



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

February 26, 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-14-1057

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Philadelphia Department of Veterans Affairs (VA) Medical Center, Philadelphia, Pennsylvania (hereafter the Medical Center). The whistleblower alleged that Nutrition and Food Service (NFS) employees at the Medical Center are noncompliant with sanitary standards and the Chief, NFS, does not correct their shortcomings. 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 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 on November 18-21, 2014, and substantiated both allegations, finding violations of VA and VHA policy, gross mismanagement, and a substantial and specific danger to public health and safety.

VA made three recommendations to the Medical Center and one to Veterans Integrated Service Network 4. Findings from the investigation are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in blue ink that reads "Jose D. Riojas".

Jose D. Riojas
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Number DI-14-1057**

**Department of Veterans Affairs
Philadelphia Veterans Affairs Medical Center
Philadelphia, Pennsylvania**



Report Date: February 3, 2015

TRIM 2014-D-1255

Executive Summary

The Interim Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a VA team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Philadelphia Department of Veterans Affairs (VA) Medical Center (hereafter, the Medical Center), located in Philadelphia, Pennsylvania. Troy Thompson (hereafter, the whistleblower), who consented to the release of his name, alleged that Nutrition and Food Service (NFS) employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on November 18–21, 2014.

Allegations

The whistleblower alleged:

1. NFS employees habitually fail to comply with sanitation standards while handling food; and
2. The Chief of NFS has not taken appropriate action to ensure employee compliance with sanitation standards despite being aware that violations were regularly occurring.

Allegation 1 is comprised of 14 individual suballegations; all but 1 were investigated by VA.

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 with reasonable certainty whether the alleged event or action took place.

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

Conclusion for Allegation 1

VA **substantiates** Allegation 1. Of the 14 suballegations included in Allegation 1, we substantiated 9, did not substantiate 4, and did not investigate Suballegation 5, based on the whistleblower's retraction of record.

Recommendations to the Medical Center

1. Develop a plan to address each of the nine substantiated suballegations, and
2. Develop performance metrics to ensure compliance and sustainability of the measures put into place pursuant to the plan developed under Recommendation 1.

Conclusion for Allegation 2

VA **substantiated** that the Chief of NFS has not taken appropriate action to ensure employee compliance with sanitation standards, despite being aware that violations were regularly occurring. Although there is evidence of documents signed by the Chief addressing deficiencies, staff members who were interviewed consistently maintained that there was a lack of enforcement. So, based on the continued inappropriate behavior or condition, her corrective actions could not be found to have been adequate.

Recommendations to VISN 4

3. Perform a comprehensive, top-to-bottom management review of the NFS.

Recommendation to the Medical Center

4. Take appropriate disciplinary, administrative, or instructional action against the Chief of NFS.

Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a Human Resources (HR) perspective to establish accountability for improper personnel practices when necessary.

Based on its investigation, VA found violations of VHA policy, gross mismanagement, and a substantial and specific danger to public health and safety. VA found; however, no violation of law, rule, or regulation. No changes to VA policy or practice are planned as a result of this investigation; however, pending the release of this report, VA will determine the need for disciplinary action, particularly with respect to the management of this service line. VA will inform OSC of any personnel action(s) taken based on this investigation via supplemental reporting if requested.

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I. Introduction

The Interim USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center. The whistleblower, who consented to the release of his name, alleged that employees are engaging in conduct that may constitute violation of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health.

II. Facility Profile

As a member of Veterans Integrated Service Network (VISN) 4, the Medical Center provides health care to more than 57,500 Veterans in the city of Philadelphia, plus six surrounding counties in southeastern Pennsylvania and southern New Jersey, and is an acute referral center for VA health care facilities in eastern Pennsylvania, Delaware, and southern New Jersey. The facility has 145 acute care beds, a 135-bed Community Living Center (CLC), and operates community-based outpatient clinics (CBOC) in Fort Dix, Gloucester County; Camden, New Jersey; and Horsham, Pennsylvania. The Medical Center is affiliated with the University of Pennsylvania and numerous other allied health schools and colleges. Providing treatment in more than 460,000 outpatient visits annually, the Medical Center offers comprehensive surgical, medical, and psychiatric care, including special emphasis programs in alcohol- and drug-dependence treatment, and rehabilitative care.

III. Specific Allegations of the Whistleblower

The whistleblower alleged:

1. NFS employees habitually fail to comply with sanitation standards while handling food; and
2. The Chief of NFS has not taken appropriate action to ensure employee compliance with sanitation standards despite being aware that violations were regularly occurring.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of (b) (6), MD, Deputy Medical Inspector from OMI; (b) (6), RN, BSN, MSN, CPUR, Clinical Program Manager from OMI; (b) (6), MA, Health Systems Specialist from OMI; (b) (6), BA, RD, Quality Management Coordinator from VISN 3 Commissary in Nutrition and Food Services; and (b) (6), MBA, HR Specialist. The VA team reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents that are listed in Attachment A.

The VA team interviewed the whistleblower via teleconference on November 6, 2014, and in person on November 18.

VA conducted a site visit at the Medical Center on November 18–21, 2014, commencing with an entrance briefing with Medical Center leadership: the Director, Chief of Staff, Associate Director for Clinical Operations, and the Associate Director for Patient Care Services and Nurse Executive. The VA team toured the Medical Center's NFS area, which included the food preparation areas in the main hospital and in the CLC. We interviewed the following Medical Center employees:

- (b) (6), Chief, Volunteer Service
- (b) (6), Chief, NFS
- (b) (6), RN, Patient Safety Officer
- (b) (6), Associate Director for Clinical Operations
- (b) (6), Inspection (pest) Control
- (b) (6), Associate Director for Patient Care Services and Nurse Executive
- (b) (6), Food Service Supervisor, NFS
- (b) (6), Nurse Manager, CLC
- (b) (6), Registered Dietician (RD), Administrative Dietician, NFS
- (b) (6), Employee, NFS
- (b) (6), Environmental Management Service (EMS) employee
- (b) (6), Associate Chief, Nursing Service, CLC
- (b) (6), License Practical Nurse, CLC
- (b) (6), MD, Behavioral Health Physician
- (b) (6), MD, Clinical Pathology
- (b) (6), RD, CLC Dietitian
- (b) (6), RN, Quality Management Director
- (b) (6), RN, Infection Control Inpatient
- (b) (6), Employee, NFS, CLC
- (b) (6), Employee, NFS
- (b) (6), Employee, NFS

We held an exit briefing with the same Medical Center leadership who had attended the entrance briefing.

On November 24, the VA team held a conference call with the whistleblower to seek clarification on one of his allegations.

VI. Findings, Conclusions, and Recommendations

The Medical Center's NFS prepares and serves daily meals from a main food preparation area in the hospital, and a smaller one in the CLC, to Veterans in the acute

care hospital and in the CLC respectively, from 7:00 a.m. to 7:00 p.m, 7 days a week. The service is staffed by a Chief (who is an RD), other RDs, RD technicians, food service supervisors, cooks, and food service workers, who assemble food trays and deliver them to the Veteran dining areas. Food service supervisors provide the first level supervision of employees performing food service tasks.

Allegation 1

The Nutrition and Food Service (NFS) employees habitually fail to comply with sanitation standards while handling food.

In his complaint to OSC, the whistleblower alleged 11 specific deficiencies as instances of failure to comply with sanitation standards, and he cited 3 additional deficiencies in our telephone interview with him. We addressed these 14 suballegations in our investigation of Allegation 1.

Findings

VHA Handbook 1109.04, October 11, 2013, *Food Services Management Program*, (the Handbook), based on the 2009 Food and Drug Administration (FDA) *Food Code* and the *2009 Supplement to the 2009 FDA Food Code*, identifies general sanitation guidelines that all NFS personnel are required to follow. The guidelines in the Handbook provide standards against which all 14 alleged suballegations were evaluated.

Because Allegation 1 claims habitual failure to comply with sanitation standards, the VA team **substantiated** a suballegation when we found evidence that the deficient behavior or condition alleged in the suballegation continued after it had been addressed by management either in writing or orally. We considered continued deficient behavior, or a deficient condition to be present if we observed it on our tour of the NFS areas, or if the preponderance of our interviews indicated it was still occurring or present. We **did not substantiate** a suballegation if the deficient behavior or condition had occurred in the past, but we did not observe it on our tour and the preponderance of the interviews indicated that it was no longer occurring.

Suballegation 1

NFS employees fail to wear beard guards or hair nets.

Section 26 a.(4)(d) of the Handbook states: "Hair Restraints–Hats, hair coverings or nets, beard restraints, and clothing that cover body hair are to be worn in food production and food service areas."

VA observed three employees in the NFS areas not wearing beard guards; other employees were wearing them, but not correctly. Beard guards did not cover the upper lip areas of employees with mustaches. We brought this to the attention of the

employees and their supervisors during the tour, and the employees corrected their beard guards at this time. In addition, VA observed three NFS employees without hair nets. On interview, we found that the Chief of NFS expected the proper use of beard guards and hair nets to be enforced by the front-line supervisors.

Conclusion

Based on our observation, VA **substantiated** the suballegation that NFS employees were not properly wearing their beard guards and hair nets.

Suballegation 2

NFS employees wear soiled uniforms from the previous day's shift while preparing meals.

Section 26 a.(4)(e) of the Handbook states: "Uniforms must be clean, and changed daily. When working in refrigerated units, only jackets or coats issued as part of the uniform may be worn." Further, the Medical Center's Dress code policy of August 2012 states, "Unkempt-Any torn, frayed, ripped, dirty, soiled, or stained clothing, or clothing with holes, is prohibited."

Eighty percent of NFS employees interviewed reported that there are individuals who wear stained and wrinkled uniforms to work. Two supervisors acknowledged that some individuals do appear with dirty uniforms; however, they claimed that they called it to the employees' attention. We reviewed the minutes of the meetings between NFS Leadership and Supervisors from January 2009 to September 2013, and found that they discussed the employee dress code frequently.

Conclusion

VA **substantiated** the suballegation that some employees wear soiled uniforms in the food preparation area, based on our interviews with NFS supervisors and employees.

Suballegation 3

NFS employees fail to their wash hands after using the restroom.

Section 26 a.(4)(a) of the Handbook states: "Hand washing-Proper procedures should be followed, using designated hand sinks to wash hands immediately before engaging in food preparation; after touching bare human body parts; after using the toilet; after coughing or sneezing; after using a handkerchief or tissue; using tobacco; eating; drinking; after handling soiled equipment or utensils; during food preparation when switching between raw food handling and ready-to-eat food handling; and immediately before putting on and after removing disposable gloves. Designated hand sinks should not be used for any other purpose other than hand washing."

NFS employees interviewed generally agreed that this had occurred in the past, specifically with one employee; but that after it had been addressed, the behavior had not reoccurred. Infection Control staff includes NFS as part of their hospital hand washing surveillance program and reported that NFS was sustaining 100 percent compliance. VA observed various hand sanitizer dispensers throughout the NFS entrance, exit, and food preparation areas.

Conclusion

VA **did not substantiate** this suballegation, as interviewees agreed that the deficient behavior had ceased after employee counseling by a supervisor.

Suballegation 4

NFS employees chew toothpicks during food preparation or service.

Section 26 a.(6) of the Handbook states: "Employees must not chew gum while preparing or serving food, while in the food preparation areas, or in areas used for equipment and utensil washing. **NOTE:** Employees must only eat, drink, chew gum, or use tobacco products in designated areas." Although toothpicks are not specifically mentioned, this policy provision is intended to apply to any object in an employee's mouth that might fall into food during preparation, including saliva. For our purposes here, we thus find it reasonable to interpret the policy to have intended to include a prohibition on the chewing of toothpicks during the preparation or serving of food.

On interviews, the NFS employees and supervisors unanimously agreed that this deficient behavior had occurred in the past with one employee, but had not reoccurred since a supervisor addressed the problem with the employee.

Conclusion

VA **did not substantiate** this suballegation because our interviewees agreed that the deficient behavior had ceased after employee counseling by a supervisor.

Suballegation 5

NFS employees improperly dispose of waste.

The VA team attempted to determine the circumstances of alleged improper waste disposal during our tour and in our interviews with NFS supervisors and employees. Because we could not identify irregularities in waste disposal, we contacted the whistleblower again by telephone on November 24. He indicated that the improper disposing of waste occurred so long ago that he was unable to remember the details, but would think about it further. On December 9, 2014, we received an email from him stating "as of recent last 4-5 months this area has been maintained adequately to my surprise; I don't believe it is necessary to address at this time due to the efforts

displayed by the agency concerning my complaint to them." A copy of the whistleblower's email is in attachment B.

Conclusion

The VA team did not investigate this suballegation based on the whistleblower's retraction of record.

Suballegation 6

NFS employees wear jewelry such as braided, plastic bracelets and earrings during food preparation.

Section 26 a.(4)(c) of the Handbook states: "Jewelry can harbor microorganisms and may pose a safety hazard around equipment. Rings, (except for plain bands), bracelets (including medical information jewelry), watches, earrings, necklaces, and facial jewelry (such as nose rings, tongue piercings, etc.) must be removed. Necklaces, including medical information, must be secured underneath the uniform."

During our tour of the NFS areas, we observed one staff member wearing a large wrist watch on top of gloves and four individuals wearing dangling earrings hanging outside of hair coverings. In addition, we observed men and women wearing stud ear rings which were not covered by hair nets.

Conclusion

Based on the team's direct observation during the site visit, VA **substantiated** the suballegation that some employees wear uncovered jewelry in the food preparation area.

Suballegation 7

NFS employees use unclean ice machines and ice scoops for food service.

Section 26 a.(1) of the Handbook states: "All NFS areas are maintained in a clean, safe, and orderly working environment. A comprehensive sanitation program must be established that assures a procedure for cleaning and sanitizing equipment and work areas. The food service areas must be cleaned routinely to maintain sanitation. . . . Working surfaces, utensils, equipment, and other food-contact surfaces are thoroughly cleaned and sanitized after each period of use or at 4 hour intervals, if the utensil or equipment is in constant use."

Section 20 a.(8) of the Handbook states: Ice used for food or a cooling medium must be made from drinking water which is safe for consumption (potable). A closed system for ice making and automatic dispensing should be used."

Also, the National Restaurant Association Educational Foundation's *ServSafe Manager 6th Edition*, Chapter 6: page 6.5, (ServSafe) **Containers and scoops** advises, "Use clean and sanitized containers and ice scoops to transfer ice from an ice machine to other containers. Store ice scoops outside of the ice machine in a clean, protected location."

We did not find the ice machine unclean; however, NFS employees and supervisors interviewed agreed that soiled ice machines had been a concern in the past, but they explained that a contract with a cleaning service had since resolved the issue. Our review of the maintenance records showed that the ice machines are cleaned monthly.

During our tour of the CLC kitchen, we observed what appeared to be food on an ice scoop left on top of a serving counter uncovered and exposed. We brought this to the attention of the NFS employee working in that area, and he placed it in a bin for cleaning.

Conclusion

Based on direct observation during the site visit, the VA team **substantiated** that, on at least one occasion, an ice scoop was found to be soiled and left in the food preparation area. While the utensil was not properly placed in the appropriate bin designated for dirty utensils, the team did not observe that the soiled utensil was being used in actual food preparation and further we cannot comment on whether it may have been used for such purpose given that clean scoops were also there and available for use by staff.

Suballegation 8

NFS employees wear aprons while using the restroom and return to the food preparation area without changing those aprons.

Section 2 6 a.(4)(g) of the Handbook states: "A clean apron needs to be worn daily. Aprons need to be removed when leaving food preparation areas, and properly stored, prior to using the restroom or taking out the garbage."

During the interviews with NFS staff and supervisors, NFS employees and supervisors said that this deficient behavior had occurred in the past with one employee, but had not reoccurred since being addressed with the employee. In addition, we found signage indicating that all aprons needed to be removed prior to entering the restrooms on all restroom doors.

Conclusion

The VA team **did not substantiate** this suballegation because our interviews indicated that the deficient behavior ceased after a supervisor counseled the employee.

Suballegation 9

The walls and floors are dirty in the food preparation area.

Section 19 a.(1) of the Handbook states: "Facilities need to provide, safe, sanitary, and secure conditions for storage of subsistence, non-food supplies and chemicals."

In addition, Section 26 a.(1) of the Handbook states, in part: "All NFS areas are maintained in a clean, safe, and orderly working environment. A comprehensive sanitation program must be established that assures a procedure for cleaning and sanitizing equipment and work areas. The food service areas must be cleaned routinely to maintain sanitation. Cleaning must be done during periods when the least amount of food is exposed. This requirement does not apply to cleaning that is necessary due to a spill or other accident."

The FDA's Food Code 2013 page 76, *Preventing Contamination from the Premises* 3-305.11 Food Storage states, "(A) . . . food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor."

According to ServSafe, Chapter 5 page 5.10: "Keep all storage areas clean and dry. Clean floors, walls, and shelving in coolers, freezers, dry-storage areas, and heated holding cabinets on a regular basis... Clean up spills and leaks promptly to keep them from contaminating other food."

VA found dirty floors and walls in the CLC kitchen. The NFS supervisor in the CLC indicated that the Medical Center EMS had power cleaned the floors and walls, but because the kitchen has not been remodeled since constructed in 1985, it has a rundown appearance. However, we observed puddled water in areas that contained drains, and some of the walls appeared soiled. The NFS supervisor showed us the cleaning contract with a private company: they clean only twice per month and EMS cleans in between.

Conclusion

The VA team **substantiated** this suballegation based on our observation of soiled floors and walls in the CLC NFS area.

Suballegation 10

NFS employees do not properly cover dishes.

Section 20a.(7) of the Handbook states: "For foods requiring refrigeration (chilled foods), the time out of the refrigerator is restricted to 30 minutes or less. The critical safety limit for chilled foods is 10 degrees C (50 degrees F). If the internal temperature of chilled food rises above 10 degrees C (50 degrees F) during storage, preparation, or

distribution, the food must be discarded. Food preparation work must be completed away from heat sources such as ovens.”

Also, FDA Food Code 2013, page 68 (4) says, “store the food in packages, covered containers, or wrappings; (5) Clean hermetically sealed containers of food of visible soil before opening.”

In the CLC kitchen, we observed cooked eggs, uncovered and unmarked, next to the ice machine in the production area.

Conclusion

The VA team **substantiated** this suballegation based on our observation of uncovered and unmarked food in the CLC kitchen.

Suballegation 11

The NFS staff is not properly cleaning dishes.

Section 26c.(5)(a)-(d) of the Handbook states: *“The applicable temperatures are recorded according to local policy, by meal and are checked by Food Service Management. These temperatures for multiple tank ware washers are:*

- (a) Pre-wash, from 37.8 °C – 60 °C (100 – 140 °F);*
- (b) Wash from 66 – 71 °C (150 – 160 °F);*
- (c) Pumped Rinse, from 71 – 82 °C (160 – 180 °F); and*
- (d) Final Rinse, from 82 – 90.5 °C (180 – 195 °F).*

In addition, section 26.c. (6) provides that: “Conveyors in dish washing machines must be accurately timed to ensure proper exposure times in wash and rinse cycle per manufacturers’ recommendations.”

During our interviews with NFS supervisors and employees, we were told that, on occasion, dishes or silverware emerged from the dishwashing process retaining food residue, and that while occasionally there may be residual food on the silverware, exposing the dishes and silverware to the required rinse water temperature makes them safe for use. However, dishes or silverware with identified residual food should be removed from service until the residual food is removed, even though the item might be safe to use.

The VA team reviewed the dishwashing machine temperature logs for both the Medical Center and the CLC kitchen for the following periods in 2014, which were the only periods for which these data were available:

- Hospital kitchen: April 2014, and July–December 2014,
- CLC kitchen: May–December 2014.

The hospital kitchen recorded rinse temperatures were between 190/200 °F, within the safety standard. In the CLC kitchen, recorded rinse temperatures ranged between 190/197 °F, also within the safety standard.

Conclusion

VA **substantiated** the suballegation that dishes and silverware may not be properly cleaned based on our interviews with employees. However, we do not conclude that the occasional occurrence of residual food remaining on the dishes and silverware after automated dishwashing posed a substantial and specific danger to public health because rinse water temperatures of the machines were consistently within the temperature standard, ensuring that the dishes and silverware were safe to use.

Suballegation 12

NFS employees working in the CLC have left children unsupervised in the CLC area.

The NFS employees, supervisors and CLC Nursing staff who were interviewed all told us that in October 2013, a child of an NFS staff member had been left unattended in the CLC break room. We reviewed a written counseling statement given to that employee explaining that if the behavior continued, disciplinary action would be taken. Our interviews confirmed that this behavior had not reoccurred.

Conclusion

The VA team **did not substantiate** this suballegation because our interviews indicated that the deficient behavior ceased after a supervisor counseled the employee responsible.

Suballegation 13

Pests are not adequately controlled in the kitchen areas.

Section 26.f.(1) of the Handbook states: "The presence of insects, rodents, and other pests needs to be controlled and minimized by routinely inspecting incoming shipments of food and supplies, routine departmental inspections, and eliminating harborage conditions." Section F.(3)(c) calls for "inspecting behind refrigerators, freezers, stoves, sinks, and floor drains for signs of pests during daily walkthroughs by a designated nutrition and food service employee."

During our tour of the CLC kitchen, a team member observed a roach exiting a crack in the floor next to one of the pipes. In our interview with the EMS Pest Control Operator, he told us that he would set traps for mice or treat for insects as requested by NFS staff, usually after a NFS staff member had spotted a rodent, rodent droppings, or an insect. The request was made by a work order. He estimated that he was asked to evaluate the kitchen areas about once a quarter. However, in our interview, he was unable to

remember the last date he had treated NFS and CLC kitchens for pests. The VA team reviewed pest control maintenance records and work orders and found that throughout the years EMS has been on an ad-hoc basis rather than on a scheduled one. The last maintenance service took place on November 11, 2014.

Conclusion

The VA team **substantiated** the suballegation that pest control measures are not adequate in the Medical Center kitchen areas based on our observation of the insect in the CLC kitchen and our review of pest control records that indicate an ad-hoc approach is being taken to matters of pest control despite these being high-risk areas.

Suballegation 14

NFS management improperly forecasts the need for food products and supplies.

Section 17.a. of the Handbook states: "NFS is responsible for the identification and purchasing of all subsistence items and food service supplies needed for patient and resident food services. All products are purchased in accordance with the Subsistence Prime Vendor (SPV) Contract, and other authorized procurement sources, as needed."

Also, VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers (CLC) (August 13, 2008), at Section 9.d.(1) states: "Snacks are to be readily available to CLC residents between meal times, 24 hours a day. Staff needs to be available to assist those who are unable to obtain their own snacks or who may need guidance on making better snack choices. The variety of snacks needs to be extensive enough to meet all residents' needs."

NFS supervisors and employees told us consistently that on occasion there have been shortages of milk or bread during meals at the CLC. The team visited the CLC during lunch time, and spoke to some of the Veterans. One confirmed that the week before our visit there had been no milk during lunch; he added that occasionally there is no bread or other items such as sodas. The CLC NFS supervisor also indicated to us that there are times when these products may not be available during meals. She stated in order to get supplies like bread and milk for the CLC, she submitted an ad-hoc request to the NFS CLC administrator for the items and the quantities she needed as she ran low on them. The administrator; however, would reduce the amounts on the food orders, saying that they were excessive and not needed. We found no evidence of an inventory management system by which to adequately predict low food and beverage inventories, including supplies of such staple items as milk and bread.

Conclusion

The VA team **substantiated** that the NFS occasionally has shortages of food items at the CLC and that NFS lacks a food and beverage inventory management process for the CLC.

Conclusion for Allegation 1

VA **substantiates** Allegation 1. Of the 14 suballegations included in Allegation 1, we **substantiated** 9, **did not substantiate** 4, and did not investigate one based on its retraction by the whistleblower.

Recommendations to the Medical Center:

1. Develop an action plan to address each of the nine substantiated suballegations, and
2. Develop performance metrics to ensure compliance and sustainability of the measures put into place pursuant to the plan developed under Recommendation 1.

Allegation 2

The Chief of NFS has not taken appropriate action to ensure employee compliance with sanitation standards despite being aware that violations were regularly occurring.

Finding

VA reviewed documents and memorandums signed by the Chief of NFS addressing some of the deficiencies noted by the whistleblower (see list of documents in Attachment C). In her interview with us, she explained that she expected her subordinate supervisors to carry out her expectations as written in her memos and in discussions held during meetings. However, she could not document how she followed up with those supervisors to see that they met her expectations. In nine of the suballegations investigated under Allegation 1, the improper behavior or condition continued despite her having addressed it in writing.

Conclusion for Allegation 2

VA **substantiated** that the Chief of NFS has not taken appropriate action to ensure employee compliance with sanitation standards, despite being aware that violations were regularly occurring. Although there is evidence of documents signed by her addressing deficiencies, staff members interviewed consistently maintained that enforcement was lacking. Based on our finding that many of the reported inappropriate behaviors or conditions continued after the Chief took action, we conclude her corrective actions in those cases were inadequate and thus enforcement of her directives to staff was lacking.

Recommendation to VISN 4

3. Perform a comprehensive, top-to-bottom management review of the NFS.

Recommendation to the Medical Center:

4. Take appropriate disciplinary, administrative, or instructional action against the management of the service line including the supervisory chief.

Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, and OAR has examined the issues from an HR perspective to establish accountability for improper personnel practices as necessary.

Based on its investigation, VA found violations of VHA policy as specifically identified herein, gross mismanagement, and a substantial and specific danger to public health and safety all as discussed above. VA found, however, no violation of law, rule, or regulation. No changes to VA policy or practice are planned as a result of this investigation; however, pending the release of this report, VA will determine the need for disciplinary action, particularly with respect to the management of this service line. VA will inform OSC of any personnel action(s) taken based on this investigation via supplemental reporting if requested.

Attachment A

Documents Reviewed

Department of Veterans Affairs Medical Center, Philadelphia, PA, Partnership Forum Agreement, Dress Code, August 2012.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Medical Center Memorandum No. 111-13, Hand Hygiene, May 2014.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Medical Center Memorandum No. 120-5, Nutrition and Food Services in the Community Living Center, May 2014.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Nutrition and Food Services Memorandum No. 120-9, Grooming and Personal Hygiene of Personnel, August 2010.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Medical Center Memorandum No. 120-02, Diet Order and Food Service Procedures, June 2014.

Nutrition Committee Meeting Minutes, July 2010 – March 2014.

Nutrition Food Services Supervisor Meeting Minutes.

Nutrition and Food Services Employee Meeting Minutes.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Medical Center Memorandum No. 181-25, Resident Council Community Living Center, February 2011.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Community Living Center (CLC) Resident Council Meeting Minutes.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Pest Management Maintenance Records, Nutrition and Food Services Kitchen and Community Living Center Kitchen, 1994 - 2007 and February 2014 through November 2014.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Cook Cleaning Detail, May 2011 – August 2012.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Ingredient Control, Items Discarded Due to Damage, March 2010 – May 2012.

Department of Veterans Affairs Medical Center, Philadelphia, PA, HACCP Monitoring Report Ingredient Control.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Medical Center Dish Machine Temperature Log, April 2014 and July –December 2014.

VHA Handbook 1109.4, *FDA Food Code and ServSafe Managers, 6th Edition*.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Meat, Poultry, and Fish Temperature Log.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Food Production Record for CLC.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Medical Center Organizational Chart.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Nutrition and Food Services Organizational Chart.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Medical Center Memorandum No. 00-55, Compliance and Business Integrity Auditing Policy, October 2006.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Administrative Investigation Board, Nutrition and Food Services, August 2009.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Patient Event Report, November and December 2013, February 2014, May 2014, October 2014.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Nutrition and Food Service Employees Currently Employed.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Nutrition and Food Services Separations from January 2009 to Present.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Nutrition and Food Services Performance Appraisals, Fiscal Year 2014.

Department of Veterans Affairs Medical Center, Philadelphia, PA, Nutrition and Food Services Performance Ratings, Fiscal Year 2014.

Attachment B

From: Thompson, Troy R.
Sent: Tuesday, December 09, 2014 8:56 AM
To: (b) (6)
Cc: (b) (6)
Subject: Waste issue

Good Morning (b) (6) and (b) (6),

In reference to my allegation of "improperly disposing of waste" the only concern that came to mind; was an issue regarding the biohazard trailer. That I utilize to dispose of hazardous waste from the lab areas.

I will send you the string of emails email detailing my concerns to the powers that be; but as of recent last 4-5 mos. this area. Has been maintained adequately to my surprise; I don't believe it is necessary to address at this time due to the efforts displayed by the agency concerning my complaint to them.

Although I have included another item as an attachment; that I located depicting my concerns with the operations within nutrition.

Thank You

Troy Thompson

From: (b) (6)
Sent: Monday, December 08, 2014 10:13 AM
To: Thompson, Troy R.
Cc: (b) (6)
Subject: RE: Items of possible concern

Good morning Mr. Thompson,
On November 21, 2014, (b) (6) and I requested that you clarify the allegation of "improperly disposing of waste". You indicated that the occurrence was so long ago, you were unable to remember; however, you further stated would "think about it" and e-mail me if you remembered. To date, I have not received any clarifications to this issue. Please note that if you are unable to clarify the allegation, we will be unable to address it. Thank you.

V/r

(b) (6), R.N., B.S.N., M.S.N., C.P.N.R.
Clinical Program Manager/Office of the Medical Inspector(10 .MJ)
1717 H St. N.W., Suite 550
Washington, D.C. 20420
Office phone: 202-266-4657
BB(b) (6)

Attachment C

Summary of Documents from Chief NFS to staff

September 17, 2008

Memo from (b) (6) to NFS Employees

Subject: Directive

Employees reminded patient food is not to be consumed by NFS employees. No personal food is allowed in kitchen areas.

April 29, 2009

NFS Employee Meeting Minutes

Several agenda items discussed which includes use of proper and clean uniforms.

December 10, 2009

Nutrition Committee Minutes

Announced Troy Thompson as new Chief, Food production. Responsible for improving efficiency and quality in food service organizations.

April 7, 2010

Written Communication from Chief NFS, (b) (6) to Food Service Supervisors (FSS), Work Leaders (WL), Nutrition & Food Service Workers & Health Technicians

Re: NFS Leadership conducted an informal investigation as a result of an incident March 20 & 21, 2010.

April 9, 2010

NFS Meeting Minutes

Addressing clean uniforms, beard guards, and head coverings required even if employee has no hair.

Notes approved by (b) (6), Acting Chief NFS.

November 16, 2010

NFS Employee Meeting Minutes

Troy Thompson addressed importance of proper hand washing after breaks etc., and discussed the appropriate use of aprons.

March 7, 2011

NFS Employee Meeting Minutes

Note "Other Issues"

Addresses multiple issues i.e. no sleeping allowed in NFS, FT employees required to take lunch breaks, employees cannot leave early if you do not take lunch breaks. No chairs or stools used in kitchen.

August 21, 2013

Memo from (b) (6); Chief, NFS to NFS Supervisors and Work Leaders.
Addressing allegations of consuming food, arriving late, leaving early, closing CLC kitchen early, employees bringing in personal food and cooking it; Employees not wearing proper food safety attire (hairnets/beard guards).