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VIA HAND DELIVERY AND VIA EMAIL TO: ipennington@osc.gov

May 28, 2015

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

Re: *Valerie Riviello, OSC File No. Dl-14-2519*

Dear Ms. Lerner:

As you know, this firm represents Ms. Valerie Riviello, Nurse Manager of the Inpatient Psychiatric Unit at the Samuel S. Stratton VA Medical Center, Albany, New York, in her whistleblower disclosure case, OSC File No. DI-14-2519, and in her whistleblower reprisal case which is under investigation. This letter is sent in response to OSC's letter dated May 11, 2015, received by this office on May 13, 2015 requesting Ms. Riviello's comments on the supplemental report of the Department of Veterans Affairs, TRIM 2014-D-1254, dated April 30, 2015, in her disclosure case.[1] *See* 5 U.S.C. § 1213(e)(l). This letter is sent on her behalf as the whistleblower and contains her timely comments and concerns on TRIM 2014-D-1254.

As set forth herein, the supplemental report, like the original, contains both erroneous and groundless factual findings, lacks clarity and transparency, reflects a clear VA bias against the whistleblower in continued retaliation for her disclosure of patient abuse at Stratton, and does not comply with the statutory requirements for a whistleblower disclosure report to OSC. It is therefore both factually and legally insufficient. Moreover, this report appears to contain deliberate falsehoods and false information provided by management and staff at Stratton to the Inspectors. As shown herein, the statements and information relied upon by the Inspectors in the supplemental report are false and misleading and reliance thereon by the Inspectors has directly lead to the incorrect conclusions they have drawn therein.

As the supplemental report taken as a whole is both factually inaccurate and legally unsound, Ms. Riviello requests that the Special Counsel take into consideration her comments below in making its findings and recommendations to the President and the appropriate congressional oversight committees of Congress. *See* 5 U.S.C. § 1213(e)(3). As set forth in the attached consent, Ms. Riviello consents to the public release of these comments. *(See* Exhibit 1, "Consent Form").

[1] The transmittal letter to OSC is dated May 5, 2015.

I. *Patient A's Hospitalization on November 5, 2013:*

Initially, the Inspection Team found, *erroneously,* "based on the *Medical Center's position* that they did not have a policy in place on that day" that "Ms. Riviello released Patient A from restraints on November 5, 2013 without proper authority." (Emphasis added). That statement in the original report was shown to be factually inaccurate, as Ms. Riviello provided the Inspection Team with policies which the Team now must acknowledge were in fact in place. *(See* April 30, 2015 Supplemental Report, p. 3). Instead of questioning *why* Medical Center management would mislead the Inspection Team with respect to policies management knew existed and failed to share with the Inspectors, the Inspectors now find that, despite the fact that there was indeed a policy in place allowing Ms. Riviello to remove the subject patient's restraints, Ms. Riviello was not on duty that day on the 10b unit, and thus, the policy did not apply to her. This too is a patent falsehood perpetrated by the management at Stratton upon the Inspectors, VA senior management and OSC. Indeed, Stratton management has *again* deliberately misled the Inspectors, falsified records, and removed Ms. Riviello's time keeping records from the official files in order to cover up the fact that she was indeed on duty on 10b and acting within her authority to remove a patient from restraints.[2] By now, it should be plainly apparent that Stratton management does not want the VA Inspection Team to have the full truth in this matter because it validates the very concerns Ms. Riviello has raised concerning patient abuse at Stratton.

It is clear, as set forth below and through the attachments hereto (Tabs A-K), that Ms. Riviello was on duty on 10b on November 5, 2013 and that she had the authority, based upon the nursing policies the Inspection Team (and management) now must admit exist, to remove the patient from restraints. She in fact followed the two nursing policies in effect in November 2013. If as the Inspection Team notes, however, that there were no local or facility policies for *the physicians to follow,* how then did the *doctors have the authority to even order her placed into restraints to begin with?* This question raised by OSC to the team in its request for a supplemental report was never answered in that report.[3] The OMI team also neglects to mention that *Dr. Gorospe's own documentation* states that the patient should remain in restraints "to show her the consequences of her behaviors." Placing a patient in restraints so that they might "learn a lesson" and/or when they are not demonstrating any violent or disruptive behaviors is in fact patient abuse and runs counter to all existing policies. There is simply no accountability being assessed upon the physicians for their inappropriate and non-compliant behaviors.[4]

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[2] Moreover, even if she had not been on duty that day (on the ward she manages), the policy itself does not eliminate any nursing staff from taking appropriate actions to properly treat a patient. *See* NSG Policy 1-007-12 ("The decision to discontinue restraint is the responsibility of the registered nurse or provider.")

[3] Also, the question as to how the appropriate care this patient received from Ms. Riviello and her team of nurses somehow disrupted the treatment plan (that does not exist in the records) was never answered by the supplemental report even though also requested by OSC.

[4] Indeed, it was only *after* Ms. Riviello reported the abuse by the physicians to proper authority that she was retaliated against and told by Nurse Spath that if she did not *thereafter step down as Nurse Manager of 10b,* "things would get very ugly." *If she really had nothing to step down from,* this verbal threat and later management action to idle her with no work or work that had already been accomplished would have been completely unnecessary (as she would not have been nurse manager of 10b as management now states). That unnecessary work included Spath tasking her to solely develop and run a nurse residency program which would entail a 2 step decrease in pay. She was instructed to put this program in place as a Nurse of one. Shortly thereafter, Ms. Riviello found 2010 nursing journal article containing interviews of Ms. Spath and Linda Mock (nurse recruiter at the time) wherein they both bragged of the wonderful nurse residency program they already had in place. Therefore, this "job" she was given was one that had already been completed.

A. Ms. Riviello was nurse manager on l0b on November 5, 2013:

First, Ms. Riviello was indeed on duty on 10b that day and all others before that time and thereafter, while she was pulling "double duty" on 7b and 10b. Apparently, in an attempt to fool the VA Inspection Team again, VA management submitted only 7b time sheets to the Team. Management apparently *again* neglect to submit l0b time sheets *(see* time sheets attached for August 2013- December 2013, Tab A) which indicated that indeed Ms. Riviello was *at all times* continuing to function as the 10b nurse manager in addition to her 7b duties, which were collateral.

In fact, Ms. Spath and Mr. Maloney gave Ms. Riviello a "collateral" duty in August 2013 to fill in administratively on the 7b unit and to specifically orient the new assistant nurse manager there. Those duties, however, were in addition to Ms. Riviello continuing to be the 10b nurse manager. Ms. Riviello (at Tab A) has submitted all l0b time sheets from August 2013 through January 2014 which again indicate that she was in fact listed on the l0b time sheets as *present and working*[5] She continued to complete and post time for *both units as she was required to do,* and therefore her time was listed on both time sheets in a transparent effort so that all staff would know when she was and was not on duty. During that time period, she continued to hold staff meetings on both 10b and 7b; she continued to complete all competencies and proficiencies for both units; she signed all time cards for payroll for both units; she was involved in treatment team meetings for both units; she made out the daily assignment for 10b every morning that she was on duty; she met with patients and families on both units; and she led both teams from August through December 2013. This is not a description of someone not on duty that day. VA management has simply again misled the Inspectors, VA management and OSC in a not so veiled attempt to deflect blame for their actions that day.

Specifically, with respect to the November 5th 2013 incident on 10b, Ms. Riviello was the nurse manager on 10b that day and continued to function as the team leader; she had been invited to a 12 noon interdisciplinary meeting on 10b about this patient, which she did indeed attend with Mr. Maloney wherein they were both pulled aside by Dr. Haley at 12 noon and told specifically that the meeting was cancelled on the inpatient unit, but would take place on the outpatient unit, but only with the outpatient providers. Mr. Maloney apparently neglects to confirm this – both were excluded from meetings after Ms. Riviello advised management that the patient was being improperly restrained.[6]

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[5] When Ms. Riviello went to pull her copies of all of these certified timesheets for this response, she discovered that someone else had removed *the certified time sheets* for November 5, 2013 in a blatant and obvious attempt to hide her on duty status on 10b that day. We have included the original, uncertified time sheet for November 5, 2013 which clearly shows Ms. Riviello on duty that day ("D" denoting off days for November 3 and 9 only). *See* Tab A.

[6] Further, the report is erroneous and does not address the facts as alleged and proven by the patient's own records and others. First, the patient was released from restraints at l:30 pm (not 11 am) and only after Ms. Riviello called Mr. Maloney on the telephone for permission. On that call, he gave her permission based on the patient's current condition to release the patient from restraints. This conversation took place in the nurses' station and was overheard by staff. Mr. Maloney continuing his unethical conduct denies that he gave her permission, but when confronted by Ms. Riviello immediately thereafter, he did not deny such approval. Indeed, he advised Ms. Riviello at that time that it was amusing that "Dr. Haley was angry with me [him] for giving you [Valerie] permission." Further, just because an order was renewed at 11am and good for 4 hours, does not mean that the patient has to stay in restraints the entire 4 hours. Instead the patient should be continually reassessed every fifteen minutes by the RN for release as soon as possible.

Further documentation shows that Ms. Riviello was indeed conducting her management duties on l0b while also collaterally assisting 7b throughout the period August 2013-December 2013. Tab B contains several representative emails sent to and from Ms. Riviello by others inside and outside Stratton concerning nurse manager duties and issues for which she was responsible as having been tasked by Stratton management. Further, and specifically, Tab C is a report of the inpatient BH nursing staff meeting notes for 9/10/2013 which Ms. Riviello led that day with respect to issues confronting that staff. Tab D importantly contain representative emails from Mr. Maloney during the relevant period of time wherein he was tasking Ms. Riviello to create a sitter program and forwarding others' policies for her consideration. There is no reason for Ms. Riviello to create a sitter policy for 10b if she is not in fact the nurse manager of 10b.[7]

Importantly, Ms. Riviello had been caring for Patient A for quite some time and on other occasions prior to the November 2013 admission and specifically as nurse manager of l0b. As shown in the documents submitted to OSC in this investigation itself, Patient A had been brought to the unit with a tracheotomy at one point which she tried to dislodge. (Whether or not she should have been brought to the unit in that state is questionable). Nonetheless, Ms. Riviello worked diligently with respect to this particular patient to train her staff on Tracheostomy and Laryngectomy Care Protocols merely a couple of weeks before the November 5 incident in question. *(See* Tab E, October 18, 2013 email to 10b Staff regarding "trach care and suctioning"). Ms. Riviello at all times was managing and teaching her staff on l0b while collaterally assigned to assist 7b. This is just another example that reflects this management and education with respect to Patient A herself. Tab F is even more illustrative of her ongoing nurse manager duties on l0b on November 5, 2013. This document shows definitively that the inspection team is reaching an incorrect conclusion based on deliberate false information provided by Stratton management. Tab F is the 10b Assignment sheet *(see* Tab G for more examples during the relevant time period). Ms. Riviello is responsible for and in fact completes these assignment sheets for the nurses under her charge. Tab F not only shows that she did so on the date she was allegedly "not on duty" but also importantly notes two meetings with respect to Patient A (called Patient S by Ms. Riviello on the document and in her allegations to OSC). In addition to charging each nurse with their assigned duties, at the top is a note for "12N Exceptional pt mtg-Ms. S." This note refers to the 12 noon patient meeting about Patient A that Ms. Riviello had been scheduled to go to and was later deliberately excluded from. At the right margin, on the top there are two noted meetings with respect to her duties that day. First, there is "Val 12N mtg l0b" referring to the patient A meeting from which she was excluded; then there follows the "2P NM mtg" notation. That refers to the 2:00 pm Nurse Manager meeting that she attended as Nurse Manager of l0b. This document shows definitively (along with the others) that Ms. Riviello was present, on duty, and performing nurse manager duties on l0b on November 5, 2013, the date of the restraint incident. Ms. Riviello did indeed have full authority under NSG Policy 1-007-12 to take Patient A out of restraints that afternoon. ("The decision to discontinue restraint is the responsibility of the registered nurse or provider.")[8] Any other conclusion flies in the fact of reality and the facts.[9]

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[7] The headers of two of the emails make it clear that they refer to 10b (the psychiatric unit), as they are entitled "Mental Health patients admitted through the ED [emergency department]."

[8] The Inspection team also neglects the fact that the patient was taken out of restraints only after Ms. Riviello was given permission by Mr. Maloney to do so and that the staff (James Cooper) called her for help as the patient was in pain, disrobing, diaphoretic, and wet. Policy requires that patients are to be allowed their rights to receive care and treatment and nurses are to trial patients out of restraints for toileting and bathing etc. The patient was escorted to the bathroom where she was allowed to void; Ms. Riviello assisted with her shower, provided skin care, provided trach care, and provided clean pajamas. During the entire procedure, the patient was calm, grateful, and in appropriate behavioral control. When completed, she was escorted to bed and the discussion ensued with 3 nurses involved regarding the necessity or lack thereof to reapply restraints to this cooperative

B. Ms. Riviello was not on duty February 14-15. 2014 and could not have "coerced" nurse St. Denis to remove restraints from Patient A:

The Report also explains (at page 6) in response to an OSC question regarding conflicting evidence on the use of and removal of restraints on Patient A in February 2014, what evidence is allegedly conflicting and the Team's conclusion concerning this incident. The inspection team resolves this conflicting evidence by stating that Nurse St. Denis indicated that on that date "he was coerced by Nurse Manager Riviello to assist in removing Patient A from restraints." (Report at p. 6). Either Nurse St. Denis is having difficulty recalling specific details of this patient's history or he is misstating the truth deliberately.[10] Ms. Riviello did not coerce anyone at any time to do anything with respect to Patient A. In fact, Ms. Riviello *was not even on duty* the weekend of February 15-17, 2014. Attached is Tab I which contain the certified time sheets for the weeks of 2/9/2014 through 2/17/2014. The time for Ms. Riviello clearly shows "D" denoting "day off ' for both Saturday and Sunday, February 15 and 16, 2014 and an "H" for Monday, February 17, 2014, President's Day. Ms. Riviello was not on duty and did not even talk to Mr. St. Denis that entire weekend. Mr. St. Denis never called Ms. Riviello at home that weekend nor did she contact him. In fact, Ms. Riviello was called by another female nurse on duty and Ms. Riviello specifically instructed her to speak with the nursing supervisor on duty.

II. VA's Response to OSC concerns on the Status of the Recommendations made are not entirely accurate:

The inspection Team made 8 recommendations. OSC tasked the VA with explaining the status of VA compliance with each of them. The supplemental report attempts to do so on pages 7-9. Some of the stated progress reports are inaccurate.

Recommendation 1: Develop and Implement a new policy and SOP regarding restraint and seclusion. A new seclusion and restraint policy is still in draft form, but staff, including Nurse Managers have not been educated on it or any changes made in accordance therewith. It will be difficult for nurse managers such as Ms. Riviello to "provide the education [on the new policy]" if she has had no education on it herself.

Recommendation 2: Conduct a Root Cause Analysis (RCA) addressing Nursing Restraint Flow sheets. An RCA may have been initiated regarding missing nursing electronic restraint data. There is no policy or procedure in place as of yet to prevent this from happening again.

Recommendation 3: Audit the Interdisciplinary Treatment Plans of all current psychiatric patients. Ms. Riviello was asked to audit the interdisciplinary treatment plans for one month. She did so and handed in her report which indicates that the hospital is not 100 percent compliant. *(See* Tab J, redacted).

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controlled patient. The patient was lying cooperatively and comfortably in bed at 2 pm when she was seen by Dr. Gorospe and Dr. Haley. Dr. Haley agreed at that time (out loud verbally) that there was no justification to re restrain her.

[9] Tab G, page 1 even shows whimsical artwork reflecting the fact that Ms. Riviello was indeed the leader of 10b at all relevant times.

[10] This behavior is alarming to Ms. Riviello as Mr. St. Denis' current supervisor.

Recommendation 4: Review the methods of other VA medical centers for electronic documentation. This task has not been completed. Nursing restraint flow sheets are still kept in hard copy and then scanned in to a patient's chart after discharge. There is no plan in place to prevent their loss or misplacement or to ensure scanning was completed.

Recommendation 5: Conducting an independent review of management practices on the mental health unit to determine the compliance with national, local, and accepted standards. This is a vague recommendation and has not been done yet. It is unknown how a target date of June 30, 2015 is possible. The inpatient handbook and recovery-oriented practice performance improvement initiatives deem a restraint fee environment which Stratton strives for or should.

Recommendation 6: In the new policy and SOP resulting from recommendation 1, specify the roles of physicians and nurses. As noted, this new policy is not complete nor distributed. During the Joint Commission survey just concluded at Stratton, VA, the reviewers witnessed an elderly demented female in four point restraints while she was asleep. They questioned why she was kept in restraints the entire 4 hours of the renewal order when she had been sleeping. They also suggested developing a new policy clearly identifying when a patient should be taken out of restraints. *(See* Joint Commission Report, Tab K). The Joint Commission, still to this date, as an outside body, is still observing the same restraint procedures in place even after the investigation and recommendations made by the Inspection Team. No progress appears to be made in practice, even as new policies are being developed.

Recommendations 7 and 8: No comments.

CONCLUSION

For the foregoing reasons, the whistleblower requests that the conclusions reached in the Supplemental Report of the Department of Veteran's Affairs be reviewed and revised in light of the evidence and argument she has presented herein. She requests that the final report correctly note that she was in fact on duty as nurse manager of 10b on November 5, 2013 (and in fact at all times from August 2013- December 2013) and that she acted in accordance with a valid policy memoranda allowing a nurse to remove patients from restraints without a physician's order; and issue a finding that she was not on duty in February 15-17, 2014 when the second incident of prolonged restraint of Patient A occurred and that she did not by words or actions "coerce" Nurse St. Denis to remove restraints from a patient she never saw nor interacted with on those days. The accurate record reflects that Nurse St. Denis and she had no contact whatsoever over that weekend.

Ms. Riviello appreciates the opportunity to comment on this Report and asks that the attack on her professional reputation due to obvious factual inaccuracies and oversights by the inspection team which have been engendered by false and misleading statements and documentation from Stratton VA be removed from the amended Report that it submits to OSC for review a final time.

Sincerely,

Cheri L. Cannon

Cheri L. Cannon Partner Chairperson
Federal Labor and Employment Law Team

Encls: as stated