, insulin, etc on your units and that the med rooms are organized and clean."

Griffith said the VA inspected centers any time there was a complaint.

"They did that with the Claremore thing," he said. "They come out any time."

Like 1 2 0

2

The Journal Record

<http://journalrecord.com>

Aragon: Restore state inspections of veterans centers

by M. Scott Carter

Published: September 24th, 2012



Retired Air Force Maj. Gen. Rita Aragon, Veterans Affairs secretary, right. (Photo by M. Scott Carter)

OKLAHOMA CITY – The state secretary of military and veterans affairs said Monday she would support a move that required Oklahoma veterans centers to be inspected again by the state Health Department.

Retired Air Force Gen. Rita Aragon, appointed by Republican Gov. Mary Fallin as VA secretary in 2010, said she would encourage members of the Oklahoma Legislature to restore the law requiring the inspections. *Journal Record* stories have detailed cases of abuse, neglect, assault, rapes and deaths at several state veterans centers.

"I believe that will happen and I would encourage that to happen," Aragon said. "I

believe the Legislature and the War Veterans Commission are convinced the centers need an additional layer of inspection."

Funded with state revenue, federal funds and payments from veterans, Oklahoma's seven veterans centers were originally inspected by the state Health Department and by the federal Department of Veterans Affairs until 2003.

After the Oklahoma Legislature repealed state inspections, the VA outsourced its examination of the facilities to a private company, Ascellon. In Oklahoma, federal VA inspections occur regularly each year and staff members are usually aware of when inspections will take place.

Those changes occurred despite a federal study by the Office of Management and Budget – released in 2000 – that said state inspections were more rigorous and discovered more problems than federal examinations.

Aragon said new leaders at the Oklahoma Department of Veterans Affairs and the WVC are pushing veterans center staff members to always be ready for an inspection.

"If you're doing what you're supposed to be doing, then you should always be inspection-ready," she said. "That's a military thing."

She said the changes were part of a major overhaul of the state's veterans system and its administrative office. Aragon said those changes would include new oversight, more authority for the governor, better training for staff members and a reorganization of the ODVA central office.

"The War Veterans Commission is taking a very active role," she said. "They are working hard to gather information and improve the system."

War Veterans Commission Chairman Richard Putnam told lawmakers the agency is working to restore the public's trust.

"We lost your trust and we're working to get it back," he said.

However, at least one veterans center resident said he has a wait-and-see attitude about the changes.

"The system has been broken for a long time," said Mike Simmons, a resident at the Norman Veterans Center. "And it's going to take a while to improve it."

Simmons, who fought a three-year court battle to remain at the Norman center, said it has been his experience that some areas of the system have been improved, but more work remains.

"My impression is that our VA centers need another agency's involvement to improve," he said. "When it's just left up to them (the ODVA), that's when all the problems start happening. I think they definitely need to go back under Health Department inspection. That way the veterans who live at the centers and their families will have someplace to go if there are problems."

State lawmakers will continue their examination of the ODVA and its veterans centers on Thursday, when the state Senate's Veterans and Military Affairs committee holds its second meeting at the state Capitol.

Like 0

0

Complete URL: <http://journalrecord.com/2012/09/24/aragon-restore-state-inspections-of-veterans-centers-capitol/>

OKLAHOMA CITY – Staff members of the Oklahoma Department of Veterans Affairs hid more than \$9 million in federal funds from members of the Oklahoma Legislature during the 2009 budget crisis, documents obtained by *The Journal Record* show.

Buried deep in budget documents and ODVA financial data, records indicate that the ODVA had \$9.197 million in federal reimbursement funds on hand when its staff members testified at legislative hearings in December 2009.

During the hearings, neither Martha Spear, the agency's executive director, nor Acting Deputy Director Roy Griffith said anything about more than \$9 million in federal funds, but instead told lawmakers the agency could not afford a budget cut. Records show that the funds were hidden in other portions of the agency's budget.

The money was part of an initiative from the federal VA to retroactively refund the cost of caring for veterans who were listed as 100-percent disabled. Previously, the VA only covered about 70 percent of the cost.

Passed by Congress in 2008, the program refunded millions of dollars back to veterans' families and state veterans departments to repay the costs of caring for veterans who were 100-percent disabled.

In Oklahoma, more than \$9.6 million was paid back to veterans and their family members, while another \$9.197 million was paid back to the state's veterans system.

Under state law, the Office of State Finance and state lawmakers should have been notified about the funds.

However, documents show that the ODVA received a standstill budget that year due in part to statements made by Spear and Griffith. Spear announced her retirement in August. She is on family medical leave until her Nov. 1 retirement.

Griffith is also the administrator of the Talihina Veterans Center.

During the legislative hearing, Spear, Griffith and other ODVA staff members said any funding cuts would send the agency into a death spiral and prevent it from capturing federal money needed to pay for the care of veterans living at state centers. An ODVA financial officer told lawmakers that additional cuts to the agency would also cause major problems for the centers and could force agency staff members to turn away veterans needing help.

Yet even while the ODVA leadership testified and painted a dark, foreboding image of the agency's budget situation, documents show that the millions in federal money had been placed in various departments within the agency just prior to the legislative hearings.

Moving the funds prevented legislative staff and analysts with the Office of State Finance from discovering the federal windfall.

Records show that the funds were placed in departments that included personnel, construction and other agency programs. Once the agency's appropriation was approved and had passed the Legislature, those funds were moved back into the ODVA general revenue fund.

Internal ODVA budget documents indicate that the funds were eventually used to leverage more than \$20 million in federal stimulus funds, including a \$2.7 million renovation for the Ardmore Veterans Center, a \$6.9 million renovation of the Clinton Veterans Center dining and food service facility and \$5.8 million for telecommunications and telemedicine infrastructure.

At that time, Oklahoma was one of the few states that had funds to qualify for matching federal funds from the VA for construction projects.

State Rep. Joe Dorman, the Rush Springs Democrat who called for an legislative study of the state veterans system, said he was surprised that agency officials would mislead lawmakers.

"I'm disappointed," Dorman said. "We ask those questions because we are serious about trying to prioritize spending. When agencies are less than candid, it makes the process that much more difficult."

Dorman said the revelations cast a shadow over the agency's financials.

"It makes me wonder what else they are hiding," he said. "And it makes me question how those funds were spent."

Telephone calls to Spear and Griffith were not returned.

ODVA funding facts

OKLAHOMA CITY – With three different revenue streams, the Oklahoma Department of Veterans Affairs and its seven veterans centers receive funds from their residents, state appropriations and payments from the federal government.

Often called the three-legged stool approach, each set of funds represents roughly one-third of the agency's budget. In addition to its state funds, the agency receives payments by each veteran who is a resident at one of the seven centers.

Each center also receives a per-diem payment for the total number of veterans living there.

Data from the Office of State Finance shows that the ODVA has a total budget of more than \$134 million for the 2012 fiscal year. Those funds include \$102.2 million for personnel services; \$17.3 million for administrative expenses; about \$10.4 million for furniture, fixtures and property; more than \$4.2 million for programs, awards and general assistance; and \$178,633 for travel.

As part of that FY 2012 budget, state and federal funds are provided for each of the state's seven veterans centers, including \$24,884 million for the Claremore center, \$16,163 million for the Ardmore center, \$15,438 million for the

Clinton center, \$24,518 million for the Norman center, \$15,585 million for the Sulphur center, \$17,207 million for the Talihina center and \$21,813 million for the Lawton center.

Additionally, about \$2.33 million is appropriated for the ODVA main office, another \$2.3 million for its claims administration department, \$1.7 million for claims and benefits and \$11.3 million for statewide capital improvement projects.

M. Scott Carter,
Capitol Bureau Reporter
The Journal Record
(405) 278-2838 - Downtown
(405) 524-7777 - Capitol bureau
scott.carter@journalrecord.com
www.journalrecord.com

inspector Marilyn Klotz wrote that Claremore's plan for correction was not acceptable.

Klotz wrote that Claremore's corrective plan did not address what measures would be put into place or systemic changes made to ensure that the deficient practice would not occur.

Oklahoma Department of Veterans Affairs Acting Deputy Director Roy Griffith said the agencies were trying to move beyond hiring the lower 20 percent of applicants.

"We're trying to move to hiring the top 20 percent, because we're taking care of wartime veterans and they deserve it," he said.

Like

0

1

0

1

Complete URL: <http://journalrecord.com/2012/10/01/records-claremore-veterans-center-cited-for-noncompliance-capitol/>