U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

August 23, 2023

The President
The White House
Washington, D.C. 20500

Re: OSC File Nos. DI-22-000594 and DI-22-000637

Dear Mr. President:

I am forwarding to you a report transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA) in response to the Special Counsel's referral of a disclosure of wrongdoing by employees of the Veterans Health Administration (VHA), Atlanta VA Medical Center (Atlanta VAMC), Atlanta, Georgia. The whistleblowers, Registered Nurse [redacted] and Recreation Therapist [redacted], who consented to the release of their names, alleged that Atlanta VAMC officials engaged in conduct that constituted a violation of law, rule, or regulation, and a substantial and specific danger to public health and safety. I have reviewed the disclosure, agency report and the whistleblower comments. In accordance with 5 U.S.C. § 1213(e), I have determined that the report contains the information required by statute and the findings appear reasonable.[1] The following is a summary of the allegations and findings.

The Allegations

[redacted] alleged that Atlanta VAMC employees in the facility's Inpatient Psychiatric Unit (IPU) violated federal COVID procedures for VA facilities and endangered the health of long-term patients in the unit by failing to maintain a clean, COVID-compliant facility. Specifically, [redacted] alleged that employees repeatedly violated the VA Memorandum, "Managing Operations of Mental Health Unit While Managing COVID-19" (VA Memo) between 2020 and 2022. [redacted] alleged that the Atlanta VAMC failed to provide personal protective equipment (PPE) to staff and providers in the IPU and that staff failed to test and move patients who tested positive for COVID-19 out of the unit to prevent increased exposure to others, failed to inform other staff members when they had been exposed to COVID-19, and failed to thoroughly clean spaces where COVID-positive patients had stayed.

Additionally, [redacted] alleged that social distancing rules were not followed even during situations when patients were eating and therefore could not wear masks. [redacted] alleged that the unit was regularly understaffed and staff were often asked by leadership to violate the 1:1 monitoring policy for patients that pose a risk to themselves or others as outlined in VHA Directive 1160.06. [redacted] alleged that IPU staff's capacity to monitor patients in accordance with

[1] The allegations were referred to the Secretary of Veterans Affairs Denis R. McDonough for investigation pursuant to 5 U.S.C. §1213(c) and (d). The VA Office of Medical Inspector conducted the investigation and Secretary McDonough reviewed and signed the report.

the VHA Directive was further affected by the improper floating of IPU staff to the Emergency Department to aid in COVID-19 testing in direct violation of the VA Memo.

[redacted] also alleged that the conditions for the unit were not properly maintained. [redacted] reported that there was dirt and grime covering most surfaces in the IPU and that it had been infested with insects. [redacted] reported that the sinks and showers in patient rooms did not have access to hot water and were in a general state of disrepair. Finally, [redacted] alleged that, in violation of the VA Memo, staff failed to perform temperature checks on patients and providers to determine whether they were infected with COVID-19 upon entering the unit and that social distancing was not maintained for unmasked patients in common areas.

The Agency Report

Following an unannounced site visit, the investigation substantiated the lack of social distancing in common spaces while patients were not wearing masks but did not substantiate the other allegations. The agency provided 17 recommendations to ensure future compliance with agency and facility rules and regulations, including recommending nursing staff attend remedial trainings on COVID-19, cleaning and patient monitoring policies and establishing a method to monitor the cleaning of unit surfaces.

The investigation found that necessary PPE was available to staff, but many were not wearing masks properly. The investigation also found that all patients were tested before they entered the floor. And it found that patients that tested positive while in the unit they were quarantined and isolated. The investigation further found that it was not IPU management's responsibility, but rather the responsibility of the Infection Control and Occupational Health Services, to notify staff if they were exposed to any COVID-positive patients.

The investigation did not substantiate a failure to clean spaces where COVID-positive patients stayed and noted that IPU's nursing staff was responsible for requesting cleaning when necessary. The report noted that the nursing staff lacked understanding of the requirements surrounding terminal cleaning procedures.[2] Specifically nursing staff believed that terminal cleaning necessarily involved the use of ultraviolet light for the disinfection of surfaces, but this is not required by facility infection control guidelines.[3] The report also found that shortly after the investigation into these allegations, the mental health unit established a team to ensure work orders for future health environment issues are appropriately entered and ultimately resolved.

The investigation did not find a lack of cleanliness at the facility, despite a minor lack of consistency with the hot water in some sinks. The investigation also did not substantiate that patients do not have access to hot water or that showers and sinks are in a general state of disrepair. Notwithstanding these findings, the report recommended remediation plans to resolve the minor discrepancies, to monitor cleanliness going forward, and for additional cleaning practices and protocols. Finally, the investigation did not conclude that nurses in the

[2] "Terminal cleaning" is defined as is the thorough cleaning of a room after use, used in healthcare environments to control the spread of infections.
[3] *See* Atlanta VA Medical Center: *Clinical Environment Surface Cleaning and Disinfecting Procedures*.

mental health unit were improperly floated to the Emergency Room, nor did it find violations of 1:1 monitoring policies.

The Whistleblower Comments

[redacted] disagreed with multiple findings made by the investigation. [redacted] maintains that 1:1 monitoring and staffing continues to be a problem and that the agency disregarded photographs showing the filth in the facility when they made their cleanliness determination. [redacted] disagrees that staff will be informed if they are exposed to COVID-19 except by word of mouth, and [redacted] blames many of the problems in the facility on a lack of stable management, an allegation [redacted] feels is corroborated by the recommendations concerning management action. Finally, [redacted] was dissatisfied by the agency's use of a single unannounced visit as the means of investigating her allegations. [redacted] noted that the investigation occurred after many COVID-19 protocols were lifted by the VA and the federal government and therefore some of her allegations could never be substantiated. [redacted] did not comment on the report.

The Special Counsel's Determination

I thank [redacted] and [redacted] for bringing this matter to OSC's attention. Given the changing circumstances concerning COVID-19, we understand the whistleblower's concern that the findings may not be reflective of the agency's practices several months prior, but I am pleased that the investigation found the facility generally in compliance with agency regulations and issued recommendations where necessary.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter and the agency report to the Chairs and Ranking Members of the Senate and House Committee on Veterans' Affairs. I have also filed redacted versions of these documents and the redacted referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel