Allegation #1

Management's failure to properly train SPS employees and provide cleaning instructions from the manufacturer.

Page 5 Paragraph #1: "VHA Directive and VA Handbook 7176, in effect through March 12, 2012, required an initial orientation and continued on the job training for all SPS employees with SPS Level 1 training, to occur in the initial 20 weeks of work."
Whistleblower: There was much "talk" about the VHA Directive and VA Handbook 7176, however, I have never seen it and there was never a book available for the staff to readily reference.

Page 6 Paragraph #2: "When new equipment is purchased or loaned to the Medical Center, SPS employees on both tours of duty are trained by the manufacturer's representative."
Whistleblower: Not all new equipment that was purchased or loaned had training offered by the manufacturer's representative, some did, but most did not. The Agency statement is only true concerning scopes or sterrad machines.
Paragraph #3
While OMI could not determine the number of SOP documents that were available prior to 2011, we learned that, since 2009, there has been an ongoing effort to convert all Manufacturer's processing instructions to SOPs.
"The overall completion rate of 72% includes the new employees."
Whistleblower: Why is the overall completion rate only 72%? Wouldn't the lack of knowledge of SOPs cause the issues I, the Whistleblower, am claiming? Hence the ongoing problems of mislabeled, improperly cleaned, inappropriate instruments and lack of properly packaged instruments.
There were no available SOPs on how to properly clean, maintain or package the instruments and equipment, except that of the scopes. **Paragraph #4**: "The three circular vertical files contained label shelves (see attachment B)" are instrument checklists for OR trays and the type of sterilization used. They do not state the type of packaging (ie, an OR tray metal pan, peel pouch or wrapped in paper), how to package the instruments or equipment (ie, together, some instruments separate, or individualized) or where the equipment should be labeled to.
Paragraph #5: "All SPS employees interviewed, (only three SPS employees were interviewed with a total of 13 SPS employees in the department) reported an awareness of oneSource, the national online database for locating manufacturer's processing instructions, in mid-2013." **Whistleblower:** Hence the truth that manufactures instructions were ***not*** available to SPS Staff prior to mid-2013. I don't see how an appropriate Investigation can be complete, when all parties involved were not spoken with, but a select few and all the evidence presented was not looked into. Seems the Agency chose only certain issues to "investigate."
Agency Conclusion: "There is evidence that substantive efforts have been made since 2012 to provide both hard copy and online access to manufactures reprocessing instructions and SOPs." Clearly efforts may have been made, but were not forthcoming until mid-2013.

Allegation #2 Page 7

Management's failure to take sufficient action to correct or curtail the following behaviors:
A. Employees' failure to properly clean dental hand pieces, washing them only with water rather than using the required enzyme cleaning solution;
B. Employees' failure to adequately stock essential supplies on cardiac crash carts; and
C. Employees' failure to wear PPE while working within SPS.

Allegation 2A: Employees' failure to properly clean dental hand pieces, washing them only with water rather than using the required enzyme cleaning solution
Paragraph #1: "other types of dental hand pieces include drill parts
and low speed hand Pieces." **Whistleblower:** What are the specific instructions to clean these, as these were the items I have the concern about? We were "cleaning" these with water and gauze only, prior to sterilization. ***Water is not an effective cleaner for blood.*** At no time did I ever mention I had any concern about the sterilization process of the ***dental handpieces.*** Why did they not look up the manufacturer's instructions for these specific instruments? I was very specific when I explained this to them, as OSC was in their letter as well.
" OMI queried the Chief, Dental Service, about any reported concerns on the failure to properly clean dental hand pieces." **Whistleblower:** The Chief of Dental Service does not know how SPS clean the actual instruments, as he is not anywhere in the area at the time of cleaning. So as far as the actual procedure of cleaning, he would not be the person to question. The people who actually clean the instruments are the SPS staff. The SPS staff should've been questioned on how they clean the handpieces and then the manufacturer's instructions should've been checked and verified, since SPS Staff did not have access to the manufacturer's instructions until "mid-2013." Water does not remove the contaminant in blood and dirty instruments cannot be sterilized.

Allegation 2B: Employees' failure to adequately stock essential supplies on cardiac crash carts
Page 8
"During her interview, the whistleblower described this allegation as SPS' failure to have a sufficient number of back up crash carts available for the Medical Center on weekends and holidays. She did not provide specific dates or details for this allegation, nor did she describe any evidence of threats to patient safety."
Whistleblower: This is completely false, as it was specifically mentioned to them that the Agency could obtain several email conversations with myself and the previous SPS Chief. It was specifically explained that there were a lack of Respiratory Boxes on the crash carts and what was in the Respiratory Boxes. It was explained that the Respiratory Boxes have everything needed for Airway Management and without it, a patient's life could not be viable. The previous SPS Chief could not effectively take care of the issue and had me, the whistleblower, meet with the person in charge of Respiratory to try and settle the ongoing problem. The people involved in the investigation are MDs and RNs and should clearly understand the obvious "threats of patient's safety," respectfully speaking.
Page 9 Paragraph #1: "a cart can be appropriated from one of several clinic areas where patients are not present on weekends."
Whistleblower: There was a problem with the Endoscopy clinic, as the clinic could not open on a Monday, because they were missing their crash cart.(Two SPS Staff members work in that clinic and that is where the information was obtained.). Also, the Agency states, "SPS employees are available at all times, should they be needed to clean resuscitation equipment and an on-call policy for the SPS MSTs' when called during a night, holiday, or weekend, the SPS MST is expected to report for duty within 30 minutes." With all due respect, the Agency seems quite confused as they are giving a couple answers here.
Paragraph #2: "SPS employees are available at all times, should they be needed to clean resuscitation equipment."
Whistleblower: SPS Is not a 24 hour department. Simply false.
"In February 2012, the Medical Center instituted an on-call policy for the SPS MSTs' when called during a night, holiday, or weekend, the SPS MST is expected to report for duty within 30 minutes."
Whistleblower: There are several on going issues with SPS staff being unreachable. Not to mention, SPS Staff claim they are on call for scopes and OR instruments only. Again, this is information that could've been obtained from the SPS staff themselves.

Allegation 2C: Employees' failure to wear PPE while working within SPS
Page 10 Last Paragraph:

"OMI found evidence that management continues to take action to correct and control the issue, providing training for compliance with PPE standards, and appropriately managing cases of noncompliance , in their efforts to protect the noncompliant employees."
Whistleblower: This has been an ongoing issue since 2010, at what point do they start holding people accountable? The SPS Staff were trained as the Agency has admitted and as the Agency once again admitted, "there are posters" on the doors entering the decontamination area, pictures to show the SPS staff what they are to wear and how they are to wear it. Respectfully, An elementary student could appropriately don PPE, because of those posters. These SPS staff walk around the hospital going to various clinics, break and smoking areas, not to mention the places they go once leaving the facility grounds. If they were to contract an infection or disease, due to their negligence, they could potentially infect or transmit it to others (staff, patients, family and all VA visitors). Also, it is a Medical Center where immune-compromised patients and staff are, death could be imminent had they come in contact with contaminated SPS staff, carrying germs, secondary to their failure to properly don PPE. The Agency has a policy that scrubs are not to be worn off the facility grounds. It seems very obvious, that SPS Staff's negligence to properly contain the germs through the disposable PPE is a far more serious matter.
On **page 6 "Conclusion:"** "OMI did not substantiate the allegation that the Medical Center managers have failed to properly train SPS employees. Historically, all full-time SPS MSTs achieved Level 1 and Level 2 training certifications."
Whistleblower: Yet, a simple task of donning PPE cannot be controlled by SPS management, so not really understanding how they can be succeeding in their training.

Additional Issue 1:
The whistleblower alleges that on October 22,2013, two instrument sets opened in the catheterization suite were found to contain blood and had to be returned to SPS for additional cleaning.
Page 11 Paragraph #3: "OM I interviewed the chief, SPS, and reviewed the close call report for this event, which included photographs of the forceps and the SPS tray count sheet. The Chief reported he was notified by OR staff of this discovery. He went to the catheterization suite and viewed the first tray, reporting that he saw nothing untoward in that tray, He was shown a second tray that contained a forceps with "obvious blood." He provided a replacement sterile instrument tray, and queried OR staff about the event, He observed that the blood on the instrument appeared to be bright red, not dark-colored (as blood would appear if it had been present during sterilization). The Chief concluded that the blood was fresh and thus must have contaminated the instrument after the tray was opened in the catheterization suite.
He, nevertheless, addressed the matter with SPS staff, reinforcing the requirement that sterile trays receive two SPS inspection signatures before sterilization. The matter was reviewed and closed by the Risk Manager. OMI reviewed photos of the. instrument tray, confirming the bright red color on the forceps. OMI also reviewed the photo of the SPS tray count sheet for this specific tray, and confirmed the presence of two signatures, The close call report did not indicate a delay in care or an adverse event."
"while OMI substantiates that an instrument in an opened catheterization tray
appeared to nave a bright red substance on it, OMI could not substantiate the implication that this apparent blood was present on the instrument during sterile
processing. The tray was returned to SPS and a replacement tray provided. No
delays were reported and there is no evidence of an adverse patient event.
Whistleblower: Please refer to the attached emails from the SPS Chief Dated 0ctober 22, 2014, as he admits that the trays were in fact contaminated by the SPS staff. He also, claims there ***was*** in fact **"several"** delays in patient care, because of it.

"Recommendation
The Medical Center should:
Continue the SPS practice of two-person sterile tray inspections and two-person signature sign-offs on sterile processing product inspections."

Whistleblower: Respectfully, it seems very evident that the "two signature," theory is ***not*** working effectively, as stated in the attached emails by the SPS Chief himself. He complains about SPS staff not using the "two-signatures" in emails just weeks apart. Maybe it is accountability, or lack there of, that is the actual problem.

Additional Issue 2:
The whistleblower alleges that SPS employees frequently fail to place sterilization indicators in peel pouches and sterilization locks on OR trays, and are mislabeling the number of instruments in sets, which requires those items to be reprocessed. On one occasion in 2011, the missing sterilization lock on an OR tray was not discovered until it was about to be opened in the OR.
Page 13 Conclusion:
."OMI cannot make a conclusion about the increase in Close Call reporting of the frequency to "fail to place sterilization indicators in peel pouches and sterilization locks on OR trays, and the mislabeling of instruments in sets, which requires those items to be reprocessed." The increase may be the result of the Medical Center's greater emphasis on reporting and is evidence of a strong quality improvement environment, which supports SPS' opportunity to use data to strengthen their quality assurance and improvement efforts."
Whistleblower: With all due respect to the agency, This seems such a shocking response from MDs, RNs and people of such high regarded positions . If the evidence is there and clearly it is, then there would be an increase in close calls. It was admitted by the Chief of SPS, himself in his emails as well as the factual findings by OMI. When an item needs to be reprocessed there is the strong potential for delay of patient care. OR Personnel cannot identify an issue with instruments until the OR tray is actually opened immediately prior to surgery, as the OR trays must remain tightly sealed to maintain sterility. The OR trays are not transparent. In peel pouches, the items can be seen, but an integrator isn't always visible until the pouch is actually opened, as it can get caught up in the instruments. The instruments would have to be reprocessed. They get sent back to SPS and might not even get reprocessed immediately, if the work load is already heavy that day.
In the documentation from beginning from April 2010 (provided to the agency on December 6, 2013), concerns were mentioned of SPS Staff talking on their cell phones while attempting to assemble OR trays and doing other required work loads. SPS Staff were obviously distracted and many times things were not done appropriately, causing ***documented*** delays of patient care.

Why there is a graph regarding Sepsis, but not a graph regarding communicable diseases or death rate, since those are also critical things that can potentially result from the negligence of the SPS Department?

After reading the Agency's report, it was noticed that the issues raised in the documentation from the whistleblower, provided to the agency on December 6, 2013 were not investigated. The documentation was from April 2010 up until January 2012 and had many instances of SPS Staff leaving the department for hours, taking lengthy breaks, talking on their cell phones for lengthy amounts of time while attempting to assemble OR trays, etc. Please see the attached email by the SPS Chief dated September 30, 2014 claiming "job abandonment". The SPS Chief claims "excessive amount of trays not being assembled." The exact claims in the provided documentation from the whistleblower.

Again, with due respect to the Agency, It seems to be obvious the Agency hasn't taken any of the Whistleblower's allegations seriously. The investigation seems flawed in the respect that only a select few SPS staff were actually spoken with and all the allegations presented were not thoroughly or properly investigated. It seems the Agency ignored several allegations presented and they seemed to talk to many managers who honestly wouldn't know what goes on in SPS, let alone how

the department should properly function. I wonder if the agency will attribute the most recent close call concerning the fecal matter on the scope button as " result of the Medical Center's greater emphasis on reporting and is evidence of a strong quality improvement environment, which supports SPS' opportunity to use data to strengthen their quality assurance and improvement efforts."

This report is respectfully submitted by myself, Whistleblower Lisa Marie Magin on April 15, 2014

There was no mention of the Report of Contact Dated March 4, 2014, regarding the fecal matter left on a supposedly sterilized scope button. And it is my understanding that the emails provided by SPS Supervisor will be supplemented into the report upon investigation.

During the month of April 2010

I been having issues with people at work. I have been speaking to my boss Sue Swords. She told me I need to speak to Kathy as I am new to the department and have "fresh eyes". I met with Kathy and Sue to tell her the issues I was having with Sherri and Jennair. They both were nasty and bossy to me I told them I don't want to 'cause any problems, just want to do my job to the best of my ability. I work with lori, who is also white. Jennair told me a lot of negative things about lori when I first started. I listen, but don't judge her as I don't know her. It seems everyone has a problem with lori. I don't know why as lori seems to be the hardest working person I've came across. Lori told me no one talks to her and she is very isolated.

I had another meeting with Kathi regarding Sherri and the way she works. Sherri is always concerned with what everyone else is doing, yet she isn't worrying about her own work. Sherri and I got into an argument in decontam, because SHE noticed the paper of the Steris machine was red-lining. She screamed "Lisa, why can't you change this paper?" I said "I didn't even notice it. I'm busy." Sherri went on screaming and Sue Swords came in and told us she wanted to see us in her office. Sue asked us what was going on, Sherri did all the talking and Sue said "Are you ok Lisa? You seem intimidated by Sherri." I shook my head yes. I have to work with everyone and I do not want to cause problems.

During the month of May 2010 Diane, Lori and myself have been complaining to Sue Swords about the fact that we are all working hard and our black coworkers would stand around and do nothing or they would gather around the computer, Kathy would walk in and talk to them like nothing. Lori, Diane and myself would be the only ones working. Sue says she is aware, however, she was told us she cannot discipline, so her hands were tied. She told us to keep going to Kathy. We told her Kathy does nothing. Sue said she understands and her hands were tied as well. Sue said that Liz had told Sue and Kathy if they were to discipline anyone, make sure it's the "whitey" as they do not want any EEO complaints. In fact, every time Sue would tell Sherri to do her job, or to do something the proper way. Sherri would run around the department saying she was going to the EEO constantly accusing Sue of racial discrimination.

She told us, the 3 of us need to go upstairs and speak to Liz Weiss.

On or around the end of May 2010, Kathy asked me into her office and told me her and Sue Swords have been noticing that I have been taking my breaks and lunch alone and have noticed me leaving here in tears. Kathy asked me what was wrong. I told her I was having problems with Jennear Quarles. I told her Jennear trained me one way and then suddenly she would give me an "attitude" and tell me I wasn't doing things right and that she never taught me "that" way, in a nasty tone of voice, even though she DID tell and/or train me the way I was doing things. As soon as I would come in at 0600, Jennear would start "flipping" out on Laurie Depzynski and me about "everyone" not doing the work they should, when in all actuality Jennear was one of the ones pushing HER work onto us. Jennear had both Laurie and I in tears and we haven't even left the locker room, at that point. Jennear became "nasty", 'causing me to stay away from her. On or around the beginning of June, I had left decontam and went to prep and pack to help do some work, as the work in Decontam was done. I went over to prep and pack as I always have when the work had shifted from decontam to prep and pack. Erian Felder said "hey, you have to go back into Decontam as Sherri (Collins) and Jennear (Quarles) were complaining to Erian that I was over there. I asked Erian what the "issue" was and he said "I don't know, but they are complaining that you are over here." I walked back and as I went to go into decontam Jennear, Sherri, Ebony Statton, and Vanessa Hatten were all just standing at the door. I noticed Jennear with a "smerky" grin on her face and Sherri was laughing. I went into decontam where Laurie Depzynski also happened to be, and I broke down into tears, as I couldn't understand why this was happening. Laurie tried to keep me from crying and tried to appease me. Kathy asked if she moved me to another shift, if maybe that might rectify the situation. I gladly agreed, never truly understanding why Jennear and Sherri were acting in this way. I went to 1230-2100 on June 21, 2010.

On or around the end of June 2010, I had a couple informal conversations with The Chief Union steward, Gerry, as to the events of that were taking place in SPD. I told him I felt like I was being harassed and I had no idea why other then Jennear and Sherri having personal issues with me. I told him I was told they had problems with me, because I was friends with Larry Owens and the fact that he is black and I, white. Gerry told me to document and let him know if it continues.

On or around August 12, 2010, Kathy asked me into her office and told me Wade Garner had been complaining that "every time" he comes into Decontam at the start of our shift, that I would leave and go to the prep and pack side. I simply told Kathy that "you said if the work is done in decontam, go to the clean side and help them out, I couldn't see myself standing around with Wade in Decontam when all the work was in prep and pack." Kathy agreed with me, but said it was brought to her attention, so she had to address it. I told her I felt I was being harassed and I need it to stop as I have done nothing to deserve this. She then asked me if I wanted to be moved to the 1500-2330 shift and again, I said "definitely". So on or around August 16, 2010, I was moved to that shift.

On or around August 16, 2010, Erian knew of the way I felt about Wade Garner and had everyone on our shift sit down to talk things out, as Erian likes to keep things running smooth. So., Erian, myself, Diane Rogowlski , Wade and I were trying to "iron" our issues out. I told Wade I didn't appreciate the fact that he went to Kathy about something he could have just told me himself at first. I told him "I am a 44 year old woman and I like to handle "issues" as an adult, we aren't in high school and we don't need to run to the principal, per say." Wade told us that "I said, I only went to Kathy, because Jennear told me to." I

told him "well, you are an adult and you can make your own descions, Jennear has an obvious problem with me and she is just trying to continue them, while dragging you into it." I told him that I was told Jennear had problems with me being friends with Larry Owens, for whatever reason, because I have done nothing wrong. He said "ok". Then I told him "I didn't appreciate the time I told you you left blood and tissue on the table in decontam and then told me "no I didn't", as if I was lying. Why would I lie about that? I told you to your face, I didn't run to Kathy, so it makes no sense that I would make this up." He said "well Larry checked before we left and he said everything was good." I said, "ok, I'm just saying I didn't appreciate how you made it seem like I was making this stuff up." Then I told him I didn't care for his attitude and how he spoke to Erian in a condescending tone." Erian said "I'm not gonna lie, Wade, I don't appreciate that either, it's like you're always trying to brush me off." Wade explained "that's just how I am." I said "sometimes Erian talks to you and you don't even acknowledge him". So Wade said "alright". And Erian said "See Wade that's exactly what you do." So Wade said that's just how he is.

During the month of September, Sherri Collins would get on my case about work that the day shift didn't do as soon as I would walk in the door. I simply explained myself, once again, and told her I didn't appreciate what she was doing. Then I attempted to settle this matter as an adult and explain to her that I was tired of her jumping down my back the minute I walked in the door and why was she trying to put their work onto us, when clearly the day shift had ample amount of time to do the work and then some. I showed Sherri that everyone's work is documented and it was obvious that the day shift was dumping their work onto us. She became irate and posted some nasty things on Facebook. So, I went to Kathy and Kathy asked what my problem with Sherri was and I explained the incident as stated above. She asked if she should get a mediator in here and have a "sit down" with Sherri and I. I didn't agree at this time, because I felt it was both Sherri and Jennear that were the problems and quite honestly, thought it would just make matters worse for myself, because these women are obviously out to get me. Kathy said she knows, I try to be "superwoman" and to "back off" a little. She said don't be a "slacker" but just not work so hard and that my work standards are much higher than theirs. In any event, that is not my nature and I will continue to work hard. I enjoy being busy.

On or around the end of February or beginning of March 2011, Kathy had gone on Vacation. While she was off, Jennear had pasted a description of what a Lead Tech does on the scheduling board, our agenda board and apparently Erian Felder's Locker. I had told Kathy about it when she came back. I told her, how they waited till Kathy was off to do this and then they had taken them down when she had come back. I found this childish and inappropriate as these women were trying to cause problems. I wanted her to be aware and see what's really going on here. These women were so consumed with what we were doing and yet, they weren't doing their own jobs.

On March 17, 2011, it was brought to my attention that Jennear had gone to Kathy and said the night shift was leaving early. I was upset, as I feel now they are messing with my livelihood. I told Kathy that this is getting out of hand, now this is affecting my family. Kathy said she doesn't understand what I mean, and I told her, w/o my income, my family suffers. Kathy told me to keep doing what I'm doing and I have no worries, I will not lose my job. I talked to several people and union stewards and they told me, I need to document and file a formal complaint. On or around March 10, 2011, Erian Felder and I were in

decontam doing our work and talking about non-work related issues. Sherri Collins came out of the women's bathroom and turned to Erian and me and said "let's take this outside". We looked at each other confused and had no idea what she was talking about. I wasn't sure if she was talking to me or Erian, but either way, I felt it was completely inappropriate and uncalled for. I felt she was making this a hostile work environment and obviously I felt threatened. This came out of nowhere and I wasn't sure if she had a weapon or something to really 'cause harm.

On or around March 24, 2011, Herb Yazzie was the supervisor while Kathy was on vacation. He was questioning us about an issue with the autoclave and why things were left the way they were. Erian had explained he left a note on the agenda board and Herb said he never saw it. So SOMEONE had erased the note between 0600 and the time Herb went in the back to check the autoclave. Jennear and Sherri were both on the prep and pack side that day. Now I'm very upset, because this is now affecting the patients. During our meeting with Herb, I asked Herb why half of the hand towels (Erian, Shannon and I folded, wrapped and put on the sterilization cart the night Before) on the cart were taken off and not sterilized. Herb responded "Because They weren't labeled". I said "Why couldn't they just label them themselves and Sterilize them, so we have them? I saw how busy Sherri was standing around". And Herb just went back to saying "the towels weren't labeled". Shannon said "she Could've labeled them on the cart, she didn't even have to take them off." Herb Just rambled on about something else and the issue was once again, ignored. I explained this to Herb and he started bringing up things that didn't pertain directly to our shift stating "people on nights leave early". Erian, Shannon Cross and I felt like he was trying to accuse us. I went to union steward Jim Carney and he wrote down everything I needed to do. Herb had written that he wanted a meeting with Erian, Shannon and I on Monday March 28, 2011. I told Jim this and Jim said he would be up here Monday to join us in this meeting. Apparently Jim had come up here at 1500 on March 28, 2011, to which Herb told him there wasn't a meeting. I purposefully saved the card that states his meeting request. In any event, Herb took me in the area between Decontam and prep and pack and asked me what was going on. I told him I was really upset that these women are trying to sabotage us and now it's affecting the patients. I don't appreciate it as I have a great passion for our Veterans. Then he said, these issues have been going on as long as he has worked here and proceeded to give examples of past experiences. I nicely told him "Herb, no offense, but I don't care about what happened back then, I care about now." Then Herb said, "see, that's the problem, everyone wants to run to the union". I said "Herb, these issues have been going on since I started and things are getting out of control."

On March 30, 2011 @ approximately 2000, Erian Felder was wondering where Wade was. Erian asked me for Wade's phone number so he could track him down. In front of Shannon Cross and myself, Erian called Wade and said "Wade, where are you? I hope you didn't leave the building, or I'm going to have to tell Kathy". Approximately ten minutes later Wade showed up never saying a word to any of us as to where he was.

On March 31, 2011 Erian Felder had called in. Wade and Shannon Cross were walking through decontam at approximately 1630 and Wade was saying "oh there isn't going to be any talking with this mother fucker, I'm going to put my fist through the back of Erian's fucking head". Shannon said "Wade, that's some hood shit, this is not the hood, this is work, I don't want to hear that shit."

On April 27, 2011 We had noticed that the day shift had 12 CPL pacemaker cords done up and ready to be put in the GAS load, despite the fact that there are sheets on each sterrad machine to refer to as to what can be sterraded. Erian Felder had wrote a note and left it on the load for the day shift stating "All of this can be sterraded, we are trying to use gas as little as possible, so please sterrad this. Thank you".

On April 28, 2011 Sherri Collins had obviously disregarded the note and put the CPL cords in the gas load. This is a breach in patient care as the CPL cords could've been ready in 45 minutes as opposed to 17 hours. Also, upon my arrival at work, Herb Yazzie and Sherri Collins were standing around talking about non-work related issues when a code cart from days was to be done. Again that was left for us and Erian asked if we could please make sure it gets done. So.. I did it for the main reason I'm here, for the patients.

On September 13, 2011, Erian Felder and Mari Daniels left me four loads to put away and two sterrad loads as he and Mari sat in the break room for two plus hours.

On September 27, 2011 Erian Felder gave me "orders" before taking his break, as per usual. He TOLD me to do the linen cart and then proceeded to say "don't do it and see what happens".

On October 17, 2011 I was in decontam and Shannon Cross, Mari Daniels and Erian Felder were on the prep and pack side. I had cleaned a code cart and they apparently had left it for me to reassemble, despite it being their jobs.

During the week of October 3 thru 7 as well as the week of October 17 thru 21st, I was in decontam alone while Erian Felder, Mari Daniels and Shannon Cross were on the prep and pack side. I am expected to finish in decontam and go to the prep and pack side to finish up the work I had originally pushed through, according to Erian.

I am left alone in decontam, despite the fact that Erian Felder is supposed to be in there with me. On the other hand, Shannon Cross and Mari Daniels work in decontam together.

I was the only one in the department @ 1600 hours on October 26, 2011. Kathy Hoezlel came and asked me where everyone was. I said "IDK, I never know where they are." Kathy brushed it off saying "It's 4:00, they are probably at lunch"

On October 31, 2011 I was working in Decontam, Kathy walked by and saw all the work I had. Erian, Marisol , Shannon and Kelmah Liverpool were all on the prep side. Kathy said "do you need help? I am witness to what's going on" I said "I'm used to it." Kathy knows there should be two people in decontam. Erian was supposed to be in there with me.

On November 8, 2011 Erian and Marisol worked in decontam while together and once again leaving me to do all the work alone. Erian and Marisol stayed for OT (and did nothing). The ETO alarm went off and Erian Felder had the "monitor" on. Kathy told me "when Erian Leaves, make sure you wear the monitor". Erian was not in the department with the monitor for an hour and half, then stayed telling Marisol "we should stay for OT and fold towels, because you know Kathy ain't gonna ask the day shift to do it."

On November 9, 2011 Erian was missing out of the department for approx. an hour and half.

I was in prep Pack

On November 10, 2011 Erian Felder asked me to wrap and push towels, the entire table full. I didn't say anything and Erian said "but I asked you, right?" I said "yep". Erian was once again gone out of the department for approx. 2 hours. All Erian did while I was working and when he was in the dept. was fold towels. I was in prep in pack and did everything that needed to be done, was done by me. I had went and picked up a code cart from er. I came back up and Erian asked ME to clean and reassemble the code cart. I did, however, Marisol should've cleaned it, as she was in decontam with nothing going on. Erian was folding towels.

The day before Erian shoulder butt Me.

On November 14, 2011 I was told Erian came in to meet with Kathy @1030. As Kathy was leaving, she said "I need to ask you something." I said "do I need a union steward, she said "no". Kathy started asking me about wrapping "a pack" of towels Erian asked me to fold. I told her "I didn't do it, because I do everything else". (not thinking at the time, but Erian did not ask me to fold "a pack", he asked me to wrap up the entire table full, that's why he left everything on the table for me.) I asked "why is it that Erian isn't expected to put his eight hours in decontam?" Kathy said, "Lisa, I asked you about the towels and you are going off on other things." I said "because this goes so much deeper then wrapping "a pack" of towels, I want a union steward". She said she was going to offer Erian a union steward as well and that she has to leave so, so we are going to have to do this another time. I was in decontam.

On November 14 and 15,2011 Marisol and Erian left me a load to put away. The load came out at 2003 and was still sitting there when I had got done pushing the decontam stuff through and when they left @2100. It's not a big deal, but just proving my point of Erian leaving his work for me, because he can.

On November 21, 2011 Marisol sat in the break room from 1800 till 2015

On November 22, 2011 Mari sat in the break room from 1730 till 1930

On November 29, 2011 Kathy asked me who was supposed to be in decontam and I said "it's supposed to be Marisol, she hasn't put in an 8 hour shift in decontam since she got here." Kathy became all upset and waved me off and said "I'll just go check the schedule". Marisol folded towels and did some of the urology while talking on her phone for over an hour.

On November 30, 2011 Marisol sat in the break room from 1740 till 2000

On December 6, 2011 Kathy walked by me as I was putting a work order in. I simply told her, I had put a work order in for the sonic yesterday, because the lid was broken. I had put one in yesterday and Today, Mari was putting the entire TWO Omni retractors in ONE pan and loaded it onto the sonic. I told Mari not to and why. Mari ignored me and continued to slam the tray onto the sonic. Kathy very snottily said as she was walking away, "anything else you need to tell me?" as she was walking away. I said "Nope".

On December 8, 2011 I was told by the day shift that Kathy was calling them in their office to ask if they heard anyone speak with foul language, however, she never called me into the office to ask me.

On December 14, 2011 All Mari did was fold towels. All work was done by me, even a case cart in Decontam. Mari was on break from 1830 till 2010.

On December 22, 2011 Kathy had Marisol doing LMS from 1600 until the time she left @ 2100, leaving Shannon in decontam and myself in prep n pack to do all of the work that normally she has a full staff do. I did everything that needed to be done, by myself.

On January 9, 2012 Kathy and Dee come up to me and Kathy said "Next time you leave early, you need to let someone know." I said "I let Shannon know". She said "no, a supervisor." I said "we have never done that in the past." She immediately got cocky, like she always does when I ask her a question and said "I always knew when someone was leaving early in the past." I however, know this not to be true and even asked my coworkers and they also agreed that we never had to let a supervisor know in the past.

On January 10, 2012 Marisol was talking on her phone while doing trays from 1845-1945 or longer as I went back into Decontam, so not sure if it was even longer. I told Marisol she needed to lay the cataract trays flat. She ignored me and laid them on their side.

On January 12, 2012 Shannon was out of the building for over and hour, from 1830 to 1945. James Carney was also in the coffee shop and was a witness to seeing Shannon leave and return with his coat and hat on.

On January 17, 2012 Shannon and Marisol were on break from 1815 till 1945

On January 18, 2012 I told Marisol she needed to run the tubing from 8a and she kept insisting the tubing was wet when it was dry.

On January 19, 2012 Marisol and Shannon were on break from 1815 till 1930

On 1/23/12 at approximately 1730 Marisol Daniels came into prep and pack and said "Are these dental handpieces done?' I said "I already ran some and we need to get these OR trays done." Marisol said "That's not what I axed you." I said "Well what do you think?" Marisol said "FUCK YOU." I ignored her response and kept working.

On 1/24/12 Marisol followed Shannon Cross around not helping in prep in pack. Also, Marisol was only wearing an opened whit jacket in decontam when she was in there.

On 1/25/12 Bob the nursing Supervisor grabbed my in the hall and asked me to follow him into his office and asked me what was going on, as he said I was "visably shaken."

From: Mccurdy, Larry L
Sent: Wednesday, September 04, 2013 2:38 PM
To: VHABUF SPS
Subject: staff meetings

Good afternoon All,

There will be no staff meeting this Thursday, we will start having staff meeting once a month and pass information via email in between time there will be a CREW meet next Thurs 09-12-13 at 1300.

Additionally I prefer the approach of teaching and learning but it is getting out of control where we are not labeling set correctly or not counting properly saying there is 6 items and there may only be 4, please consider this as a wake-up call for everyone focus on the set that you are doing at the time. Label sets and item correctly it is causing patient to be exposed to anesthesia

Larry L McCurdy CST CRMST
Chief SPS
3495 Bailey Ave.
Buffalo, N.Y 14215
716-862-8669

From: Mccurdy, Larry L
Sent: Monday, September 30, 2013 3:12 PM
To: VHABUF SPS
Subject: Job abdonment

Good afternoon,

During an walk through of the department it was noted that there was an excessive amount of trays not being assembled, unexcitable upon inquiring about staff members, you have a right to go to the union office you must get permission to go, NO ONE IS TO GO TO THE UNION WITHOUT GETTING PREMISSION, you will be count AWOL, from the time I notice that you are gone until the time I see you back in the space. This also is part of your union reg.

Thank you,

Larry L McCurdy CST CRMST
Chief SPS
3495 Bailey Ave.
Buffalo, N.Y 14215
716-862-8669

From: Mccurdy, Larry L
Sent: Monday, October 07, 2013 12:30 PM
To: VHABUF SPS
Subject: Second.Sig.

Importance: High

Good afternoon,

Effective immediately every set must that is assembled must have a second signature, this is getting ridiculous that people is saying that there is 2 items on a set when there is only one or the is items that are on sets that are not there. Are we not counting the items, everyone must have a second verifier on all trays assembled for the Operating Room.

Also there are 3 4mm 0 degree that belongs to the ENT clinic these scopes look like Arthroscopic scopes but they are not they are ENT, the container has one of the green cards that was bought to identify Batavia stuff but they have ENT written on them, "DO NOT SEND THESE SCOPES TO BATAVIA" . Label them as ENT Clinic and send them back to ENT, the scope with the light cord each one has a light cord with it..

Thank you

Larry L McCurdy CST CRMST
Chief SPS
3495 Bailey Ave.
Buffalo, N.Y 14215
716-862-8669

From: Mccurdy, Larry L
Sent: Tuesday, October 08, 2013 3:56 PM
To: VHABUF SPS
Subject: crew

Good afternoon,

1. Thursday is CREW training is mandatory for everyone, if you got any questions as to if you have to attend talk to me, but the answer will be yes you have to attend.
2. This is for everyone it is important that we reduce the number of close calls that is being generated I will be meeting with the OR to address some identified issues but we have to do what is expected of us in a professional manner, I don't buy into the concept "The beating will continue until the Moral improve". So that being said I do expect people to do their job and to do it correctly. And I will discuss with Sue and Dee how we can help each other.
3. Remember get a second signature on all trays.
4. It has come to my attention that there is abuse of the Scrub wearing policy, as to who is authorized to wear scrubs and where there are to be worn and where ensure that no one is wearing scrubs off the compound, nor in placing that you shouldn't be wearing them.

Thank you,

Larry L McCurdy CST CRMST
Chief SPS
3495 Bailey Ave.
Buffalo, N.Y 14215
716-862-8669

From: Mccurdy, Larry L
Sent: Tuesday, October 22, 2013 12:22 PM
To: VHABUF SPS
Subject: Solid Instruments set

Afternoon All,

Today there was several instruments sets opened in the Cath Lab that was dirty, upon examine of the sets 2 of them contained blood, the first part of assembly of a set is inspection of instrumentation before putting in the tray, this step was obvious missed on f few occasions, all is to be manual cleaned prior to putting the in the ultrasonic or automatic washer and inspected for cleanliness as well as proper functionality the first place this should be done is in decontamination, and finally in Prep during the assembly process> This is the last day that Cath Lab or any place else will receive dirty instruments from people not inspecting sets, any farther instances of this will be handled as a behavior issue not as a performance issue, or you not knowing jobs, I am convinced that everyone here knows their job, so do your jobs. This issue led to several patient being delayed.

Thank Larry,

Larry L McCurdy CST CRMST
Chief SPS
3495 Bailey Ave.
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