

# United States Senate

WASHINGTON, DC 20510

November 16, 2018

The Honorable Robert Wilkie  
Secretary of Veterans Affairs  
U.S. Department of Veterans Affairs  
801 Vermont Ave NW  
Washington, D.C. 20571

Dear Secretary Wilkie:

We write to express our profound concern and to request information about another disturbing report of misconduct at a Department of Veterans' Affairs (VA) medical facility – this time at the nursing home (community living center) on the campus of the Brockton VA Medical Center.<sup>1</sup> As Senators from Massachusetts, we wish to know more about the reported deficiencies in care to veterans at this facility, what concrete steps have been and are being taken to remedy any deficiencies, and why we were not previously informed of these issues.

A *Boston Globe* article published earlier this week identified significant lapses in care at the Brockton VA nursing home. If these reports are true, they raise serious questions about the operations and leadership of the facility. The *Globe* article described “a nurse and a nurse’s aide fast asleep during their shifts” and nurses “often sleep[ing] when they were supposed to be working.” There were also instances of “nurses and aides [...] not emptying the bedside urinals of frail veterans,” “fail[ing] to provide clean water at night and [not] check[ing] on the veterans regularly, as required.”<sup>2</sup> Another harrowing allegation of poor care, although unconfirmed by VA investigators, included a veteran who “fell — his feeding tube got disconnected and the liquid splashed onto the floor — and didn’t appear to have been monitored by staffers for hours.”<sup>3</sup>

These problems were revealed because a Brockton VA nurse-turned-whistleblower raised the alarm about this misconduct “after her repeated complaints to supervisors were ignored.”<sup>4</sup> We are equally alarmed by the observation of the Office of Special Counsel (OSC) that the whistleblower “felt that she needed to resign [...] due to the retaliatory environment created at the Brockton [nursing home].”<sup>5</sup> Moreover, the VA’s data indicates that “Brockton residents

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<sup>1</sup> Andrea Estes and Donovan Slack, “‘Blatant disregard’ for safety at Brockton VA nursing home, US finds,” *Boston Globe*, November 14, 2018, [https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s\\_campaign=breakingnews:newsletter](https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s_campaign=breakingnews:newsletter).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> Andrea Estes and Donovan Slack, “‘Blatant disregard’ for safety at Brockton VA nursing home, US finds,” *Boston Globe*, November 14, 2018, [https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s\\_campaign=breakingnews:newsletter](https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s_campaign=breakingnews:newsletter).

<sup>5</sup> Henry J. Kerner, Special Counsel, U.S. Office of Special Counsel, Letter to President Trump forwarding VA report of investigation into Brockton Community Living Center, October 23, 2018, <https://osc.gov/PublicFiles/FY2019/19-01-DI-18-2407/OSC%20File%20No.%20DI-18-2407%20-%20Letter%20to%20the%20President%20%28Redacted%29.pdf>.

were, on average, more likely than residents of other VA nursing homes to deteriorate, feel serious pain, and suffer from bed sores, [... and ...] were nearly three times as likely to have bed sores than residents of private nursing homes.”<sup>6</sup> These reports follow the news that the Brockton VA nursing home has the lowest possible quality rating – one star – according to the VA<sup>7</sup> and that the VA’s Office of the Medical Inspector (OMI) investigation found “a substantial and specific danger and safety exists at Brockton.”<sup>8</sup>

The Brockton VA whistleblower observed that she “could not believe that this was how we treat the people that fought for our country.”<sup>9</sup> We cannot believe it either – but it keeps happening, and it is unacceptable. For too long, we have learned of the mistreatment of our veterans – at Bedford<sup>10</sup> and at Brockton – through the media instead of through VA leadership. The continued care lapses at VA facilities raise questions about whether concrete, lasting measures are being implemented to prevent misconduct from occurring again – or whether certain VA facilities are unable to institute changes necessary to provide our veterans with the care befitting their service to the country.

We know you agree that all veterans deserve the highest quality medical care – whether at Brockton, Bedford, or any other VA facility. The majority of VA employees are dedicated and hardworking, and the stories of outstanding patient care often do not make headlines. We acknowledge that the two nurses who were caught sleeping no longer work at the Brockton VA or elsewhere in the greater VA Boston health care system, and that “the nurse executive and

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<sup>6</sup> Andrea Estes and Donovan Slack, “‘Blatant disregard’ for safety at Brockton VA nursing home, US finds,” Boston Globe, November 14, 2018, [https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s\\_campaign=breakingnews:newsletter](https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s_campaign=breakingnews:newsletter).

<sup>7</sup> The Brockton VA Nursing Home has one star, which is the lowest possible rating. See Department of Veterans Affairs, Nursing Home Care for Veterans, “Brockton MA CLC,” Accessed November 14, 2018, <https://www.accesstoshep.va.gov/CNH/FindCommunityNursingHomes?LocationText=MA&Radius=50&SortOrder=1&UserLatitude=-1&UserLongitude=-1>; USA Today, “Secret VA nursing home ratings hide poor quality care from the public,” Donovan Slack and Andrea Estes, June 17, 2018, <https://www.usatoday.com/story/news/politics/2018/06/17/secret-va-nursing-home-ratings-hide-poor-quality-care/674829002/>.

<sup>8</sup> Department of Veterans Affairs, Report of the Office of Special Counsel, Boston Healthcare System, Brockton, MA, September 11, 2018, [https://osc.gov/PublicFiles/FY2019/19-01-DI-18-2407/OSC%20File%20No.%20DI-18-2407%20-%20Agency%20Report%20\(Redacted\).pdf](https://osc.gov/PublicFiles/FY2019/19-01-DI-18-2407/OSC%20File%20No.%20DI-18-2407%20-%20Agency%20Report%20(Redacted).pdf).

<sup>9</sup> Andrea Estes and Donovan Slack, “‘Blatant disregard’ for safety at Brockton VA nursing home, US finds,” Boston Globe, November 14, 2018, [https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s\\_campaign=breakingnews:newsletter](https://www.bostonglobe.com/metro/2018/11/14/could-not-believe-that-this-was-how-treat-people-that-fought-for-our-country/kcJIRzI9UksZiyO2Sqow4K/story.html?s_campaign=breakingnews:newsletter).

<sup>10</sup> Andrea Estes, “A nurse’s aide plays video games while a veteran dies at Bedford VA hospital,” Boston Globe, Oct. 17, 2017, <http://www.bostonglobe.com/metro/2017/10/17/nurse-aide-plays-video-games-while-vietnam-veteran-dies-bedford-medical-center/IsWg0TU12q0mSoxgsa5eFM/story.html?event=event12>; Todd Feathers, “Bedford VA whistleblower: Agency trying to ‘scare me away’ through retaliation,” Lowell Sun, Oct. 17, 2017, [http://www.lowellsun.com/local/ci\\_31381379/bedford-va-whistleblower-agency-trying-scare-me-away](http://www.lowellsun.com/local/ci_31381379/bedford-va-whistleblower-agency-trying-scare-me-away); Todd Feathers, “Behind midnight escape, a botched VA probe,” Lowell Sun, Aug. 27, 2017, [http://www.lowellsun.com/todayshadlines/ci\\_31252826/behind-midnight-escape-botched-va-probe](http://www.lowellsun.com/todayshadlines/ci_31252826/behind-midnight-escape-botched-va-probe); Boston Globe, “Bed sores, neglect, alleged abuse: inside the Bedford VA nursing home,” Andrea Estes and Donovan Slack, September 4, 2018, <https://www.bostonglobe.com/metro/2018/09/03/bed-sores-neglect-alleged-abuse-inside-one-lowest-rated-veterans-nursing-homes-country-bedford/9COivG8mpVathjErrrA9nM/story.html>.

health care system director visited all units personally to communicate to all staff OMI's findings and the steps [the VA is] taking to address them."<sup>11</sup> But this latest report of patient neglect at the Brockton VA is part of a troubling pattern of misconduct at VA facilities in Massachusetts and across the country, and underscores the need for rapid and lasting improvements in quality of care. We cannot be satisfied until every veteran receives the services they need and deserve.


Accordingly, we respectfully request written answers to the following questions or requests for information by November 30, 2018:

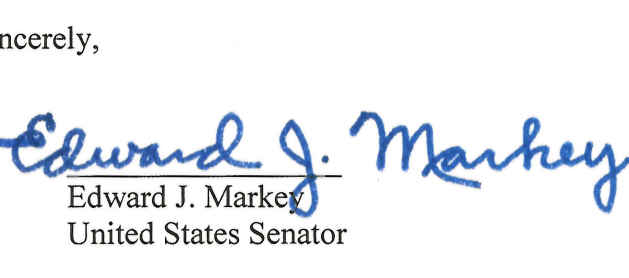
1. Please describe in full the actions that have been taken by the VA to remedy problems in patient care at the Brockton VA nursing home in the previous 12 months, including disciplinary action against senior managers and any others steps to ensure that future lapses in care are not repeated.
2. What steps have been taken to ensure that Brockton VA employees do not suffer retaliation for reporting misconduct? How has the Brockton VA engaged with the VA Office of Accountability and Whistleblower Protection to safeguard whistleblower rights and prevent retaliation?
3. Please provide an electronic copy, with redactions as necessary, of the most recent survey results by the Long Term Care Institute (LTCI) evaluating the quality of care at the Brockton VA nursing home.
4. The *Globe* reported that "records had been shredded" regarding the alleged failure of Brockton VA nursing home staff to promptly attend to a veteran, who allegedly fell when his feeding tube became disconnected, "in accordance with the local policy." Please provide an electronic copy of the VA policy regarding the preservation of records involving the care of individual patients.
5. Since their reported termination from the Brockton VA, have "the two sleeping nurses" since been permitted to work at any other VA facility?
6. If "the two sleeping nurses" or any employee terminated from the Brockton VA apply for a position at another VA medical facility, will their reported misconduct be flagged for the administrative staff at such facility? Please explain this process and provide any relevant documents articulating a policy on the management of VA personnel.

In addition, we respectfully request, as rapidly as possible, a staff briefing by the VA Office of the Medical Inspector (OMI) regarding its investigation and findings at the Brockton VA.

Thank you for all that you do in the service of our veterans.

Sincerely,

  
Elizabeth Warren  
United States Senator

  
Edward J. Markey  
United States Senator

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<sup>11</sup> Department of Veterans Affairs, Office of Congressional and Legislative Affairs, Email to Office of Senator Warren, Received November 15, 2018 [on file with Office of Senator Warren].