U.S. OFFICE OF SPECIAL COUNSEL
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Washington, D.C. 20036-4505

The Special Counsel

October 19, 2015

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

Re: OSC File No. DI-12-4027

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find reports from the Department of Veterans Affairs (VA) based on a disclosure of wrongdoing at the VA Caribbean Healthcare System, Community Living Center (CLC), San Juan, Puerto Rico. The Office of Special Counsel (OSC) has reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the investigation, the whistleblower's comments, and my findings. The whistleblower, Jorge Reyes-Mendoza, who consented to the release of his name, disclosed that the nursing staff at the CLC neglected elderly residents by failing to assist them with essential activities of daily living. He also alleged that the nursing staff failed to properly record and report patient falls, as required by VHA Handbook 1050.01.

The VA investigation substantiated Mr. Reyes-Mendoza's allegation that the nursing staff at the CLC neglected elderly residents by failing to assist them with essential activities of daily living, such as bathing, toileting, eating, and drinking. This neglect created significant and serious health issues for those residents. The investigation did not substantiate the allegation that nursing staff failed to record and report patient falls as required; however, it determined, by comparison, that the fall rate at the CLC was higher than at the VISN and VHA. In response to these findings, the VA took disciplinary action against CLC management employees: Associate Chief of Staff for Geriatrics and Extended Care Melba Feliciano, M.D., was demoted to a staff physician; CLC Associate Chief Nurse Myrna L. Jimenez-Miranda, R.N., and CLC Nurse Manager Lisa Gonzalez-Ramirez, R.N., were both demoted to staff nurse positions. The VA also reviewed and revised staffing levels, re-educated all CLC staff, implemented an improved tracking system for patient complaints, and increased management oversight of staff providing direct care to CLC residents. I have reviewed the original disclosure, the agency reports, and the whistleblower's comments. I have determined that the reports meet all statutory requirements and that the findings appear reasonable.

In his comments, Mr. Reyes-Mendoza indicated he was pleased that the investigation included a review of reports regarding fall rate and dehydrations statistics, and thus substantiated his allegations despite denials made by employees. He stated that he is happy measures have been taken to correct deficiencies at the CLC.

The whistleblower's allegations were referred to then-Secretary of Veterans Affairs Eric Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki referred investigation of the matter to then-Under Secretary for Health Dr. Robert Petzel, who tasked the Office of Geriatrics and Extended Care Operations with the investigation. Secretary Shinseki submitted the agency's report to OSC. In response to OSC's requests for additional information, the VA submitted supplemental reports. The whistleblower provided comments on the agency reports.

As required by 5 U.S.C. §1213(e)(3), I am now transmitting the unredacted agency reports and whistleblower's comments to you and to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs.[1] I have also filed copies of the redacted agency reports and whistleblower's comments in OSC's public file, which is available online at www.osc.gov.[2] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[1] The Office of Special Counsel (OSC) is authorized by law to determine whether a disclosure should be referred to the involved agency for investigation or review, and a report OSC may refer allegations of violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety. 5 U.S.C. § 1213(a) and (b). Disclosures must include information that aids OSC in making its determination. Disclosures must include information sufficient for OSC to determine whether referral is warranted. OSC does not have the authority to investigate disclosures and therefore, does not conduct its own investigations. Rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

[2] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.