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Edward F. Flood  
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RE: OSC File No. DI-07-1039

Dear Mr. Flood:

Thank you for allowing me the opportunity to respond to the letter of Mr. Nicholson, and the report that he commissioned through the Undersecretary for Health, and ultimately the Office of Medical Inspector. I found that the report was a continuation of the Veterans Administration's policy of not addressing the problems, but rather of attempting to circumvent the allegations. My reply will be supplemented by declarations from some of the personnel involved.

### **Joint Commission on Accreditation of Health Care Organizations**

In his letter of July 11, 2007, Director Nicholson plainly states that the initial investigation opened up by JCAHO in August 7, 2003 was closed in 2003. That is simply false. While it is true that JCAHO did not issue a final report, they indicated to me that the matter was still under review, and their difficulty in issuing a final report stemmed from the lack of response from the Veterans Administration. I wrote letters in November and December of 2005, and spoke with Rosemarie Savino the lead investigator of JCAHO regarding this incident during that period. The matter was still under an open investigation, and the implication from Director Nicholson that they had found no substance to the complaint is simply false. I must note for the record that Mr. Nicholson must have signed this just before giving up his position.

**OIG Case Number 2006-03311-HL-1019**

The letter from Director Nicholson also states that there was a previous OIG complaint. That is true. The Inspector summarily states that OIG closed its case in October of 2006. That is also true. What the Director does not state was the fact that the case was closed because, during that time-frame, there was an on-going federal lawsuit. Your colleague Jacob Briem explained to me and my attorney Michael Heath that the OIG case could not go forward at the same time as the lawsuit. The implication that the matter was closed due to a finding of a lack of substance is simply false.

### **Substance of the Complaint**

I think it is important that, prior to addressing the latest response from the VA, I summarize what I have been trying to do almost since the beginning of my employment at the Spinal Cord Injury Unit.

I have long been concerned that patients in the Spinal Cord Injury Unit were being given substandard medical care. The VA was allowing Nursing Assistants to perform procedures on patients that directly violated all standard of acceptable medical care. For the past seven years, I have attempted to rectify this situation. I am pleased that my efforts have resulted in a change in policy and practices (on paper, at least). Since my initial complaint in 2003, there have been indications that the hospital is adhering to my suggestions. I would like to point out for your review, specifically, the VA Directive of September 12, 2006 (see Exhibit 1), and the deposition testimony of Sandra McDonald, which relates the change of policy (see Exhibit 2).

What is frustrating to me is that, during the time period when I was putting forth those complaints, the VA was denying that these problems existed. Indeed, a simple review of the letter from Joyce Freeman to JCAHO leaves the unmistakable impression that the VA was doing everything correctly, and that my complaints were unfounded. This cannot be squared against the facts, neither at that time, or as seen in the light of the VA's subsequent remedial action. I need to be clear that I applaud the remedial actions. I am concerned that, rather than my getting the credit for being the impetus for these actions, I am instead been the victim of increasing discipline leading to the loss of my job because of my unwillingness to accept substandard care.

### **Part A: What remains to be fixed**

While acknowledging that on paper the VA has instituted some changes as a direct result of my advocacy, I would like to specify what remains to be fixed. One my initial complaints were that Nursing Assistants were required to perform invasive care tasks on patients. Indeed, my concern reached a peak of sorts when I was directed by Nurse Karen Blair to perform precisely that invasive technique. When I explained that I was unable to do so because I was unqualified, she insisted on escalating the situation and complaining to Alice Navqi, the Associate Chief of Nursing. Nurse Navqi then directed my supervisor, Sandra McDonald, to write me up. Ms. McDonald did not want to do so. Indeed, she

acknowledged in deposition testimony that she did not think I had been trained to perform the task, and that she would not have written me up but for the fact that her refusal to do so would have required her to disobey a direct order (see Exhibit 3).

When I was written up for this "refusal" to perform the invasive health care procedure, I was found to be insubordinate for failing to follow directions. Consequently, I became subject to discipline. It is therefore startling to me, given three-plus years that have since passed, that the VA's internal report from OMI indicates that "the OMI is concerned about Nursing Assistants assessing pressure or decubitus ulcers." This finding came after a formal educational policy had been implemented, in large part because of my actions, and after I had been forced out of my job.

**Part B: The continuing problem of procedures performed by unqualified Nursing Assistants**

I have also been concerned about Nursing Assistants performing other medical procedures on spinal cord patients. The report from OMI indicates that: (1) Nursing Assistants are allowed to do so because they are not subject to the credentialing and privileges directives, and (2) the educational program in place at the VA is such that the procedures are being performed properly. I would like to address each of these in order.

I am uncertain as to how the OMI can conclude that Nursing Assistants are not subject to the credentialing privileges directive. I am again enclosing as Exhibit 4 the 1100.19 credentialing privilege for your review. The reason for this rule is simple. We do not want untrained and unsupervised medical professionals engaging in medical procedures that they are not qualified to do. It is elementary that in every hospital throughout the country there are rules and regulations governing which medical professionals can perform which medical procedures. Obviously, you do not want the cafeteria cooks to perform a quadruple bypass. Just as obviously, you do not want Nursing Assistants to administer medications, perform invasive care, and work without supervision by RN's. These situations continue to exist at the VA.

The second aspect of the report that I would like to address is the remedial educational policies that have been implemented as a result of my whistleblowing. It is beyond my comprehension how I can be told in 2003, 2004, and 2005 that the VA is doing nothing wrong with regard to caring for the patients in the spinal cord unit, and then watch the VA implement changes in the manner that care is given. The changes are directly in line with what I have been advocating for all along. How can it be that, when I first brought the deficiencies in training and care that I had observed to the Director's attention, I was told that my complaints had no substance? Indeed, Director Nicholson's letter of last month indicates that JCAHO had found no substance to my complaints. If they had substance, then why was the September 12, 2006 directive directly in line with many of my proposed changes?

Once again, I applaud these remedial actions. My question is why this remedial action has not been taken for what it is: a response to my legitimate complaint about the care of

the veterans. I am quite certain that, without my complaints, none of these changes would have occurred. I need only point to the deposition testimony of from Alice Navqi and Sandra McDonald to show that the VA's position of 18 months ago was that these changes were unnecessary (see Exhibit 5).

At this point in this case, I have turned to the Office of the Inspector General as a last port in the storm. For four-plus years, I have been actively involved in advocating for better patient care on the Spinal Cord Injury Unit. As a result of this, I have been forced to defend against trumped up charges. I have had to spend countless hours attempting to get someone to look under the blanket, and see what sort of care the patients were getting. This OMI investigation is a direct insult to me. Rather than look at the timing of the complaint, and the agencies responses over the years, OMI has taken a snapshot of today's activity, as filtered through the lens of Director Nicholson. I have attached hereto as Exhibit 6 declarations from patients that directly substantiate the allegations that I have been making for four years.

I can also say that, if the Office of Special Counsel would care to talk with any of the Nursing Assistants on the spinal cord ward in a confidential manner, they would substantiate that:

- (1) all of the changes that have been implemented were the direct result of my advocacy;
- (2) the care given to the patients is still substandard;
- (3) the Nursing Assistants have, for four years, performed invasive procedures, administered medications, performed other tasks beyond their credentialing, and performed duties that should be reserved for RN's.

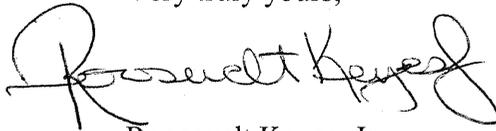
We would hesitate to tell the Office of the Inspector General how to do its job. However, it seems imperative that an interview with some of the Nursing Assistants, with the assurance that their statements would not be used against them, should be conducted. Indeed, this should have been done many years ago.

I must point out that perhaps the reason that nobody has been anxious to speak to the nursing assistants is that all of the nursing assistants are people of color and the demonstration of the hospital is overwhelmingly white females. I would like to point out that both the NAACP and Congresswoman Eschoo's office have been involved in making sure that the discriminatory practices stop immediately.

I feel the need to expand a bit on the last statement. In 2002, I filed a formal complaint with EEO, with the support of five other Nursing Assistants on the ward. The other Nursing Assistants agreed with me, and filed other EEO complaints regarding the issues that remain unresolved five years later. Each of the Nursing Assistants watched me go through the succession of disciplinary actions that ultimately led to my being removed from the VA. My colleagues are not foolish or stupid. They clearly understood that, if they were to begin advocating as I did, they would share the same fate as me. I feel it is imperative that someone speak with the Nursing Assistants and ensure that they feel that they can freely discuss the situation with the Office of the Inspector General.

Thank you for your help in this matter.

Very truly yours,

A handwritten signature in cursive script that reads "Roosevelt Keyes, Jr". The signature is written in black ink and is positioned above the printed name.

Roosevelt Keyes, Jr

Encl.