U.S. OFFICE OF SPECIAL COUNSEL
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The Special Counsel

March 29, 2018

The Honorable Robert Wilkie
Acting Secretary
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

VIA ELECTRONIC MAIL

Re: OSC File Nos. DI-18-2407
Referral for Investigation – 5 U.S.C. § 1213(c)

Dear Acting Secretary Wilkie:

I am referring to you for investigation deeply disturbing disclosures from a whistleblower alleging that employees at the Department of Veterans Affairs (VA), VA Boston Healthcare System, Community Living Center (CLC), Brockton, Massachusetts, engaged in conduct that may constitute violations of law, rule, and regulation, gross mismanagement, and a substantial and specific danger to public health. A report of your investigation on these allegations and any related matters is due to the Office of Special Counsel (OSC) on May 28, 2018.

[redacted] a CLC licensed practical nurse (LPN), who consented to the release of her name, disclosed that CLC nursing staff in short-term care[1] neglect veteran patient needs and fail to provide required assistance with essential care. The allegations to be investigated include the following:

- CLC nursing staff have repeatedly failed to meet agency standards of care, which may constitute a violation of Veterans Health Administration (VHA) Handbook 1142.01, *Criteria and Standards for VA Community Living Centers*; Charge Nurse [redacted] and Unit Manager [redacted] have failed to address the deficiencies in patient care; and
- [redacted] instructed [redacted] to alter an adverse incident report on a patient fall, which may violate VHA Handbook 1050.01, *National Patient Safety Improvement Handbook.*

[1] The short-term care unit staffs five nurses, LPNs or resident nurses, and three certified nursing assistants (CNAs) for day shifts, and two to three nursing staff members and two CNAs for overnight shifts. The Brockton CLC short-term care unit currently houses 30 patients.

Since [redacted] began working at the CLC in December 2017, she has observed significant neglect of patients. She asserted that nurses and CNAs failed to make rounds to check on patients, and failed to provide required assistance for essential care resulting in the following: a patient found gasping for air in his room with an empty oxygen tank; a patient left lying in his own fecal matter in great discomfort; and a patient forced to urinate in a cup because the urine container in his room was overflowing.

[redacted] detailed another incident where she discovered a patient who had fallen--his glasses were broken, a water pitcher spilled, blood and the contents of his feeding tube were all over the floor, and the patient had lacerations above his eye and on his head. [redacted] checked the patient's vitals and then contacted the medic on duty (MOD).[2] At the same time, [redacted] heard yelling from the room next door. She responded and found a second patient on the floor by his bed, who appeared pale and disoriented. [redacted] learned the individual was left in a wheelchair for several hours with no food or water. After evaluation by [redacted] and the MOD, the patient was taken to a nearby hospital to be treated.

Following the patient falls, [redacted] began writing an adverse event report as required[3], when [redacted] instructed [redacted] to state in her report that CLC nursing staff checked on the patient five minutes prior to the fall. [redacted] told [redacted] that this was not accurate, as the amount of tube feed on the floor and disarray did not reflect that CLC nursing staff checked on the patient five minutes prior. Despite [redacted] many attempts to change the report, [redacted] submitted an accurate account reflecting that she did not know when the last time CLC nursing staff checked on the patient prior to his fall. Since reporting these incidents, [redacted] reported that she has not observed improvements in patient care. Instead, CLC managers are either dismissive of her concerns or instruct her to stand down. When attempting to address these matters, she has been told repeatedly by [redacted] "that's the VA for you."

Pursuant to my authority under 5 U.S.C. § 1213(c), I have concluded that there is a substantial likelihood that the information provided to OSC discloses violations of law, rule or regulation, gross mismanagement, and a substantial and specific danger to public health. Please note that specific allegations and references to specific violations of law, rule or regulation are not intended to be exclusive. If, in the course of your investigation, you discover additional violations, please include your findings on these additional matters in the report to OSC. As previously noted, your agency must conduct an investigation of these matters and produce a report, which must be reviewed and signed

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[2] According to [redacted] the MOD initially did not want to examine the patient, and only did so at her insistence.

[3] VHA Handbook 1050.01 outlines procedures for reporting adverse events. Adverse events are defined as "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a …VHA facility." Patient falls are included in the list of examples of adverse events. VHA Handbook 1050.01(4)(a).

by you. Per statutory requirements, I will review the report for sufficiency and reasonableness before sending copies of the agency report along with the whistleblower's comments and any comments or recommendations I may have, to the President and congressional oversight committees and making these documents publicly available.

Additional important requirements and guidance on the agency report are included in the attached Appendix, which can also be accessed at https://osc.gov/Pages/DOW.aspx. If your investigators have questions regarding the statutory process or the report required under section 1213, please contact Catherine A. McMullen, Chief, Disclosure Unit, at (202) 804-7088 for assistance. I am also available for any questions you may have.

Sincerely,

Henry J. Kerner
Special Counsel

Enclosure

cc: The Honorable Michael J. Missal, Inspector General