U.S. Department of Justice

Office of the Deputy Attorney General

Washington, DC 20530

December 16, 2013

The Honorable Carolyn N. Lerner
Special Counsel
Office of the Special Counsel
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

Re: OSC File No. DI-13-2349

Dear Ms. Lerner:

I am in receipt of your August 16, 2013 correspondence wherein you conclude that allegations raised by Adam Berg, an employee of the United States Department of Justice, Federal Bureau of Prisons, constitute a substantial likelihood that a violation of law, rules or regulations has occurred, and that an abuse of authority and a specific danger to public health and safety, have occurred. Mr. Berg has made allegations related to the Nursing Department at the Federal Medical Center (FMC) Rochester, in Rochester, Minnesota.

According to Mr. Berg, FMC Rochester Nursing Department Nursing Assistants failed to change inmates' soiled undergarments for long periods of time or after instances of incontinence, and did not regularly empty urine from full bed pans, which prevented inmates from being able to relieve themselves. Mr. Berg also alleged that FMC Rochester Nursing Department Nursing Assistants failed to provide physical care to an HIV-positive inmate, such as feeding, bathing, and dressing.

The Office of Special Counsel requested an investigation and report on the allegations made by Mr. Berg. Please accept this correspondence as a summary of our investigation and findings. It should be noted that the Attorney General has delegated to me authority to review and sign the report, in accordance with 5 U.S.C. § 1213 (d).

Sincerely,

Julie R. Zebrak
Deputy Chief of Staff

Enclosure

United States Department of Justice
Federal Bureau of Prisons - Office of Internal Affairs

Report of Investigation

OIA Case Number 2013-07603
OSC File Number DI-13-2349

Subject: ALLEGED VIOLATION OF LAWS, RULES, OR REGULATIONS AND ABUSE OF AUTHORITY AND SPECIFIC DANGER TO PUBLIC HEALTH AND SAFETY AT THE FEDERAL MEDICAL CENTER, ROCHESTER, MINNESOTA

(1) Summary of the Information with Respect to Which the Investigation was Initiated

This investigation was initiated based upon a whistleblower disclosure alleging that employees at the United States Department of Justice (DOJ), Federal Bureau of Prisons (BOP), Federal Medical Center (FMC), Rochester, Minnesota, are responsible for violations of law, rules, or regulations and engaged in abuse of authority and danger to public health and safety. The Office of Special Counsel (OSC) received these allegations from Adam Berg, Nursing Assistant (NA), at FMC Rochester, Minnesota, who consented to the release of his name.

In brief, the allegations involved the following:

- Two FMC Rochester Nursing Assistants failed to change inmates' soiled undergarments for long periods of time or after instances of incontinence;
- Two FMC Rochester Nursing Assistants did not regularly empty urine from full bed pans, which prevented inmates from being able to relieve themselves; and
- Four FMC Rochester Nursing Assistants failed to provide physical care such as feeding, bathing, and dressing to a HIV-positive inmate.

(2) Conduct of the Investigation

On August 16, 2013, OSC referred this matter to the Attorney General for investigation. The matter was referred to the United States Department of Justice, Office of the Inspector General for investigative disposition on August 26, 2013. The OIG deferred the matter for a BOP, Office of Internal Affairs (OIA) administrative investigation on September 5, 2013. On September 5, 2013, the OIA initiated contact with Adam Berg by e-mail and requested an initial telephone contact to review his complaint with him. On September 6, 2013, the OIA spoke with Mr. Berg by telephone and on September 8, 2013, Mr. Berg e-mailed what he considered to be pertinent inmates' medical records to the OIA. Between September 6, 2013, and November 1, 2013, the OIA reviewed available records for 11 inmates whom Mr. Berg alleged had not received proper care and treatment from the named Nursing Assistants at FMC Rochester. The

OIA consulted with BOP Central Office Chief Nursing Supervisor Michelle Dunwoody concerning the Nursing Assistant care at FMC Rochester. Over September 11 - 13, 2013, the OIA visited FMC Rochester to review relevant documents and to conduct interviews of 20 BOP employees, six inmate patients, and six inmates who worked as nursing care attendants.

(3) Summary of Evidence Obtained from the Investigation

Evidence Pertaining to FMC Rochester:

FMC Rochester is located in Rochester, Minnesota. This administrative BOP facility[1] has been in operation since 1985. Male offenders who require chronic care for medical/surgical and psychiatric conditions are housed at the main facility. Female offenders are housed at the Satellite Prison Camp. Inmates who require medical attention that cannot be provided by the medical center are routinely taken to Mayo Clinic, St. Mary's Hospital, or Rochester Methodist Hospital, all of which are located in Rochester.

A regularly scheduled program review of FMC Rochester's Health Services department occurred November 27 – 29, 2012. A "program review" is a comprehensive audit to determine policy compliance and program quality. Program reviews are conducted by the BOP Program Review Division (PRD). Program reviews typically occur every three years for all departments at all BOP facilities, although they occur more frequently if significant problems were identified in a prior program review. The Health Services department at FMC Rochester received a "Superior" rating -- the highest possible rating -- in November 2012.

At the time of the 2012 program review, the FMC Rochester Nursing department was led by Director of Nursing Lorelei Klema, and Assistant Director of Nursing and Commander, Public Health Services Chad Garrett, who supervised 16 Certified Nursing Assistants.

Noted comments from the FMC Rochester Health Services department program review included the following:

> FMC Rochester is endowed with very knowledgeable, highly professional, and meticulous medical staff....This characteristic and the integrated works of the Quality Improvement Program, mental and behavioral health, nursing, and long-term care not only provide effective medical care that can ensure compliance to all mandatory programs, but can also set a standard of care in other medical facilities.

On February 3, 2012, FMC Rochester received compliance accreditation from the Joint Commission: Accreditation of Health Care Organizations (JCAHO) for the Ambulatory Health Care, Long Term Care, and Behavioral Health Care programs. The JCAHO Executive Summary report noted for all three programs, "As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified."

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1 "Administrative" facilities are correctional institutions with a special mission and are designed to house inmates of all security levels. However, the majority of FMC Rochester inmates are low security offenders.

Evidence Pertaining to Adam Berg's OSC Complaint

Allegations 1 and 2. ***Mr. Berg alleged that two FMC Rochester Nursing Assistants failed to change inmates' soiled undergarments for long periods of time or after instances of incontinence as required by agency rules. Mr. Berg also alleged that two FMC Rochester Nursing Assistants did not regularly empty urine from full bed pans and prevented inmates from being able to relieve themselves, in violation of agency rules.***[2]

Mr. Berg reported that he had observed and perceived neglect and abuse of authority by fellow Nursing Assistants (NAs) Joshua Geier, Jeremiah Lockie, Jessica Nierman, and Heidi Wiplinger. Mr. Berg stated that his specific concern was that NAs Lockie and Nierman "regularly" failed to change inmates' soiled undergarments for long periods of time or after instances of incontinence, or had left inmates on bed pans full of urine which kept inmates from being able to relieve themselves. Mr. Berg reported that he observed these failures on almost a daily basis on the 9-2 Long Term Care unit where he worked. Mr. Berg explained that he suspected NAs Geier, Lockie, Nierman, and Wiplinger deliberately had failed to provide timely nursing care for incontinent inmates during the day work shift.

Mr. Berg named the following inmates as having received improper care: [redacted], and former inmate [redacted]. Mr. Berg reported that he had observed inmates [redacted] and [redacted] with disposable "Chux pads"[3] placed inside their undergarments so they did not have to be changed as frequently. Mr. Berg stated that he reported his concern about this "double diapering" to Clinical Nursing Supervisor Mary Porter during March 2013. Mr. Berg said fellow NA Karisa Rindels informed him that Director of Nursing Lorelei Klema and Assistant Director of Nursing Chad Garrett had held a meeting about "double diapering" at which they told the nursing assistant staff members to stop the practice of "double diapering" because it was improper. Mr. Berg learned from NA Rindels that during the meeting, NA Nierman had admitted she had been placing Chux pads inside inmates' undergarments. Mr. Berg stated that, for a limited period of time, inmates' undergarments were changed regularly and the "double diapering" stopped. Since June 2013, however, Mr. Berg noted that he has observed that the aforementioned inmates' undergarments were not regularly changed and the "double diapering" practice resumed.[4]

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2 The OSC complaint noted that Mr. Berg named NAs Lockie and Nierman as those he believed had failed to provide proper nursing care to incontinent inmates and that the nursing care lapse affected two to five inmates. During the OIA investigation, Mr. Berg stated he believed NAs Geier and Wiplinger also failed to provide proper nursing care to incontinent inmates and alleged the total number of inmates who had not received proper nursing care was nine.

3 "Chux" are disposable pads that are placed on medical examining tables, hospital beds and other areas where patients lie or sit. Chux pads are used in hospitals, nursing homes and private homes for ill and/or elderly patients who have bladder control problems.

4 There is no policy requirement for Nursing Assistants to document regular toileting such as emptying bed pans or changing incontinent inmates' undergarments.

FMC Rochester's Patient Care Manual, Pressure Ulcer Prevention, Managing Moisture, states that skin that is either too wet or too dry is at greater risk for breakdown. The Manual further states, "Incontinence of urine and stool pose the greatest risk. Moisturize dry skin twice a day with regular lotion. For incontinent patients, check incontinence briefs or toilet every two hours. Apply moisture barrier for patients after each episode of incontinence care."

The OIA's investigation at FMC Rochester included interviews of six inmates named by Mr. Berg [redacted].[5] Five of the named inmates denied they had been "double diapered," had Chux pads placed inside their undergarments, had been left on full bed pans, or had been unable to relieve themselves when needed. The sixth, inmate [redacted], stated he had not been "double diapered," but he added, "The nursing staff use extra what I call dinner napkins to place inside my pull ups to absorb my urine. I think it's a good idea because of my incontinence....Both the nursing staff on the day shift and night shift use these with me." Inmate [redacted] also referred to Mr. Berg, "He has helped me. He has also helped me with placing the extra napkins inside my pull ups so that I do not leak urine since the pull ups are too small for me." Inmate [redacted] complained about NAs Geier, Lockie, and Nierman stating, "I don't believe they have the proper training to assist in this field." Inmate [redacted] indicated that the day shift NAs did not respond in a timely manner when he pushed his call button.

Three of the nine inmates Mr. Berg identified [redacted]) were required to wear urinary catheters some time during the time frame in question. A review of relevant medical records from June 2013 through mid-September 2013 revealed no evidence that their catheter care had ever been untimely.

During his OIA interview, Mr. Berg indicated that inmate nursing care attendants who work on the 9-2 Long Term Care unit could provide witness testimony in support of his allegations against Geier, Lockie, Nierman, and Wiplinger. Mr. Berg provided OIA with a Nursing Attendant Schedule list that showed eight inmates assigned to work on the 9-2 Long Term Care unit. Six inmates were interviewed[6] and all six inmate nursing care attendants denied that they had ever observed any patients on the unit "double diapered," having Chux pads placed inside their undergarments, or left on full bed pans and unable to relieve themselves. One of the inmate nursing care attendants, inmate [redacted], reported he perceived that, generally, the NAs were not timely in responding to call buttons, and it was common for an inmate to wait ten or fifteen minutes before nursing staff entered the room. Inmate [redacted] reported that Mr. Berg in particular was "very slow in responding to call lights," and that NAs Pamela Ledebuhr and Karisa Rindels were, "by far the best at responding to the call lights." Inmate [redacted] further stated, "I do not know of any specific time where an inmate had soiled himself and staff did not respond in a timely manner."

During the OIA visit to FMC Rochester, Director of Nursing Klema, Assistant Director of Nursing and Commander, Public Health Services Garrett, Nursing Supervisor Porter, Clinical

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5 Of the nine inmates Mr. Berg identified, one was released ([redacted]) by the time of the OIA investigation, and two ([redacted]a and [redacted]) suffered cognitive impairment and/or dementia and were not lucid enough to be interviewed.
6 Of the eight nursing care attendant inmates named by Mr. Berg, one inmate had transferred from FMC Rochester to an outside contract facility and one inmate had not worked on the unit since June 2013.

Director Michael Nelson, and Clinical Nurse Specialist and Commander, Public Health Services Kevin Elker were interviewed about inmate patient care provided by NA staff members on the 9-2 Long Term Care unit. All denied they had ever observed the aforementioned inmates as "double diapered" or heard related complaints from them or the inmate nursing care attendants. Klema and Porter stated that in March 2013, Mr. Berg had reported to them a concern that nursing assistant staff members on the day shift had been placing disposable Chux pads inside incontinent inmates' undergarments. Klema, Garrett and Porter denied that they ever conducted any formal meetings or issued anything in writing about the matter. Klema, Garrett, and Porter recalled that they informally spoke with nursing staff members about the concern of "double diapering." They denied that any staff member admitted to "double diapering" any of the incontinent inmates.

Supervisory Chaplain Ricardo Alcoser coordinates FMC Rochester's "Comfort Care" and "Palliative Care" programs, in which inmate volunteers assist in caring for hospice care inmates on the 9-2 Long Term Care unit and elsewhere in the institution. Alcoser denied that he observed or was ever made aware of any concerns that inmates on the 9-2 Long Term Care unit were ever neglected with regard to toileting or undergarment changing needs.

NA Rindels recalled that, several months ago, she became aware of a concern that some of the nursing assistant staff members may have been "double diapering" incontinent inmates on the 9-2 Long Term Care unit. She claimed there had been a problem with inmate [redacted] catheter and, because of this, he had been "leaking urine" on a fairly constant basis. NA Rindels stated that she and other nursing staff members had used folded Chux paper type napkins and placed those near the top of his undergarments to help absorb the extra leakage. Although she could not identify who had raised the concern, she recalled hearing that someone had thought that placing the folded Chux paper type napkins near the top of inmate [redacted] undergarments was considered "double diapering." NA Rindels said she had not considered the use of the Chux paper type napkins with inmate [redacted] to be "double diapering." NA Rindels did not recall hearing from Klema or Garrett about the concern. She recalled that Porter had addressed the concern and said that if "double diapering" was occurring with incontinent inmates, such a practice was not proper and had to stop. NA Rindels denied that when Porter spoke to the NAs about the concern that Nierman admitted she had "double diapered" incontinent inmates. NA Rindels denied that she specifically said anything to Mr. Berg about what Porter had spoken to the NAs about. NA Rindels denied saying to Mr. Berg that Nierman had admitted to "double diapering" any inmates.

NAs Geier, Lockie, Nierman, and Wiplinger denied that they ever deliberately failed to regularly change any 9-2 Long Term Care unit inmates' undergarments or had left inmates on full bed pans or had failed to properly care for incontinent inmates. They denied "double diapering" any of the inmates Mr. Berg specifically named, and they denied that they ever observed any inmates as being "double diapered" with Chux pads or any material placed inside their undergarments. Lockie stated he did not remember a concern being raised about "double diapering" or Chux pads being placed inside inmates' undergarments. Lockie stated he did not remember anyone from management address any concern about it. Geier, Nierman and Wiplinger recalled hearing about a concern sometime during early 2013. Geier and Wiplinger recalled the concern was addressed at around the same time by Klema and Garrett who said that "double diapering" was not acceptable to do. Wiplinger stated, "I remember that Director of

Nursing Klema and Assistant Director of Nursing Garrett came to the unit and there was just a couple of us nursing assistants, me and Jessica Nierman and I think Jeremiah Lockie was also present." Wiplinger also stated, "I remember they asked us if we knew anything about this being done and I recall saying that I was not aware of it or had witnessed it but I said I heard that Morning Watch nursing assistant staff were saying Day Watch nursing assistant staff were doing this and vice versa." Nierman recalled that Klema came to the 9-2 Long Term Care unit and spoke with nursing staff about the concern but Nierman did not specifically remember when this was or who else was present. Nierman stated, "She (Klema) had asked about what double chuxing was and she said there had been some complaints that it was happening. I recall saying that I knew it was not me doing it because I had never heard of it." Nierman also added, "I never said that I had ever done this." Geier, Lockie, and Wiplinger denied that they heard any staff member admit to "double diapering" any inmates.

Mr. Berg reported that he had observed inmates [redacted] and [redacted] frequently with urine soaked clothing since June 2013 which suggested to him that the day shift nursing assistant staff members he had named were not tending to the inmates in a timely fashion. Mr. Berg stated he observed this daily with regards to inmates [redacted]. He stated that with inmate [redacted] "It has been about 90% of the time." Mr. Berg stated that, since June 2013, he has reported to Registered Nurses Nicole Springer, Melissa Rislove, and Trisha Sublett on an almost daily basis that he found these inmates "drenched" whenever he started his evening work shift. Mr. Berg stated that Licensed Practical Nurse David Pease also observed that inmates were being left with urine soaked clothing and not properly tended to by the day shift NAs.

Registered Nurses Springer, Rislove, and Sublett were interviewed. Springer said she never observed any inmates on the 9-2 Long Term Care unit "double diapered," although she said she had heard about a concern that it was allegedly being done. Springer reported that with incontinent inmates, it was not considered unusual to start her work shift and find that an inmate had "soaked through his diaper." She said that this would not necessarily indicate that the inmate had not been tended to by nursing staff members from the previous work shift. Springer further explained that what might indicate to her that an inmate had been in an undergarment too long would be to observe that it was "shredding" or "tearing down." Springer indicated that she had not observed this with any of the inmates Mr. Berg specifically named. Springer acknowledged that Mr. Berg complained to her about the day shift nursing assistant staff members in a general -- rather than specific -- manner. Springer stated that whenever Mr. Berg complained to her about finding incontinent inmates soaked through their undergarments, she followed up but did not perceive that his complaints rose to a level of reportable misconduct.

Rislove reported that she observes incontinent inmates in the 9-2 Long Term Care unit with "soaked through" undergarments approximately one or two times a week. She stated she does not perceive this as "overly problematic" and explained that even though an inmate may have had his undergarments changed timely, he could be so incontinent that he could be "soaked" within an hour. Rislove stated she has not observed and did not believe any of the 9-2 Long Term Care unit's NAs had ever acted improperly in their care of any inmates on the unit.

Sublett recalled that Mr. Berg mentioned to her that he had found inmates on the 9-2 Long Term Care unit whose undergarments had "broken down" and were saturated. Sublett reported that most of the inmates named by Mr. Berg required more care than usual from the NAs. Sublett observed that, generally, NAs Geier, Lockie, Nierman, and Wiplinger tended to be "mean" toward inmates on the 9-2 Long Term Care unit. As an example, Sublett cited her observation that both Lockie and Nierman tended to not lay inmate [redacted] back down in bed when he wanted them to do so. She explained that Lockie and Nierman had a tendency to "go by their own schedule" for laying inmate [redacted] down to bed rather than his need to do so. Sublett said that Lockie and Nierman also did this with another inmate [redacted]. According to Sublett, she had to resolve this by writing specific orders in both inmates' medical records to lay them down. Sublett also recalled that upon leaving work on one occasion sometime between the end of April to first of July 2013, when she had worked the day shift, she heard Geier comment about inmate [redacted] that he would give him a cold shower because he did not like him. Sublett further recalled that, on one occasion earlier this year, she heard Geier and Wiplinger joking about not giving inmate [redacted]) his meal because he did not want to wear a soiled bib. Sublett wrote a memorandum dated September 23, 2013, to Director of Nursing Klema and complained that at 10:00 p.m. on September 22, 2013, she observed inmates [redacted] and [redacted] fully clothed, in bed, and in "wet diapers." Sublett wrote that she learned the inmates had been in bed since 6:00 p.m. and she wrote, "Thus they had not been changed nor turned and repositioned for 4 + hours." Sublett also wrote that on September 13, 2013, she had observed inmate [redacted] with a disposable pull up over the top of a "blue diaper." She wrote, "When I confronted the nursing assistant (NA Jacob Averbeck, who normally works on another unit but was assisting on the 9-2 unit this date), he didn't know what the issue was. I then reiterated that double diapering is not allowed." Sublett's memorandum to Klema indicated that she believed there were NAs working on the other Long Term Care unit (9-3), who were not aware that the practice of "double diapering" was improper.

Licensed Practical Nurse David Pease stated that he has never observed NAs Geier, Nierman, Lockie or Wiplinger "double diaper" incontinent inmates on the 9-2 Long Term Care unit. He stated he was aware of the concern and that he has observed some of the nine inmates (specifically [redacted], and former inmate [redacted]) either "double diapered" or with Chux pads placed inside their undergarments. Pease clarified that, during March 2013, he tended to observe this a few times a week. Pease said it was around this time that he reported his concern to his supervisor, Porter.[7] Pease said that he has observed inmate [redacted] ask to be put to bed or to use a bed pan, and Geier and Lockie would not follow through at the time of his requests. Pease stated he was aware that the concern about "double diapering" had been addressed, but he did not believe management had adequately addressed it.

During his OIA interview, Mr. Berg stated, "I had also observed chronic skin irritation problems that most of the inmates I reported about have experienced from toilet related problems." Clinical Nurse Specialist and Commander, Public Health Services Kevin Elker, who

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7 Mr. Pease had forwarded an e-mail message response to Porter on March 18, 2013. He had written to Mr. Kenneth LaBore, Esq. at MNnursinghomeneglect.com and wrote, "I have noted that many nursing assistants at my work place are using the practice of double diapering. When they do rounds they simply pull the underlying pad/diaper out without changing. Is this in violation of state rules." Mr. LaBore had responded and wrote, "I applaud your instincts. That practice is absolutely a violation and leads to UTIs and pressure sores..."

is responsible for the tracking and monitoring of the FMC Rochester Pressure Ulcer Prevention (PUP) program, reviewed the medical records of the nine inmates Mr. Berg identified.[8] Elker reported that none of the nine inmates had evidence in their medical records of any skin breakdown or pressure ulcerations that would be expected in the event of nursing care lapses as alleged by Mr. Berg. Elker offered his impression, based on his review of records kept from March 2013 through August 2013, that the inmate patients had received "exemplary care" while housed on the 9-2 Long Term Care unit during that time period.

During the OIA investigation Mr. Berg reported that when he started his work shift on August 29, 2013, he observed that inmate [redacted] had not been bathed by NAs Geier and Lockie during their work shift. Mr. Berg also reported that Geier and Lockie had not given inmate [redacted] his dinner meal tray. Mr. Berg said this was observed by NA Ledebuhr and inmate nursing care attendant [redacted]. Mr. Berg said he reported his observation in an e-mail message to Klema.

Klema confirmed that Mr. Berg had sent her an e-mail message and reported his concern that inmate [redacted] had not been bathed or given his dinner meal tray on August 29, 2013, by the time Mr. Berg had arrived for his work shift at 6:00 p.m. Ledebuhr said she did not recall this specific incident. Inmate [redacted] confirmed that on August 29, 2013, inmate [redacted] had been left by the day shift nursing assistants (Geier and Lockie) to be bathed on the evening shift.

NAs Geier and Lockie admitted they had missed giving inmate [redacted] his bath and dinner meal tray on August 29, 2013. Geier and Lockie denied that they had deliberately or intentionally failed to give inmate [redacted] his bath or dinner meal tray that date. Geier stated, "We got short-handed that day and it was a fluke and totally unintentional." Lockie stated, "It had been a busy day and Geier and I were the only two nursing assistants that afternoon and I recall we had a discharge and admittance to take care of as well." Lockie also stated, "This was an isolated incident and was not something that regularly occurred with him [redacted])."

A review of the BOP Administrative Remedy inmate complaints records showed that none of the nine inmates Mr. Berg named as having received improper care from NAs Geier, Lockie, Nierman, and Wiplinger ever filed any administrative remedy complaints while they were at FMC Rochester[9]

8 CDR Elker is a Master's degree prepared nurse with an Advanced Practical Nurse licensure and he is a Certified Wound Care Nurse with several years of experience managing complex wound care for FMC Rochester. CDR Elker also consults on wound care issues throughout the BOP and he has participated on National workgroups for the development of National Practice Guidelines for the BOP on Wound Care and the Pressure Ulcer Prevention Program.

9 The purpose of the BOP Administrative Remedy Program, according to BOP Program Statement 1330.17, dated August 20, 2012, "is to allow an inmate to seek formal review of an issue relating to any aspect of his/her own confinement." Each written request, including appeals, is time sensitive and records of all inmates' Administrative Remedy requests/complaints and appeals are maintained.

Allegation 3. ***Mr. Berg alleged that four FMC Rochester Nursing Assistants failed to provide physical care such as feeding bathing, and dressing to an HIV-positive inmate, in violation of agency rules.***

Mr. Berg reported that on a number of occasions NA Nierman commented that she would not provide care for inmate [redacted][10] who was in the hospice program at FMC Rochester, because he had HIV and she was afraid of "catching it." Mr. Berg reported that, on one occasion during March or April 2013, he, Geier and Nierman were setting up trays in the 9-2 Long Term Care unit inmate meal room. Mr. Berg stated that he heard Nierman comment about inmate [redacted] and say, "He took himself off his AIDs meds because he wants to die here rather than go home." Mr. Berg stated Nierman also said, "That's good, it's one less mouth to feed." Mr. Berg said he perceived that Nierman's comment about inmate [redacted]'s medical condition to be a violation of his privacy because there were other inmates and an inmate worker, whom he could not specifically identify, nearby in the same room. Mr. Berg reported that Nierman told him on another occasion, during May or June 2013, that she was not comfortable doing "cares" for inmate [redacted]. Mr. Berg stated, "Because of this, she never worked with him." Mr. Berg reported that he often heard Geir, Lockie, Nierman, and Wiplinger comment that inmate [redacted] was "whiny and annoying" and he did not need any help or would not get any help from them to eat. Mr. Berg said he mentioned this to his work shift team leader Sublett. Mr. Berg stated that inmate [redacted] told Social Worker Kara Paske and other supervisors and management officials that he was being mistreated and not assisted in feeding. Mr. Berg stated that NAs Geier, Lockie, Nierman, and Wiplinger did not help inmate [redacted] eat as his condition became worse and he needed more assistance.

Director of Nursing Klema, Assistant Director of Nursing Garrett, Supervisory Nurse Porter, Registered Nurses Springer and Welch, LPN Pease, Social Worker Paske, Supervisory Chaplain Alcoser, Clinical Director Nelson, and Nursing Assistants Ledebuhr and Rindels were interviewed. All denied that inmate [redacted] had ever complained to them about not being fed, bathed, or taken care of by NAs Geier, Lockie, Nierman, or Wiplinger. Sublett reported that while inmate [redacted] had complained to her about Geier, Lockie, and Nierman not getting him up on time to attend religious services, he had not complained to her about them not feeding him.

NAs Geier, Lockie, Nierman, and Wiplinger denied that they failed to bathe or provide food and care for inmate [redacted]z. They denied ever saying that inmate [redacted] was "whiny and annoying." Inmate [redacted] did not file any Administrative Remedy complaints while he was at FMC Rochester.

A review of the "Non-Medical Orders (NMOS) Activities" records of inmate [redacted] from March 2013 through August 2013 showed that Mr. Berg documented six activities, NA Geier documented 26 activities, NA Lockie documented 65 activities, NA Nierman documented 44 activities, and NA Wiplinger documented one activity. The types of activities documented consisted of "Assist with ADLs (Activities of Daily Living)," "Assist with feeding",

10 Inmate [redacted] was released from BOP custody on August 23, 2013 for deportation to Mexico and he was not interviewed.

"Palliative Care", "Cast/Splint", "Vitals", "Bath/Shower", "Wound Care", "Inputs & Outputs", and "Weight". NA Nierman wrote a comment on July 25, 2013 under "Assist with ADLs" that included, "Reported to the nurse, helping inmate with morning cares inmate was very teary eyed and looked to be depressed, said he had nothing to loose (sic) by not eating."

Sublett reported that on one occasion during June 2013, while at the 9-2 Long Term Care unit Nurses' station, she heard Nierman comment about inmate [redacted] discontinuing his medications. Sublett stated that she heard Nierman say, "Well that's one less mouth to feed." Sublett said she was offended by Nierman's comment. Geier recalled that he heard Nierman say something about inmate [redacted] discontinuing his medications while they were in the inmate television room around lunch time on one occasion. Geier stated he thought that location was not the "best place" for Nierman to say something about inmate [redacted] medications. Geier denied that he heard Nierman comment and say, "That's good, that's one less mouth to feed."

Nierman denied that she commented, "That's good, that's one less mouth to feed," about inmate [redacted]. She conceded that she could have said something about him discontinuing his medications in an area such as the inmate feeding or television room, but she did not recall doing so. She stated that she would not have meant for any comment to be demeaning about inmate [redacted].

Additional Allegations Raised During the Investigation

During his OIA interview, Mr. Berg alleged that, while at the 9-2 Long Term Care unit Nurses' station, he heard NAs Geier and Wiplinger "joking and bragging" during the early part of 2013 about not feeding inmate [redacted]). Mr. Berg said he asked them if they fed inmate [redacted] and they said they had not. Mr. Berg stated that Pease and Sublett were also present at the Nurses' station on this occasion.

Sublett reported she overheard Geier and Wiplinger joking about not giving inmate [redacted] his meal on one occasion during the early part of 2013. She recalled the "joking comments" had something to do with inmate [redacted] not wanting to use a soiled bib. Sublett recalled that Pease and Berg were also present and that Geier's and Wiplinger's comments were made at the Nurses' station.

Pease stated he did not hear Geier or Wiplinger joke or otherwise comment about not feeding inmate [redacted]. Pease recalled that inmate [redacted] told him that Geier and Wiplinger had said something about not wanting to feed him [redacted] because he did not want to wear a "dirty bib."

Geier denied that he said any joking comments about inmate [redacted] that he had bragged about not feeding him while he was conversing at the Nurses' station and in the presence of Berg, Pease, Sublett or Wiplinger.

Wiplinger stated that she did not remember making any kind of comments about not feeding inmate [redacted] at the Nurses' station and laughing about it. She denied that she had ever withheld food from inmate [redacted].

(4) Violation of Laws, Rules, or Regulations

Allegation 1.

The investigation revealed insufficient evidence to support Mr. Berg's claim that the Nursing Assistants he identified had failed to change inmates' soiled undergarments for long periods of time or following instances of incontinence. Although there appeared to be some instances in which some of the incontinent inmates on the 9-2 Long Term Care unit were "double diapered," there was insufficient evidence to determine who specifically had done this. While the investigation revealed no evidence that the institution's Nursing Department management had held any formal meetings or issued any written directives that addressed the concern about "double diapering" or placing Chux pads inside incontinent inmates' undergarments, it was clear that management had advised several of the 9-2 Long Term Care NAs that "double diapering" was inappropriate.

Allegation 2.

The investigation revealed insufficient evidence to support Mr. Berg's claim that the Nursing Assistants he identified had ever left inmates on full bed pans and unable to relieve themselves.

Allegation 3.

The investigation revealed insufficient evidence to support Mr. Berg's claim that the four Nursing Assistants he identified had failed to provide physical care such as feeding, bathing, and dressing to inmate [redacted].

Additional Allegations Raised During the Investigation.

There is sufficient evidence to support that NAs Geier and Lockie did not bathe inmate [redacted] or provide him his dinner meal tray on August 29, 2013.

There is sufficient evidence to support that NA Nierman behaved unprofessionally when she made comments about inmate [redacted]s medications. This was witnessed by Berg, Geier, and Sublett.

There is sufficient evidence that NAs Geier and Wiplinger behaved unprofessionally when they joked about not feeding inmate [redacted]. This was witnessed by Berg and Sublett.

(5) Action taken or planned as a result of the investigation

(A) Changes in agency rules, regulations or practices.

FMC Rochester Nursing Department management should formally address with all nursing staff members that any practice tantamount to "double diapering" or placing disposable Chux pads inside incontinent inmates' undergarments is prohibited and may result in disciplinary action. Specific documentation about this should be included in all pertinent local procedure sections of the FMC Rochester Nursing Care and Patient Care Manuals.

(B) Restoration of any aggrieved employee.

Not applicable.

(C) Disciplinary action against any employee.

Disciplinary action will commence for employees Joshua Geier, Jeremiah Lockie, Jessica Nierman, and Heidi Wiplinger for Inattention to Duty (Geier and Lockie) and Unprofessional Conduct (Geier, Nierman, and Wiplinger).

(D) Referral to the Attorney General of any evidence of criminal violation.

Not applicable.