DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

January 8, 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-14-2118

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower, (b) (6) a nursing assistant (hereafter, the whistleblower), at the West Palm Beach Veterans Affairs Medical Center's Community Living Center, West Palm Beach, Florida, a part of the West Palm Beach Veterans Affairs (VA) Medical Center, West Palm Beach, Florida (hereafter the Medical Center). The whistleblower alleged that the Medical Center engaged in actions that may constitute a violation of law, rule or regulation, and a substantial and specific danger to public health through staffing shortages, and breaches in clinical safety and patient care. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Secretary asked that the Interim Under Secretary for Health to refer the whistleblower's allegations to the Office of the Medical Inspector, who assembled and led a VA team to investigate these allegations. The team conducted a site visit to the Medical Center September 30 – October 2, 2014. VA found actions that constituted a violation of VA and Veterans Health Administration (VHA) policy. In addition, we substantiated the first of the whistleblower's three allegations, partially substantiated the second, and did not substantiate the third.

VA made 10 recommendations for the Medical Center and one for the VHA Community Living Center Program Office. Findings from the investigation are contained in the report, which I am submitting for your review.

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-14-2118

Department of Veterans Affairs
West Palm Beach Community Living Center South
West Palm Beach, Florida

Report Date: November 16, 2014

TRIM 2014-D-1256

Executive Summary

At the request of the Secretary, the Interim Under Secretary for Health (IUSH) directed the Office of the Medical Inspector (OMI) to coordinate a Department of Veterans Affairs (VA) team to investigate complaints lodged with the Office of Special Counsel (OSC) by (b) (6) a nursing assistant (hereafter, the whistleblower). He alleged the West Palm Beach VA Medical Center Community Living Center – South, West Palm Beach, Florida (hereafter, CLC South), a part of the West Palm Beach VA Medical Center, West Palm Beach, Florida (hereafter the Medical Center) engaged in actions that may constitute a violation of law, rule or regulation, and a substantial and specific danger to public health. He described issues regarding breaches in clinical safety and patient care. He initially consented to the release of his name, but subsequently requested that the VA team not label him as the whistleblower during interviews with physicians. A VA team conducted a site visit to the Medical Center on September 30 – October 2, 2014.

Specific Allegations of the Whistleblower

1. CLC South has a significant staffing shortage, particularly of Nursing Assistants (NA) which is causing serious harm to patients' health.
2. The ongoing staffing shortage makes it difficult for existing staff to complete their duties, resulting in:
   a. patient neglect, including failure to consistently change patient's undergarments, unsanitary methods of care, and failure to bathe patients regularly,
   b. persistently unclean patient rooms and bathrooms,
   c. improper signage outside patient rooms specifically regarding MRSA and C-difficile; increasing the risk of patient infection and cross-contamination,
   d. failure to follow accepted policies for employee hand washing and reuse of used supplies,
   e. an ongoing shortage of clean staff garments and supplies, including gowns and soap, and
   f. disconnection of patient call bells and bed alarms by the staff with failure to respond to patient calls.
3. Management is aware of these concerns, but has taken minimal steps to correct them.

VA **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. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions about whether the alleged event or action took place with reasonable certainty.

After careful review of its investigative findings, VA makes the following conclusions and recommendations.

Conclusion for Allegation # 1

- VA substantiated that CLC South had a significant staffing shortage, particularly of NAs; however, they maintained minimum hours per patient day (HPPD) by initially utilizing overtime and subsequently by over hiring and temporarily limiting total occupied beds. There is evidence that staffing has improved over the past 6 months.

Recommendations to the Medical Center:

1. Ensure new CLC leadership understands the CLC staffing methodology and program guidelines found in Veterans Health Administration (VHA) Directive 2010-034, and they are appropriately applied.
2. Fill all vacant nursing staff positions and maintain according to VHA's established CLC staffing methodology.
3. Ensure CLC leadership consult with Human Resources on VA policy covering unscheduled leave, possible leave abuse, and other personnel matters to allow optimal staffing.
4. Submit to CLC Program Office their plan to address the temporary limitation of beds below authorization.

Recommendation to VHA:

5. Direct the CLC Program Office to work with the new CLC leadership Associate Chief Nursing Services (ACNS) and Nurse Manager (NM) to share best practices for implementing CLC staffing methodology and program guidelines.

Conclusions for Allegations #2

a. VA did not substantiate that staffing shortages resulted in patient neglect, such as failure to consistently change patient's undergarments, unsanitary methods of care, and failure to bathe patients regularly.
b. VA did not substantiate that there was a persistent problem with unclean patient rooms and bathrooms. Instances of inadequate cleaning were promptly addressed when identified.
c. VA substantiates occasions of improper contact precaution signage as reported by the Long-Term Care Institute (LTCI) and the Infection Preventionist (IP); however, VA did not observe this during the site visit. Improper signage could increase the risk of patient infection and cross-contamination.
d. The local area's high prevalence rate for Methicillin-resistant Staphylococcus Aureus (MRSA) increases the risk of infection at the Medical Center and amplifies the need for vigilance in infection control.
e. The Medical Center's CLC C-difficile is higher than national rates; however, the early detection has resulted in cases treated, with no secondary complications.
f. The Veteran, identified by the whistleblower, with the MRSA infection, presented to VA with a bone infection, and underwent an amputation secondary to severe peripheral vascular disease.

g. VA substantiates CLC South hand-washing compliance is below policy standards when entering rooms, but meets standards when leaving rooms.
h. VA did not substantiate an ongoing shortage of clean staff garments and supplies, including gowns and soap.
i. VA was able to corroborate that on one occasion a patient's call bell was disconnected, and substantiates CLC South has a documented history of delays in responding to patient calls.
j. The Medical Center monitors the functioning of call bells and lights.

Recommendations to the Medical Center:

6. Continue to conduct Environment of Care and Infection Control Rounds to ensure proper signage, cleanliness of patient rooms, and adherence to Infection Control guidelines.
7. Continue MRSA and *C-difficile* monitoring, awareness, and prevention programs.
8. Continue the secret shopper hand washing observations on the CLC to monitor and improve appropriate hand washing techniques when entering patients' rooms and to maintain the high rates reported when exiting patients' rooms.
9. Require that nursing staff test their patients' call bells and lights at the beginning of each shift, and if problems are identified, make a note in the Electronic Health Record (EHR) and report the problem to the NM and maintenance.
10. Establish a process to investigate disconnection of patient call bells, and if appropriate, hold staff accountable.
11. Continue to monitor call bell response times and appropriately staff to meet the needs of Veterans.

Conclusion for Allegation #3

- VA did not substantiate this allegation.
- Management was aware of these concerns, and had taken steps to correct them.

Recommendation to the Medical Center:

None.

Summary Statement

The VA team has developed this report in consultation with other VA and VHA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement, an abuse of authority, or risked public health or safety. In particular, the Office of General Counsel (OGC) has provided a legal review and the Office of Accountability Review (OAR) has examined the issues from a Human Resources perspective, establishing individual accountability, when appropriate, for improper personnel practices. VA found actions that constituted a violation of VA and VHA policy.

Table of Contents

I. Introduction

At the request of the Secretary, the IUSH directed OMI to coordinate a VA team to investigate complaints lodged with the OSC by the whistleblower. He alleged CLC South, a part of the Medical Center engaged in actions that may constitute a violation of law, rule or regulation, and a substantial and specific danger to public health. He described issues regarding breaches in clinical safety and patient care. He initially consented to the release of his name, but subsequently requested that the VA team not label him as the whistleblower during interviews with physicians. A VA team conducted a site visit to the Medical Center on September 30–October 2, 2014.

II. Facility Profile

The Medical Center, part of the Veterans Integrated Service Network 8, provides a full range of primary and secondary health care services to Veterans in a seven-county area along Florida's Atlantic Coast. Comprehensive services include primary, emergency, and long-term care in medicine, surgery, mental health, physical medicine and rehabilitation, radiology, dentistry, hemodialysis, comprehensive cancer treatment, and geriatrics and extended care, including hospice and palliative care. It has a total of 273 operating beds, including 63 in two medical units, 14 in the Intensive Care Unit, and 120 in a CLC.

III. Specific Allegations of the Whistleblower

1. CLC South has a significant staffing shortage, particularly of nursing assistants (NA) which is causing serious harm to patients' health.
2. The ongoing staffing shortage makes it difficult for existing staff to complete their duties, resulting in:
   a. patient neglect, including failure to consistently change patient's undergarments, unsanitary methods of care, and failure to bathe patients regularly,
   b. persistently unclean patient rooms and bathrooms,
   c. improper signage outside patient rooms specifically regarding MRSA and C-difficile; increasing the risk of patient infection and cross-contamination,
   d. failure to follow accepted policies for employee hand washing and reuse of used supplies,
   e. an ongoing shortage of clean staff garments and supplies, including gowns and soap and
   f. disconnection of patient call bells and bed alarms by the staff with failure to respond to patient calls
3. Management is aware of these concerns, but has taken minimal steps to correct them.

IV. Conduct of Investigation

The VA team consisted of [redacted] (b) (6) [redacted] M.D., Deputy Medical Inspector; [redacted] (b) (6) [redacted] M.D., Medical Investigator; [redacted] (b) (6) [redacted] RN, Clinical Program

Manager; (b) (6) RN, Director, Facility-Based Programs; (b) (6) RN, Extended Care Operations, Office of Geriatrics and Extended Care; and (b) (6) Human Resources (HR) Specialist from OAR.

Before the site visit, the Medical Center had conducted an Administrative Investigative Board (AIB), and the LTCI conducted an unannounced on-site survey, both of which addressed quality of care issues in the CLC. The Medical Center initiated actions in response to these findings prior to this investigation. VA reviewed findings from the AIB and LTCI; these and additional reports, memorandums, and other relevant documents are listed in Attachment A.

On September 30, 2014, VA held an entrance briefing and discussed the Department's whistleblower protection policy with Medical Center leadership:

- (b) (6) Associate Director (AD) and Acting Medical Center Director
- (b) (6) M.D., Deputy Chief of Staff (DCoS)
- (b) (6) AD for Patient Care Services (ADPCS)/Chief Nurse Executive
- (b) (6) Associate Chief, Quality Manager (ACQM)
- (b) (6) President, American Federation of Government Employees (AFGE)

Participating by teleconference:

- (b) (6) M.D., Chief Medical Officer (CMO), VISN 8
- (b) (6) M.D., Chief, CLC Service, VISN-8
- (b) (6) Medical Center Director (MCD)
- (b) (6) M.D., Chief of Staff (CoS)

The following staff guided us on our initial tour of CLC North and South:

- (b) (6) ACQM
- (b) (6) M.D., CLC Medical Director
- (b) (6) Chief Environment Management Services (EMS)
- (b) (6) ACNS for CLC
- (b) (6) NM, CLC South
- (b) (6) NM, CLC North
- (b) (6) RN, IP
- (b) (6) Acting Chief, Facilities Management Services

The team made two unscheduled visits to CLC South and conducted multiple interviews in person or telephonically with:

- (b) (6) NA, the whistleblower
- (b) (6) former ADPCS/Chief Nurse
- (b) (6) M.D., Medical Director, CLC
- (b) (6) former ACNS for CLC
- (b) (6) Compliance Officer

- (b) (6) AFGE Union Steward
- (b) (6) NM, CLC South
- (b) (6) NM, Emergency Department
- (b) (6) M.D., Staff Physician CLC
- (b) (6) Material Data Set Coordinator
- (b) (6) Social Worker
- (b) (6) RN, (former NM, CLC) Multi-Drug Resistant Organism Coordinator
- (b) (6) RN, Wound Care Specialist
- (b) (6) EMS staff
- (b) (6) EMS staff, CLC
- (b) (6) Chief, EMS
- (b) (6) NA, CLC South Preceptor, Day Shift (7:30 a.m.–7:00 p.m.)
- (b) (6) NA, CLC South, Day Shift
- (b) (6) RN, CLC South, Night Shift (7:00 p.m.–7:30 a.m.)
- (b) (6) RN, (former Acting NM) CLC South, Day Shift
- (b) (6) RN, Unit Facilitator CLC South
- (b) (6) RN, ACNS CLC
- (b) (6) NA, CLC South, Day Shift
- (b) (6) NA, CLC North, Evening Shift (3:00–11:00 p.m.)

On October 2, 2014, VA held an exit briefing with the Medical Center Leadership including:

- (b) (6) MCD
- (b) (6) M.D., CoS
- (b) (6) AD
- (b) (6) ADPCS
- (b) (6) M.D., DCoS
- (b) (6) ACQM
- VISN 8 physicians (b) (6) M.D., CMO, and (b) (6) M.D., Chief, CLC Service, participated by teleconference.

V. Findings, Conclusions, and Recommendations

Allegation #1

CLC South has a significant staffing shortage, particularly of Nursing Assistants (NAs) which is causing serious harm to patients' health.
Findings

VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, directs staffing levels for the CLC, including HPPD. HPPD are the direct nurse contact hours required to complete required nursing care. VHA Directive 2010-034 defines direct care responsibilities "as all patient or resident-centered nursing activities performed by staff assigned to the unit in the presence of the patient or resident, and patient or resident-related activities that occur away from the patient or resident. Examples include:

nursing assessment; planning, treatment, and preparation time; medication orders and administration; nursing rounds; admission, transfer and discharge activities; patient or resident teaching; patient or resident communication; coordination of patient or resident care; and documentation."

Over the last year, there was a lack of continuity among nursing leadership positions overseeing the CLC with four Acting Chief Nurses, and four NMs, (three of them Acting).

On March 11-13, 2014, the LTCI conducted an unannounced survey at the Medical Center's CLC. The CLC NM and ACNS told surveyors that they were actively recruiting to fill 10 vacancies for the entire CLC, 4 licensed nurses, and 6 NAs.

In March 2014, Medical Center leadership recognized several factors that contributed to staffing shortages: two CLC South NAs had been on extended family medical leave, NAs were required to cover unscheduled sick leaves in other units, and the existing nursing staff took increased amounts of unscheduled leave.

Leadership temporarily decreased the number of CLC beds and adjusted staffing levels until they could fill all vacancies. The Medical Center limited CLC North beds to 48 out of the 60 authorizations and CLC South to 38 out of the 50 authorizations. The current patient census on CLC South is 30, with 8 open available beds. The Medical Center reported that the temporary limitation on the number of beds has not resulted in a CLC wait list. Medical Center leadership allowed the ACNS to hire over-ceiling (authorization to hire above the allotted number of positions) for four NAs on extended leave, and CLC nursing staff no longer provides coverage for other units.

Since March 2014, the CLC has filled 6.5 of the vacant positions; however, as staffing is fluid, in November 2014, they reported they still have 6 vacant positions. The Medical Center has hired permanent nurse leadership, and the union steward informed us that the new CLC NM and ACNS are making a positive difference.

VA reviewed CLC South's HPPD nurse staffing and CLC South Assignment Sheets for the 1 year between September 2013 and September 2014, the Medical Center's Nursing Policy 118-053, and Nursing Staffing Adjustments for 2014. On 363 days of the 380 days from September 1, 2013, through September 15, 2014, CLC South met or exceeded the established HPPD standard. On the remaining 17 days, the HPPD fell slightly short of the standard by 0.03 to 0.95 hours, with an average shortfall of 0.32 hours.

VA also questioned staff members about their workloads. No one else corroborated the whistleblowers allegation that NAs were assigned between 30-34 patients. According to the staff interviewed, each NA is assigned 7–12 patients, and three to five NAs are routinely on duty with a minimum of three covering day shifts. During interviews, the majority of the nursing staff confirmed that limited staff, especially on days when people took unscheduled leave, had increased their workload and on those days they may be assigned up to 16 patients. To address staffing shortfalls, the Medical Center approved

nursing staff working overtime to meet the care needs of the Veterans. All staff agreed that the situation has improved over the last 6 months.

Conclusion for Allegation # 1

- VA substantiated that CLC South had a significant staffing shortage, particularly of NAs; however, they maintained minimum HPPD by initially utilizing overtime and subsequently by over hiring and temporarily limiting total occupied beds. There is evidence that staffing has improved over the past 6 months.

Recommendations to the Medical Center:

1. Ensure new CLC leadership understand the CLC staffing methodology and program guidelines found in VHA Directive 2010-034, and they are appropriately applied.
2. Fill all vacant nursing staff positions and maintain according to VHA's established CLC Staffing Methodology.
3. Ensure CLC leadership consult with Human Resources on VA policy covering unscheduled leave, possible leave abuse, and other personnel matters to allow optimal staffing.
4. Submit to CLC program office their plan to address the temporary limitation of beds below authorization.

Recommendation to VHA:

5. Direct the CLC program office to work with the new CLC leadership (ACNS and NM) to share best practices for implementing CLC staffing methodology and program guidelines.

Allegation #2

The ongoing staffing shortage makes it difficult for existing staff to complete their duties, resulting in:

- **a. patient neglect, including failure to consistently change patient's undergarments, unsanitary methods of care, and failure to bathe patients regularly,**
- **b. persistently unclean patient rooms and bathrooms,**
- **c. improper signage outside patient rooms specifically regarding MRSA and C-difficile; increasing the risk of patient infection and cross-contamination,**
- **d. failure to follow accepted policies for employee hand washing and reuse of used supplies,**
- **e. an ongoing shortage of clean staff garments and supplies, including gowns and soap, and**
- **f. Disconnection of patient call bells and bed alarms by the staff with failure to respond to patient calls.**

Findings

2a. patient neglect, including failure to consistently change patient's undergarments, unsanitary methods of care, and failure to bathe patients regularly

VA interviewed 11 CLC nursing employees including 4 NAs (the whistleblower specifically requested that we speak to 2 of them; 3 work the same shift as he). All NAs except the whistleblower reported that when changing patients' undergarments they had never encountered dried urine or stool, the presence of which would indicate a delay in care. The RNs also reported that they had never found patients with "old urine or feces." In addition, none of the CLC's wound care monitoring logs show skin breakdowns in the perianal areas; such breakdowns would result from delays in changing undergarments on a regular basis.

All, the CLC employees we interviewed, save the whistleblower, reported having linens readily available and using them to wash patients. Other nursing staff reported that they had never witnessed a care provider using soiled linens on a patient. NAs either bathe patients or assist them with bathing daily. As the whistleblower kept no identifiers on his April 6, 2014, encounter with the patient in room 116, whom he claimed had not been bathed in 3 weeks, VA was unable to access this patient's health record to review documentation to confirm or deny this allegation.

2b. persistently unclean patient rooms and bathrooms

The NM reports conducting daily rounds and observing environment of care; he reported no issues with persistently unclean rooms or bathrooms. The IP performs weekly rounds in the CLC-South, and the Environment of Care team conducts quarterly rounds on the CLC. Their methods of inspection includes walking through every pod and wing of the CLC, accompanied by the NM of the respective units. They inspect individual rooms and bathrooms including floors, walls, window casings; isolation carts, and lockers. They interview staff members including nurses, health technicians, and housekeeping aides with questions about odors, lack of PPE, or problems with isolation signage. They record their findings and track issues identified until resolution. They have not reported persistently unclean rooms or bathrooms.

Staff members call housekeeping when patients have accidents on the floor and report that housekeeping is very responsive. However, one NA confirmed that before our visit, she had found unclean rooms, specifically, the NA reported to the NM that floors under patients' beds had debris under them for 2 days, that some bathrooms smelled like urine, and that the patients' rooms were not consistently cleaned. She felt this was caused by a recent change in housekeeping staff; the NM immediately brought down the housekeeping supervisor to inspect the areas. Housekeeping immediately cleaned the affected areas.

VA observed that the CLC was clean overall, though we did note a strong odor in one of the patient rooms. Speaking with the patient, we learned that he was suffering from diarrhea and had recently been changed by the nursing staff.

The CLC uses two locked cabinets in each patient's room, called nurse servers, for the storage of clean and dirty linens. Only nurses and NAs have keys; the patients do not. They must ask nursing staff to place their dirty clothing in the locked server. Although VA did not see dirty linen on the floor during our visits, it is plausible that a patient might place dirty laundry on the floor while waiting for someone to unlock the nurse server. The staff reported locking the cabinets to prevent the spread of infectious diseases. The CLC leadership were already aware of the lack of patient accessible hampers and were in the process of obtaining them prior to our site visit.

CLC staff confirmed an occasion in which a patient who routinely hoards food, (including fruit), in his bedside stand overnight, had fruit flies in his room. The Charge Nurse immediately notified housekeeping and the exterminator, who addressed the situation. The Charge Nurse also spoke with the patient and his family about the hazards of keeping food in the rooms, and annotated in the patient's care plan to check for food during Environment of Care rounds. Staff reminded the patients at the Resident Council meeting of the importance of a safe and clutter free environment.

2c. improper signage outside patient rooms specifically regarding Methicillin-resistant Staphylococcus Aureus (MRSA) and *Clostridium difficile* bacterial infection (*C-Difficile*); increasing the risk of patient infection and cross-contamination

VA did not find improper Infectious Disease signage outside the rooms of patients on isolation precautions. Both nursing and housekeeping staff accurately articulated the correct process for placement of patients on isolation and detailed how to identify the appropriate color-coded isolation signage for both MRSA and *C-difficile*. The IP monitors and ensures the appropriate use of signage.

The Medical Center has an active surveillance program for MRSA and *C-Difficile*. The Medical Center maintains a "Census List and multidrug-resistant organisms (MDRO) history" that is generated at 7 a.m. and 7 p.m. daily. It lists every inpatient and CLC resident by unit location, personal demographics, evidence of infection by organisms including MRSA and *C-Difficile* in the past 365 days, isolation order, and start date to facilitate the proper use of signage.

The IP monitors the incidence of MRSA and *C-difficile* infections facility-wide; she monthly enters these data, including the incidence of *C-difficile* complications and compliance with Contact Precautions, into VHA's Inpatient Evaluation Center (IPEC) database. She quarterly reports the data to the Clinical Executive Board.

The IP works closely with the NM sharing these results. As noted in the minutes of a January 30, 2014, meeting, the NM alerted staff that during Environment of Care rounds the IP had identified signage on one of the rooms that did not accurately identify patients on contact precautions, emphasizing that it was imperative to move the proper signage when patients move from one room to another to ensure that staff continue to use appropriate precautions. The minutes reflect that he also informed them that a team consisting of the NM, IP, and EMS Supervisor will continue to monitor signage and

the infection control process weekly. The IP also conducted in-service training about signage and other infection control topics on all shifts.

The Medical Center closely monitors and tracks the CLC prevalence rate of MRSA based on screening performed by obtaining nasal swabs from the CLC residents on admission and clinical cultures of blood, body fluids, and wounds obtained from residents who are ill. The Medical Center's CLC has slightly more than twice the prevalence rate for nasal screening and clinical cultures as compared to the national aggregate; this high prevalence rate of MRSA is related to the high prevalence of MRSA among Veterans transferred from other health care facilities and in the West Palm Beach community population.

In fiscal year (FY) 2014 there were 11 clinically confirmed cases of *C-difficile* infection in the CLC. Of the 11 cases, 6 were CLC acquired and they involved 4 unique CLC Veterans. In all 6 cases, the Veterans had received recent antibiotics for treatment for other infections, which increases the risk of developing a *C-difficile* infection. The rate of clinically confirmed CLC-onset *C-difficile* in FY 2014 was 2.01 cases per 10,000 bed days of care (BDOC). This is slightly higher than the national aggregate case rate of 1.74 cases per 10,000 BDOC. In FY 2014, the Medical Center's identification and management of the *C-difficile* infections did not result in complications: specifically, no colectomies, no intensive care unit admissions, nor deaths for any cause associated with clinically confirmed *C-difficile.*

VA noted additional infection prevention efforts at the Medical Center including monitoring for Catheter-associated Urinary Tract Infections. Their FY 2014 rate per 1,000 device days of care is 0.00 compared to the national aggregate of 0.14. This zero rate reflects infection prevention efforts in catheter insertion and maintenance.

In the OSC letter and during his interview, the whistleblower described an incident that occurred in March 2014 in which a Veteran contracted MRSA while in the CLC. He alleged that the infection prevented the Veteran's wounds from healing, and that despite treatment it spread to his bones, ultimately requiring amputation of his leg. VA found that the Veteran identified by the whistleblower had a past medical history significant for multiple medical problems including Type II diabetes mellitus, coronary heart disease, lung cancer treated with chemotherapy and radiation, and severe peripheral vascular disease. He had undergone two prior limb salvage femoral distal bypass operations (an end stage attempt to save an extremity) at a non-VA medical facility. He presented to the Medical Center with a non-healing ulcer and osteomyelitis (bone infection) of his left foot. At the Medical Center, he underwent multiple additional procedures in an effort to save his extremity. The surgeons noted that the vascular graft that had been placed at the non-VA facility was infected and required removal. Although the Veteran did develop an MRSA infection, most likely due to appropriate treatment with long-term antibiotics required for his bone infection, it was his severe underlying vascular disease that led to the amputation, not MRSA.

2d. failure to follow accepted policies for employee hand washing and reuse of used supplies.

Several interviewees stated that they had occasionally seen other staff members either enter or leave patient rooms without washing their hands or wearing their gloves, and stated that they were empowered to make on-the-spot corrections of noncompliance. During a Resident Council meeting, one patient reported that he observed one nurse using the same gloves when caring for different patients. The Medical Center has a "secret shopper" hand washing program in which an anonymous staff member from elsewhere in the Medical Center observes the hand washing practices of the staff and completes a monitoring form. In September 2014, hand washing compliance for CLC South was 70 percent upon entering the room and 100 percent upon exiting. The VA compliance standard is 90 percent. The IP and the MDRO Coordinator continue to provide ongoing infection control training and monitoring.

The whistleblower told VA that his initial preceptor NA had asked him to reuse washcloths, but no one could confirm this allegation or any allegation of reuse of washcloths or any supplies, nor could documentation of such a practice be found. Because the whistleblower was unable to provide identifying information for a patient that he alleged had been left overnight in soiled diapers, VA investigators were unable to access the patients' EHR.

2e. shortage of clean staff garments and supplies, including gowns and soap

The whistleblower reported that there were only two gowns available for his patients one weekend and that he had gone down to the laundry room for more, but was unable to obtain additional gowns. We asked whether he had ever run out of gowns, and he replied, "no." All other staff members said they always had gowns, and, if stocks got low, they only needed to call to get resupplied. In the CLC, VA found stocks of clean staff garments and supplies, including gowns and soap, not only in patient's rooms, but also in the storage supply room on the ward. Via their Environment of Care rounds, the Medical Center monitors the par levels (the available supplies and usage) to ensure that changes in requirements results in changes in supplies provided. The housekeeping supervisor told VA that staff members request linens from the laundry secretary on weekdays from 7:00 a.m. to 3:30 p.m. Outside of those hours, they may call the 24-hour supervisor, who ensures the items are delivered as requested.

The whistleblower and another NA told us that on 1 weekend CLC South had run out of the large pump bottles of soap used to bathe patients. We asked the whistleblower whether soap was available to wash his hands; he responded "yes, but I didn't want to use this soap to bathe the patients." The majority of the nursing staff stated that in addition to the large pump bottles, individual patient admission packages, donated by volunteers, also contain soap. They reported always having a source of soap available to cleanse patients.

2f. disconnection of patient call bells and bed alarms by the staff with failure to respond to patient calls

The whistleblower mentioned specific incidents occurring on January 15 and April 15, 2014, in which patients were left unattended, in disarray, with their call bells turned off. He was unable to provide patient names that would allow review of the patient's nursing notes.

The Medical Center's Environment of Care round members review and report call bells issues in their electronic reports. In FY 2014, there were no reported disconnected call bells. In addition, the NM monitors call bells on daily rounds. The current NM reports he has never found a disconnected call bell on his rounds. A prior Acting NM said that she once found a disconnected call bell when she rounded in the morning, though she could not remember the circumstances surrounding the disconnection. All other staff members denied ever finding disconnected bells.

The CLC Staff and Resident Council Minutes noted residents complaining about delays in the nurses answering calls. The Resident Council Minutes of November 18, 2013, reflected that one resident complained of waiting 20 minutes or more for a response to his call bell. In response, the NM implemented "Integrity, Commitment, Advocacy, Respect and Excellence (ICARE) rounds" in December 2013. He personally talks with patients and their families to find out their expectations of quality care, and to listen to and address any concerns they have. The Resident Council Minutes of January 27 and February 24, 2014, reported similar complaints of delay in response times and the LTCI survey also found several patients complaining about the length of time it takes for the staff to answer the call bell. The NM discussed the issue of call bells at a recent staff meeting and directed the charge nurses to monitor staff's responses to patient call bells. The Medical Center monitors call light functioning as part of Environment of Care rounds; in FY 2014, they submitted 28 work orders related to call bells and lights. These work orders have been resolved.

While on-site, VA made two unannounced visits to the CLC. During the first, the investigative team separated, simultaneously going to CLC North and South, and activating patient call bells. On both units and in each room a nursing staff responded within approximately 18 seconds of the activation. During the second visit, we spoke with family members on both units and they reported positive feelings about the nursing staff's responsiveness and were very pleased with the care their loved ones were receiving.

Conclusions for Allegations 2

a. VA did not substantiate that staffing shortages resulted in patient neglect, such as failure to consistently change patient's undergarments, unsanitary methods of care, and failure to bathe patients regularly.
b. VA did not substantiate that there was a persistent problem with unclean patient rooms and bathrooms. Instances of inadequate cleaning were promptly addressed when identified.

c. VA substantiates occasions of improper contact precaution signage as reported by the LTCI and the IP; however, VA did not observe this during the site visit. Improper signage could increase the risk of patient infection and cross-contamination.
d. The local area's high prevalence rate for MRSA increases the risk of infection at the Medical Center and amplifies the need for vigilance in infection control.
e. The Medical Center's CLC C-difficile is higher than national rates; however, the early detection has resulted in cases treated, with no secondary complications.
f. A Veteran identified by the whistleblower who underwent an amputation did so because of severe peripheral vascular disease, not MRSA infection.
g. VA substantiates CLC South hand-washing compliance is below policy standards when entering rooms, but meets standards when leaving rooms.
h. VA did not substantiate an ongoing shortage of clean staff garments and supplies, including gowns and soap.
i. VA was able to corroborate that on one occasion a patient's call bell was disconnected; and substantiates CLC South has a documented history of delays in responding to patient calls.
j. The Medical Center monitors the functioning of call bells and lights.

Recommendations to the Medical Center:

6. Continue to conduct Environment of Care and Infection Control Rounds to ensure proper signage, cleanliness of patient rooms, and adherence to Infection Control guidelines.
7. Continue MRSA and *C-difficile* monitoring, awareness, and prevention programs.
8. Continue the secret shopper hand washing observations on the CLC to monitor and improve appropriate hand washing techniques when entering patient's rooms and to maintain the high rates reported when exiting the patient's room.
9. Require that nursing staff test their patients' call bells and lights at the beginning of each shift, and if problems are identified, make a note in the EHR and report the problem to the NM and maintenance.
10. Establish a process to investigate disconnection of patient call bells, and if appropriate, hold staff accountable.
11. Continue to monitor call bell response times and appropriately staff to meet the needs of Veterans.

Allegation #3

Management is aware of these concerns, but has taken minimal steps to correct them.

Findings

VA found that management was aware of the whistleblower's concerns. According to the November 15 and 16, 2013, CLC South Staff Meeting Minutes, the issues documented in his letter dated November 13, 2013, were discussed, and CLC leadership put a corrective action plan in place to address all of them. In addition, when the whistleblower submitted quality-of-care complaints to management in March 2014, Medical Center leaders ordered an AIB and developed a corrective action plan. The

AIB includes corrective actions such as: developing alternate ways of disposing soiled linen, reviewing the FY 2015 proposed staffing methodology, increasing participation in Environment of Care rounds, continued monitoring of hand hygiene, developing a scope of practice for responding to patient call bells, implementing a CLC cleaning project, and ordering storage bins in which patients could store food. These actions were all underway prior to the present investigation.

Conclusion for Allegation #3

- VA did not substantiate this allegation. Management was aware of these concerns, and had taken steps to correct them.

Recommendation to the Medical Center:

None.

VI. Summary Statement

The VA team has developed this report in consultation with other VA and VHA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement, an abuse of authority, or risked public health or safety. In particular, OGC has provided a legal review and OAR has examined the issues from a Human Resources perspective, establishing individual accountability, when appropriate, for improper personnel practices. VA found actions that constituted a violation of VA and VHA policy.

Attachment A

Documents Reviewed by VA:

1. VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel, July 19, 2010.

2. VHA Directive 2010-006, Methicillin-Resistant Staphylococcus Aureus (MRSA) Prevention Initiative, Attachment A MRSA Prevention, February 3, 2010.

3. VHA Directive 2011-007, Required Hand Hygiene Practices, notes that the CDC and JC have issued guidelines for hand hygiene in health care settings.

4. Medical Center Memorandum, Patient Care Services 118-053, Nursing Staffing Adjustments, September 26, 2014.

5. Medical Center Memorandum, Patient Care Services 118-054, Nursing Staffing Plan, September 26, 2014.

6. Medical Center Memorandum 548-99-262, Isolation and Precautions for Infection Prevention and Control in the Medical Center, April 1, 2012.

7. Medical Center Memorandum 548-118-439, Antimicrobial Stewardship Program, July 1, 2014.

8. Medical Center Memorandum 548-118-134, Hand and Hygiene Guideline, January 30, 2014.

9. Medical Center Hand Hygiene Performance Improvement Project, June 2014.

10. Medical Center Infection and Prevention Guideline, Clostridium Difficile Infection (CDI) Prevention and Management, May 2, 2013.

11. Medical Center Memorandum 548-118-43, Policy for Wounds and Pressure Ulcer, August 29, 2013.

12. Medical Center Annual Plan for Surveillance, Prevention and Control of Infections – 2014.

13. Medical Center Geriatric and Extended Care Service Memorandum GEC-010, Use of Physical Restraint in the Community Living Center, September 23, 2014.

14. Medical Center AIB, Part A & B, July 30, 2014.

15. CLC South Staff Meeting Minutes, January 2013 – September 2014.

16. *West Palm Beach VA Medical Center 2013 Trip Pack.*

17. CLC Staffing Plan, January 2013 – September 2014.

18. CLC NA Competencies and Education Folders.

19. CLC NA Position Description.

20. CLC South Patient Assignments, January 2013 – September 2014.

21. CLC South Staff Meeting Minutes, January 2013 – September 2014.

22. CLC Resident Council Minutes, September 2013 – August 2014.

23. EMS Environmental Rounds Schedule 2013 – 2014.

24. CLC Cleaning Schedules.

25. CLC Inventory List for linen and supplies.

26. CLC South Time Schedules, January 2013 – September 2014.

27. IPEC Data Information System, MRSA and *C-difficile* in CLCs.

28. VHA Support Service Center data for the CLC, September 2013 to August 2014.

29. CLC Veterans Electronic Medical Records