DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

MAR 0 4 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-3321

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Department of Veterans Affairs (VA) Medical Center in Syracuse, New York. The whistleblower alleged that managers in the Inpatient Behavioral Health Care Unit at that facility failed to report incidents in violation of Veterans Health Administration (VHA) protocol, that coworkers engaged in actions that compromised patient health and safety, and managers were frequently absent without excuse. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Secretary asked the Interim Under Secretary for Health to review this matter and to take any actions deemed necessary under the above code. She, in turn, directed the Office of Accountability Review (OAR) to conduct an investigation. In its investigation, OAR made the following determinations;

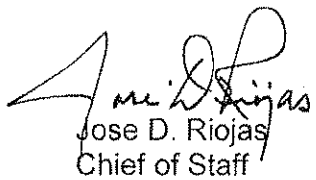
- That a patient's rape allegations were not properly reported was substantiated.
- That a Registered Nurse (RN) repeatedly fell asleep during one-on-one overnight suicide watches was not able to be substantiated.
- That a RN failed to appropriately respond to a crisis in the unit, putting patients at risk was not able to be substantiated.
- That the nurse manager and assistant nurse manager in the Inpatient Behavioral Health Care Unit are frequently absent during required working hours was substantiated.

Recommendations for corrective actions related to substantiated allegations are included within the report.

Findings, conclusions, and recommendations from the investigation are contained in the report, which I am submitting for your review. I have reviewed these findings and agree with the recommendations listed in the report. We may also send your office a follow-up response describing actions which have been and will be taken in response to this report.

Thank you for the opportunity to respond.

Sincerely,



Jose D. Riojas
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the

Office of Special Counsel

OSC File Number DI-14-3321

Department of Veterans Affairs
Syracuse VA Medical Center
Syracuse, NY

Report Date: February 6, 2015

Executive Summary

Pursuant to its authority in title 5, United States Code (U.S.C.) subsection 1213(c), the Office of Special Counsel (OSC), by letter dated July 29, 2014, to the former Acting Secretary of the Department of Veterans Affairs (VA), referred for investigation specific allegations made by a VA employee, Ms. Rachael Hogan (hereafter, the whistleblower), that managers in the Inpatient Behavioral Health Care Unit failed to report incidents in violation of the Veterans Health Administration's (VHA) protocol, coworkers engaged in actions that compromised patient health and safety, and managers were frequently absent without excuse. The specific allegations are as follows:

1. A patient's rape allegations were not properly reported:

Conclusion:

VA ***Substantiated*** that VA regulations make it clear that any information about actual or possible violations of criminal law related to VA programs, operations, and facilities must be reported immediately to law enforcement. Further, VA regulations prohibit and penalize any act of sexual gratification on VA property by persons other than those residing in quarters. VA, Veterans Integrated Service Network (VISN),[1] and the medical center's Professional Memorandum Psychiatry 11-56, Sexual Trauma Victims, all specify steps to be taken when allegations of alleged sexual assault are made, including reporting requirements. The investigators were unable to determine whether Patient 1 was raped or engaged in consensual sexual relations with another patient. However, that is immaterial. The record makes clear that several staff members knew about the incident on Thursday, October 31, 2013, the day it allegedly occurred. However, it was not until Sunday, November 3, that police were finally notified. The Nurse Manager's assertion in the patient Progress Note she wrote on October 31 - that the patient did not want the incident reported to police, is also immaterial. The Nurse Manager was required by regulation and policy to report the alleged incident immediately to police. She did not do so.

Recommendation

1. The VA Medical Center should consider issuing corrective administrative action to the Nurse Manager. The Medical Center should also provide training to appropriate staff members on reporting requirements for allegations of sexual assault or other potentially criminal activity.

[1] The VHA medical facilities are administered through a series of 21 geographic networks, each including several hospitals and outpatient clinics. Each network has authority to issue policy that is enforceable in the medical facilities it administers.

2. (b) (6) a registered nurse repeatedly fell asleep during one-on-one overnight suicide watches:

Conclusion

VA was ***not able to substantiate*** that the whistleblower reported in January 2014, she found a registered nurse (RN), (b) (6) sleeping while on a one-on-one suicide prevention watch, did not document it, but told the Nurse Manager. The RN denied ever falling asleep while on suicide watch. The Nurse Manager denied that the whistleblower ever reported this event to her. There were no other witnesses.

3. (b) (6) failed to appropriately respond to a crisis in the unit, putting patients at risk:

Conclusion

*VA was **not able to substantiate*** that the whistleblower reported that the accused RN, (b) (6) failed to respond appropriately to a situation that occurred the week of April 7, 2014, during which two patients became disruptive and that she and another RN had to manage the event. During an interview, the whistleblower stated that this incident actually occurred in late March 2014. The whistleblower further stated that she and the second RN called the police, who responded and assisted while they had the patients placed in seclusion. VA Investigators reviewed the Restraint and Seclusion Data Collection log for the second quarter of 2014, and identified that the one instance where the whistleblower, the second RN, and the accused RN all worked the same shift occurred on April 15, 2014. VA Police Report #201404151421-9775 was filed on that date indicating that a Behavioral Emergency Response Team (BERT) code was responded to by police and only one patient was placed in seclusion. The accused RN did not recall this alleged incident. Neither did the Assistant Nurse Manager. The VA Police Officer who responded to the incident did not specifically recall it. The whistleblower and the second RN witness could not verify on exactly which date this alleged incident occurred. The Restraint and Seclusion Data Collection log indicated only one patient was placed in seclusion on April 15, 2014. Because of this discrepant testimony and documentation, this charge could not be substantiated.

4. The nurse manager and assistant nurse manager are frequently absent during required working hours:

Conclusion

*VA **Substantiated*** that after receiving OSC's letter, the facility's Behavioral Health Care Line Manager investigated the attendance records and practices of both the Nurse Manager and the Assistant Nurse Manager. She discovered problems with both and submitted recommended corrective actions to Human Resources (HR).

Recommendation

2. The VA medical center (VAMC) should consider issuing corrective administrative action to both the Nurse Manager and the Assistant Nurse Manager.

The former Acting Secretary authorized the Interdisciplinary Crisis Response Team (ICRT) (now the Office of Accountability Review [OAR]) to investigate this complaint. OAR conducted a site visit and interviews at the Syracuse VAMC from November 4-6, 2014.

The OAR team **substantiated** allegations when the facts and findings supported that the alleged events or actions took place, and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. The OAR team was **not able to substantiate** allegations when the available evidence was not sufficient to support conclusions with reasonable certainty whether the alleged event or action took place.

Summary Statement

This constitutes the Department's response, as required by 5 U.S.C. § 1213(d). This report was developed in consultation with other VHA and VA offices to address OSC's concerns that the medical center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and OAR has examined the issues from a HR perspective to establish accountability for improper personnel practices when necessary. OAR found actions that constitute a violation of law, rule, or regulation and posed a substantial and specific danger to public health and safety.

Table of Contents

Report to the Office of Special Counsel

I. Introduction

The former Acting Secretary of VA authorized OAR to investigate a complaint lodged with OSC by a whistleblower employed by the VA Medical Center, Syracuse, New York. The whistleblower, Ms. Rachael Hogan, alleged that managers in the Inpatient Behavioral Health Care Unit failed to report incidents in violation of VHA's protocol, coworkers engaged in actions that compromised patient health and safety, and managers were frequently absent without excuse.

II. Facility Profile

Syracuse is a 136-bed general medical and surgical referral center. It is a teaching facility affiliated with State University of New York (SUNY) Upstate Medical University and operates community-based outpatient clinics (CBOC) in Massena, Watertown, Auburn, Rome, Oswego, Binghamton, and Tompkins/Cortland in Freeville - serving 13 counties in Central New York. Syracuse partners with Vet Centers located in Syracuse, Binghamton, and Watertown. Watertown is located adjacent to Fort Drum, the home of the 10th Mountain Division. Syracuse leases space on Ft. Drum for Physical Therapy for rural Veterans through a VA/Department of Defense (DoD) Sharing agreement, and it leases space for two facilities located in Syracuse – the Community Care Center and the Behavioral Health Outpatient Center (BHOC). A fourth lease supports the VA Dental Clinic. An addition to the medical center houses a Spinal Cord Disorder (SCI/D) Center. Syracuse is also a Level II Polytrauma Center for VISN 2 and an Amputee Center of Care.

III. Specific Allegations of the Whistleblower

A July 29, 2014 letter from OSC sent to the Acting Secretary of VA alleged:

- A patient's rape allegations were not properly reported;
- (b) (6) a registered nurse repeatedly fell asleep during one-on-one overnight suicide watches;
- (b) (6) failed to appropriately respond to a crisis in the unit, putting patients at risk; and
- The nurse manager and assistant nurse manager are frequently absent during required working hours

The OAR team **substantiated** allegations when the facts and findings supported that the alleged events or actions took place, and **did not substantiate** allegations when the

facts and findings showed the allegations were unfounded. The OAR team was **not able to substantiate** allegations when the available evidence was not sufficient to support conclusions with reasonable certainty whether the alleged event or action took place.

IV. Conduct of Investigation

An investigatory team, consisting of two employees from VA's OAR and two other VA employees, conducted a site visit during the week of November 3, 2014. The team members were (b) (6) Human Resources (HR) Consultant, OAR; (b) (6) (b) (6) HR Consultant, OAR; (b) (6) Clinical Nurse Advisor, VHA Office of Nursing Services; and (b) (6) VA Office of Security and Law Enforcement. The whistleblower was interviewed in person on November 4, 2014.

During the site visit, the OAR team interviewed the following individuals (under oath) in person or via conference calls:

Rachael Hogan, RN, whistleblower
(b) (6) Chief, HR Management Service
(b) (6) Chief, Police and Security Service
(b) (6) Ph.D., Behavioral Health Care Line Manager
(b) (6) Police Sergeant
(b) (6) RN, MSN, NE-BC, Associate Director for Patient/Nursing Services
(b) (6) RN, Staff Nurse
RN, Staff Nurse
RN, Nurse Manager
RN, Assistant Nurse Manager
Staff Nurse

Interviewees were also asked to submit emails and other documents related to the matters-at-hand.

V. Findings, Conclusions, and Recommendations

Allegation 1.

A patient's rape allegations were not properly reported *is substantiated*.

Regulations:

All VA employees with knowledge or information about actual or possible violations of criminal law related to VA programs, operations, facilities, contracts, or information technology systems shall immediately report such knowledge or information to their supervisor, any management official, or directly to the Office of Inspector General. (38 CFR § 1.201)

Information about actual or possible violations of criminal laws related to VA programs, operations, facilities, or involving VA employees, where the violation of criminal law occurs on VA premises, will be reported by VA management officials to the VA police component with responsibility for the VA station or facility in question. (38 CFR § 1.203)

Criminal matters involving felonies (including rape) will be immediately referred to the Office of Inspector General, Office of Investigations. (38 CFR § 1.204)

Any act of sexual gratification on VA property involving two or more persons, who do not reside in quarters on the property, is prohibited. (38 CFR § 1.218 [a] [16])

The fine for unlawful sexual activity on VA property is $250. (38 CFR § 1.218 [b] [44])

The steps on how to properly respond to disruptive behavior by patients are found at 38 CFR § 17.107.

Policy:

VHA Directive 2010-014, Assessment and Management of Veterans Who Have Been Victims of Alleged Acute Sexual Assault, dated March 25, 2010, provides policy regarding the treatment of victims who have sustained recent sexual assault.

VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in VHA Facilities, dated September 27, 2012, describes the steps to be followed to ensure that behaviors which undermine a safe and healing environment are appropriately reported, addressed, and monitored.

Paragraph 10.b.(1) of VHA Handbook 1160.06, Inpatient Mental Health Services, states that, "....Sexual interactions between patients must be prohibited as a preventive measure, as well as to support the patient's focus on recovery.

Paragraph 2.A. of Network[2] Memorandum 10N2-061-13, Sexual Assaults and Other Defined Public Safety Incidents in VHA Facilities, dated May 6, 2013, defines sexual assault as, "....any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity. Assaults may involve psychological coercion, physical force, or victims who cannot consent due to mental illness or other factors...."

Paragraph 3G of 10N-061-13 requires that employees immediately report all behavioral emergencies and public safety incidents to VA Police or the Behavioral Emergency Response Team (BERT) and to complete the "Disruptive, Threatening, Violent Behavior Report form that is appended to the policy.

[2] In this instance, as in the other references to network policy in this report, network refers to Veterans Integrated Service Network 2, the VA Healthcare Network Upstate New York.

Syracuse Medical Center Professional Memorandum Psychiatry 11-56, Sexual Trauma Victims, dated October 2013, outlines the policies and procedures for providing compassionate and sensitive health care services to Veterans who are the victims of sexual trauma.

Syracuse Medical Center Nursing Memorandum OPNP 003-003, 1:1 Observation Monitoring Policy & Competency, dated February 2014, established policies and procedures for one-to-one observation of Veterans whose mental status creates special risk for danger to self or others.

Findings

On Thursday, October 31, 2013, a staff psychiatrist entered a Progress Note into the medical record of Patient 1. The note indicated that Patient 1 told him she was pregnant. When he asked how she knew that, she answered, "....that last night she had sex with another Veteran, just because he wanted it...." The Patient Accountability Sheet for October 31, 2013, indicated that Patient 1 was sleeping from 12:45 a.m. until 6 a.m. Later that day, the Nurse Manager entered a Progress Note into Patient 1's medical record. The note indicated that Patient 1 advised her that the patient had consensual sex with another patient at 3 a.m. that morning. According to the whistleblower, another nurse was the staff member to whom Patient 1 originally reported the incident. The whistleblower testified that she advised this nurse to report it to the Nurse Manager which the second nurse did. The whistleblower also testified that the second nurse witnessed a discussion between Patient 1 and the Nurse Manager and that the Nurse Manager was not going to report the incident to the police. The whistleblower went on to say that she spoke directly to the Nurse Manager and told her that the incident needed to be reported to police. On Saturday, November 2, 2013, a different (the third) staff nurse entered a note in Patient 1's record that she had been overheard asking a male peer, "Can I sleep with you tonight." On Sunday, November 3, the psychiatrist entered a note in Patient 1's record indicating that she told him she had been raped and did not have consensual sex. Later that day, another nurse (the fourth), entered a note that Patient 1 told the staff psychiatrist that day that she had been raped the other night. Also on that day, a staff nurse (the fifth) submitted a Report of Contact (RoC) stating that Patient 1 reported that she had been raped. She wrote that the Nurse Manager and VA Police were contacted. Two VA police officers responded to the call. They gathered evidence and conducted interviews. One of those interviewed, the psychiatrist, submitted a RoC stating that he spoke twice with Patient 1. "The first time she told me that she had consensual sex with a male Veteran on the unit. The second time (today) she told me that she was 'raped....'" After completing his investigation, the VA police Sergeant notified a VA Criminal Investigator. This investigator investigated the claims on the following day, and not finding the allegations substantiated, closed the case.

Conclusion

That a patient's rape allegations were not properly reported is substantiated. The first three VA regulations cited above make it clear that any information about actual or possible violations of criminal law related to VA programs, operations, and facilities must be reported immediately to law enforcement. The other two VA regulations cited above prohibit and penalize any act of sexual gratification on VA property outside of persons residing in quarters. VA policy, as cited above, specify steps to be taken when allegations of alleged sexual assault are made, including reporting requirements. These policies are further underscored by the Network and medical center policies cited. While we were unable to determine whether the patient was raped or engaged in consensual sexual relations with another patient, it is immaterial. The record makes clear that several staff members knew about the incident on Thursday, October 31, 2013, the day it allegedly occurred. However, it was not until Sunday, November 3, that police were finally notified. The Nurse Manager's assertion in the Progress Note she wrote on October 31 - that the patient did not want the incident reported to police - is also immaterial. The Nurse Manager was required by regulation and policy to report the allegation immediately to police. She did not do so. ***This allegation is substantiated.***

Recommendation

1. The Medical Center should consider appropriate corrective action for the Nurse Manager. The Medical Center should also provide training to appropriate staff members on reporting requirements for allegations of sexual assault or other potentially criminal activity.

Allegation 2.

(b) (6) a registered nurse repeatedly fell asleep during one-on-one overnight suicide watches *was not able to be substantiated*.

Regulations

Title 5, Code of Federal Regulations (CFR), subsection 2635.705(a), states in part that, "....an employee shall use official time in an honest effort to perform official duties...."

Policy

VA Handbook 5011, Part II, Chapter 2, Paragraph 1.a.(7), dated October 21, 2014 - All employees are expected to be on duty during the full period of their tours of duty unless absent on approved leave; to observe the opening and closing hours established for the tour of duty; and to adhere to established luncheon periods.

Syracuse Medical Center Memorandum 00-10, Code of Conduct, dated January 2014, outlines unacceptable and inappropriate behaviors that are prohibited. Included in the list of unacceptable behaviors is indifference.

Syracuse Medical Center Nursing Memorandum OPNP 003-003, 1:1 Observation Monitoring Policy & Competency, dated February 2014, established policies and procedures for one-to-one observation of Veterans whose mental status creates special risk for danger to self or others.

Findings

According to OSC's letter, in January 2014, the whistleblower observed another RN, (b) (6) (the accused RN), asleep during an overnight suicide watch. January 2014, was covered in three pay periods beginning December 29, 2013, and ending February 8, 2014. The medical center's official time and attendance reports show that the whistleblower worked an overnight (11:30 p.m. to 8 a.m.) shift on Sunday, January 19 and 3.5 hours of overtime on Wednesday, February 5 from 4 a.m. to 7:30 a.m. The accused RN was off on January 19; he worked an overnight tour on February 5. That 3.5 hour period was the only time they worked together during that time period. When questioned by the board, the whistleblower stated that she observed the accused RN sleeping on at least one occasion, but did not recall the date. She said she did not document the event, but did report it to the Nurse Manager, who told her she would talk to the accused RN. She does not know whether the Nurse Manager pursued it further. When asked whether anyone had ever reported to her that the accused RN was found sleeping while on suicide watch, the Nurse Manager said, "No." When asked whether he had ever fallen asleep during an overnight suicide watch, the accused RN said, "No." There were no other witnesses.

Conclusion

The whistleblower reported that she found the accused RN sleeping while on a one-on-one, did not document it, but told the Nurse Manager. The accused RN denied ever falling asleep while on suicide watch. The Nurse Manager denied that the whistleblower ever reported that she had seen the accused RN sleeping during a one-on-one. There were no other witnesses.

Allegation 3.

(b) (6) failed to appropriately respond to a crisis in the unit, putting patients at risk *was not able to be substantiated*.

Policy

Paragraph 3G of Network Memorandum 10N2-061-13, Sexual Assaults and Other Defined Public Safety Incidents in VHA Facilities, dated May 6, 2013, requires that

employees immediately report all behavioral emergencies and public safety incidents to VA Police or the BERT and to complete the "Disruptive, Threatening, Violent Behavior Report" form that is appended to the policy.

Syracuse Medical Center Nursing Memorandum OPNP 003-003, 1:1 Observation Monitoring Policy & Competency, dated February 2014, established policies and procedures for one-to-one observation of Veterans whose mental status creates special risk for danger to self or others.

Findings

According to OSC's letter, the whistleblower asserted that one morning, during the week of April 7, 2014, at around 9 a.m., two patients became physically aggressive towards each other and staff members. At the time, the accused RN was the charge nurse. These patients were placed in seclusion. This situation was reported to VA police. The board reviewed documentation of several incidents during that general time period. According to the Restraint and Seclusion Data Collection log for the second quarter of 2014, on eight occasions patients were placed in seclusion during that quarter. On no occasion were two or more patients placed in seclusion at the same time. We identified three incidents that approximated the whistleblower's allegation. (1) On Friday, March 21, 2014, at approximately 9:49 a.m., a patient (hereinafter referred to as Patient 2) was disruptive when he became agitated while waiting to be discharged. A Code BERT was called and the patient calmed down. There were no other patients involved. Approximately 2 hours later, Patient 2 was placed in seclusion. The unit's, "Restraint and Seclusion Data Collection," log was annotated to document Patient 2's seclusion episode by a person with the initials, (b) (6)" The accused RN worked a double shift, including days. The whistleblower was on duty. (2) On Thursday, March 26, 2014, police were called to 7C when a patient (hereinafter referred to as Patient 3) reported that Patient 2 had threatened to kill him. According to the police report, the situation was quelled and the officer left the ward. There is no log entry for that day. The accused RN and another RN were on duty. The whistleblower was on sick leave. (3) A review of Patient 2's medical record shows that on Tuesday, April 15, 2014, the accused RN entered three Progress Notes to document that: the patient threw coffee at a staff member that day; was placed in seclusion at 2:51 p.m.; and was released from seclusion at 4 p.m. The log entries to document the seclusion episode were made by a nurse with the initials (b) (6)" Both a code BERT Worksheet and a Debrief Form were completed to document the situation. Two VA police officers responded to the code BERT. One of these officers completed Investigative Report 201404151421-9775 that indicated only Patient 2 was placed in seclusion. Although another patient also was placed in seclusion that day, that did not occur until the evening shift. The whistleblower, the second RN, and the accused RN all worked the 7:30 a.m. to 4 p.m. shift that day. The second RN said that the following day, she was called into the back and reprimanded by the Nurse Manager for undermining the accused RN the day before. She said that the Assistant Nurse Manager was present and defended her. The whistleblower stated that the following day, the second RN was again spoken to by

the Nurse Manager. Neither the Nurse Manager nor the Assistant Nurse Manager recalled this conversation. The whistleblower also stated that, "....the next week after that situation, I got called back for a union meeting, and I was told I was going for a summary review and I was going to be terminated." In addition, the whistleblower said that after this incident, she was no longer permitted to act as a charge nurse.

Conclusion

The whistleblower reported that the accused RN, (b) (6) failed to respond appropriately to a situation that occurred the week of April 7, 2014, during which two patients became disruptive and that she and another RN had to manage the event. During an interview, the whistleblower stated that this incident actually occurred in late March 2014. The whistleblower further stated that she and the second RN called the police, who responded and assisted while they had the patients placed in seclusion. VA Investigators reviewed the Restraint and Seclusion Data Collection log for the second quarter of 2014, and identified that the one instance where the whistleblower, the second RN, and the accused RN all worked the same shift occurred on April 15, 2014. VA Police Report #201404151421-9775 was filed on that date indicating that a code BERT was responded to by police and only one patient was placed in seclusion. The accused RN did not recall this alleged incident. Neither did the Assistant Nurse Manager. The VA Police Officer who responded to the incident did not specifically recall it. The whistleblower and the second RN witness could not verify on exactly which date this alleged incident occurred. The Restraint and Seclusion Data Collection log indicated only one patient was placed in seclusion on April 15, 2014. Because of this discrepant testimony and documentation, this charge could not be substantiated.

Allegation 4.

The Nurse Manager and assistant nurse manager are frequently absent during required working hours *is substantiated*.

Regulations

Title 5, Code of Federal Regulations (CFR), subsection 2635.705(a), states in part that, "....an employee shall use official time in an honest effort to perform official duties...."

Policy

VA Handbook 5011, Part II, Chapter 2, Paragraph 1.a.(7), dated April 15, 2002 - All employees are expected to be on duty during the full period of their tours of duty unless absent on approved leave; to observe the opening and closing hours established for the tour of duty; and to adhere to established luncheon periods.

Syracuse Medical Center Memorandum 00-10, Code of Conduct, dated January 2014, outlines unacceptable and inappropriate behaviors that are prohibited.

Findings

The whistleblower told the investigating board that in the 2 years she has been at the medical center, the Nurse Manager and the Assistant Nurse Manager are frequently off the unit. She estimated that the Assistant Nurse Manager is away close to 30 to 40 percent of the time. When asked how often she saw the Nurse Manager, she replied, "We never see her. It's like a Big Foot sighting. I'm not trying to make light, but I mean, that's kind of – we literally have no supervision and management occurring." She went on to say that the Nurse Manager's office is actually located off the unit.

On July 2, 2014, a Behavioral Health Care Line Manager prepared a RoC to detail a weekly supervision meeting she had the previous day with the Nurse Manager and a second meeting held on that day. Topics included the whistleblower, the Nurse Manager's tardiness both mornings, and the Assistant Nurse Manager's attendance. According to the Behavioral Health Care Line Manager, she became aware of this situation when the facility received notice of OSC's letter. The Behavioral Health Care Line Manager conducted her own investigation and substantiated that the Nurse Manager did not always show up for work on time. The Associate Director for Patient/Nursing Services stated that she and the Behavioral Health Care Line Manager reviewed the Nurse Manager's time and attendance records and determined they were not accurate.

On July 7, 2014, the Behavioral Health Care Line Manager prepared a RoC of her meeting that day with the Assistant Nurse Manager. Topics included the OSC complaint, her attendance, and an incident wherein she showed photos of her surgical site to subordinate employees. The Behavioral Health Care Line Manager's investigation substantiated that the Assistant Nurse Manager worked whenever she was needed, came in on off tours to educate staff members, but that her tour of duty did not reflect the hours she worked. All-in-all, she said the Assistant Nurse Manager spends more time at work than her scheduled hours. She re-educated both the Assistant Nurse Manager and the Nurse Manager about proper time recording. The Associate Director for Patient/Nursing Services corroborated this information.

On September 29, 2014, the Behavioral Health Care Line Manager submitted a request to Human Resources to issue a proposed 14-calendar day paper suspension to the Nurse Manager for her time and attendance issues, for not correcting the Assistant Nurse Manager when she shared the photo of her surgical site to their subordinates, and for Assistant Nurse Manager's attendance issues. On September 29, 2014, the Behavioral Health Care Line Manager submitted a request to HR asking that the Assistant Nurse Manager be issued a letter of reprimand for her poor judgment in sharing the photos of her surgical site to her subordinates and her attendance.

Conclusion

VA ***Substantiated*** that after receiving OSC's letter, the facility's Behavioral Health Care Line Manager investigated the attendance records and practices of both the Nurse Manager and the Assistant Nurse Manager. She discovered problems with both and submitted recommended corrective actions to Human Resources (HR).

Recommendation

2. The medical center should consider appropriate administrative corrective action for both the Nurse Manager and the Assistant Nurse Manager.

Documents Reviewed

5 CFR 2635.705(a)

38 CFR § 1.201

38 CFR § 1.203

38 CFR § 1.204

38 CFR § 1.218 (a)(16)

38 CFR § 1.218 (b)(44)

38 CFR § 17.107

VA Handbook 5011, Hours of Duty and Leave, dated April 15, 2002

VHA Directive 2010-014, Assessment and Management of Veterans Who Have Been Victims of Alleged Acute Sexual Assault, dated March 25, 2010

VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in VHA Facilities, dated September 27, 2012

VHA Handbook 1160.06, Inpatient Mental Health Services

Network Memorandum 10N2-061-13, Sexual Assaults and Other Defined Public Safety Incidents in VHA Facilities, dated May 6, 2013

Syracuse Medical Center Professional Memorandum Psychiatry 11-56, Sexual Trauma Victims, dated October 2013

Syracuse Medical Center Nursing Memorandum OPNP 003-003, 1:1 Observation Monitoring Policy & Competency, dated February 2014

Syracuse Medical Center Memorandum 00-10, Code of Conduct, dated January 2014

SF-50, Notification of Personnel Action documenting the Whistleblower's appointment as an RN, dated July15, 2012

Proficiency Report for Rachael Hogan, RN for period ending July 15, 2013 , dated May 3, 2013

Progress Note for Patient 1, written by (b) (6) M.D., dated October 31, 2013

VA Police Report 2013-11-03-0940-8267, dated November 11, 2013

Progress Note for Patient 1 prepared by (b) (6) RN, dated November 2, 2013

Progress Note for Patient 1 prepared by (b) (6) dated November 3, 2013

Progress Note for Patient 1 prepared by (b) (6) RN, dated November 3, 2013

Time and Attendance Reports for the Whistleblower for the period December 29, 2013 to February 8, 2014

Time and Attendance Reports for (b) (6) RN for the period December 29, 2013 to February 8, 2014

Restraint and Seclusion Data Collection Log for Second Quarter of 2014

Police Report 2014-03-21-0949-1338, dated March 21, 2013

Time and Attendance Reports for the Whistleblower, (b) (6) (b) (6) RN and (b) (6) LPN for the period March 9 to 22, 2014

Police Report 2014-03-26-1230-2956, dated March 26, 2014

Time and Attendance Reports for the Whistleblower, (b) (6) and (b) (6) for period of March 23 to April 4, 2014

Progress Notes for Patient 2 prepared by (b) (6) dated April 15, 2014

Code BERT Worksheet and Debriefing Form, dated April 15, 2014

Police Report 2014-04-15-1421-9775, dated April 15, 2014

Time and Attendance Reports for the Whistleblower, (b) (6) and (b) (6) for period April 6 to 19, 2014

Proficiency Report for the Whistleblower for period ending July 15, 2014, dated June 10, 2014

Request for Summary Review, dated June 11, 2014

Initiation of Nurse Professional Standards Board, dated June 11, 2014

Email from Director (b) (6) subject: Summary Review, dated June 26, 2014

Report of Contact prepared by (b) (6) Ph.D., dated June 26, 2014

Report of Contact prepared by (b) (6) dated July 2, 2014

Report of Contact prepared by (b) (6) dated July 7, 2014

Email confirming Ms. Hogan's employment status, dated December 12, 2014

Request for Discipline for (b) (6) RN, dated September 29, 2014

Request for Discipline for (b) (6) RN, dated September 29, 2014