Department of Veterans Affairs

Office of Inspector General

SPECIAL INQUIRY

ALLEGED MISMANAGEMENT AT THE RALPH H. JOHNSON VA MEDICAL CENTER, CHARLESTON, SOUTH CAROLINA

Date: January 10, 1997
Report No.: 7PR-A19-029

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Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

TO: Director, Veterans Integrated Service Network No. 7 (10N7)
Director, VA Medical Center, Charleston SC (00/534)

SUBJECT: Special Inquiry, Alleged Mismanagement at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina — Report No. 7PR-A19-029

1. The Department of Veterans Affairs (VA), Office of Inspector General (OIG) conducted a special inquiry at the request of Congressman Mark Sanford and House Veterans Affairs Committee staff. Congressional staff received allegations that the former Director and his staff mismanaged construction, renovations, contracts, personnel, and other activities at the Medical Center. We reviewed the complaints to determine the validity of allegations made by employees, former employees and others who wrote to congressional staff.

2. Several complainants believed that the former Director mismanaged the construction and renovation of a Nursing Home Care Unit (NHCU) and the related activation funding for the NHCU. We found that about $2.1 million was spent for construction, renovation, and activation of the NHCU, but management never used the renovated space for a NHCU. Since its completion in February 1994, the NHCU had been used as "swing space" for specialty clinics undergoing renovation. Meanwhile, VA staff placed veterans seeking nursing home care facilities near Charleston in contract facilities or VA facilities elsewhere. Our discussions with the Director, Veterans Integrated Service Network (VISN) No. 7, helped prompt plans to open the NHCU in July 1997 for patients in the Charleston area. We understand the activation of the NHCU in July 1997 will be accomplished using the equipment and staff funding previously provided to the facility.

3. Many employees we interviewed believed that the former Director focused too much of his efforts on construction projects such as the renovation of his office suite and the inclusion of an expensive fish tank in a construction project, as well as the promotion of his friends and associates during a time when the Medical Center faced a significant budget shortfall, furloughs, and possible reductions in force (RIF). With respect to the construction projects, the Medical Center's facilities needed updating and the plans for these projects had been initiated long before the furloughs and funding shortages in Fiscal Year 1996. However, there is no question that completing these projects at about the same time the furloughs, funding shortfall and plans for a possible RIF were happening gave rise to the employees impression that management had misplaced its priorities.

4. The former Director used a noncompetitive process to promote individuals within the Director's Office and for certain service chief level positions. The former Director promoted

individuals that were his known friends and associates using this process. These actions led to allegations that the former Director promoted his staff more on the basis of friendship than merit. We found that these individuals were qualified and there was no indication that the selections would have been different, even if the former Director used a competitive process to fill these positions. However, by foregoing a competitive process, the former Director precluded anyone else at this Medical Center, or any other facility, from competing for the positions. As an example, the former Director promoted two ***(b)(6)*** in his immediate office to ***(b)(6)*** grade levels at about the same time he announced to the rest of the Medical Center staff serious funding shortages and possible RIFs. The timing of these events contributed to increasing the tension between employees and top management.

5. VA employees also questioned the former Director's hiring of a management consultant to work with qualified VA program assistants and quality management staff. The former Director paid the management consultant over $90,000 and expenses in Fiscal Year 1996, to work 4 days per month. We made recommendations to reevaluate the need for this contract, and the new Director took action to discontinue the consultant's services effective December 31, 1996. This should permit the use of these funds for other health care priorities at the Medical Center.

6. Nursing staff expressed concern over the downsizing of programs, reduction of staff, and effect the reduced funding would have on the quality of patient care provided to veterans in the area. These conditions contributed to a recent vote by nursing staff to form their own union at the medical center. It also contributed to a concern by staff that management had misplaced its priorities in renovating space without intending to use it, renovating executive offices, landscaping, and protecting associates' and friends' jobs, while he subjected core professional staff and programs to reductions and closures.

7. We brought these concerns to the attention of the VISN Director, and the new Medical Center Director, and we made several recommendations. The VISN Director's and new Director's comments and implementation plans met the intent of the recommendations, and we consider them resolved. We are continuing to followup with the Director and his staff in resolving other issues brought to our attention. The VISN Director informed us that he no longer has line authority over the former Director. In our discussions with the VISN Director, he was confident that the new Director would make a significant effort to restore the confidence of employees in management at the Medical Center. We are issuing a copy of this report to the former Director's new supervisor, the Chief Network Officer, and the Undersecretary for Health to advise them of the conditions identified at the VA Medical Center in Charleston.

/s/
JACK H. KROLL
Assistant Inspector General for
Departmental Reviews and Management Support

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SPECIAL INQUIRY

ALLEGED MISMANAGEMENT AT THE RALPH H. JOHNSON VA MEDICAL CENTER CHARLESTON, SOUTH CAROLINA REPORT NO. 7PR-A19-029

INTRODUCTION

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted a special inquiry at the Ralph H. Johnson VA Medical Center Charleston, South Carolina. The special inquiry was initiated at the request of Congressman Mark Sanford and House Veterans Affairs Committee staff who received multiple complaints that Medical Center management was mismanaging the facility. The purpose of the inquiry was to determine the validity of the allegations made by employees of the Medical Center and other concerned persons.

Background

VA Medical Center (VAMC) Charleston provides comprehensive care to over 127,000 veterans in 15 counties in southeastern South Carolina and Chatham County, Georgia. The VAMC is closely affiliated with the Medical University of South Carolina and supports over 70 medical residents in 25 different medical and dental specialties as well as students from nursing, pharmacy, social work, and allied health disciplines. The Medical Center has 265 authorized beds and offers numerous special health care programs to veterans in the area.

Mr. Dean Billik began as Director of VAMC Charleston on December 27, 1992. Mr. Billik was reassigned in early September 1996, to the Veterans Integrated Service Network Office (VISN) No. 17 in Dallas, Texas, and at the time of this report was reassigned to another facility. Ms. Johnetta McKinley was Acting Director during our onsite review. Mr. R. John Vogel was appointed the new Director and arrived at the Medical Center in December 1996.

We met with Congressman Mark Sanford's staff who received numerous complaints from VAMC employees and other concerned persons. Congressional staff requested our assistance in reviewing these allegations of mismanagement and personnel irregularities at the Medical Center. Some of the complainants' allegations overlapped, and the appropriateness of the former Director's decisions and actions were common factors in

most of the issues congressional staff presented to us. Specifically, allegations were made that the former Director did not follow accepted Veterans Health Administration (VHA) procedures in construction and renovations, contracting and obtaining services, and personnel matters.

Scope

We visited VAMC Charleston on three separate occasions between August 1, and October 31, 1996. We met with many of the complainants as well as Congressman Mark Sanford's staff, and reviewed the complaints presented to us at the Medical Center. We interviewed the former Medical Center Director, current Associate Director who was also Acting Director during our review, Service Chiefs, numerous current and former employees, and others concerned about the issues at VAMC Charleston. We also reviewed construction, contracting, financial, and personnel records as determined necessary to complete this review.

We reviewed the following 27 allegations brought to our attention.

Construction and Renovation Allegations

- The former Director took action to renovate Ward 4A into a Nursing Home Care Unit (NHCU) and never used the space for this purpose.

- There was an unnecessary cost overrun of $489,000 on the Ward 4A NHCU project.

- Three grandfather clocks and a treadmill purchased for the Ward 4A NHCU were missing from the Medical Center.

- Management received activation funding for the Ward 4A NHCU project even though the NHCU unit was never opened.

- The former Director renovated his suite without advance approval from VA Central Office on the renovation costs.

- The former Director's suite was unusually plush, with expensive wallpaper, gold plated bathroom fixtures, unnecessary audio-visual equipment, and expensive carpet. Also, the former Director replaced the carpet twice in one week.

- The former Director inappropriately discarded a well-known local artist's paintings as a part of the renovation of the Director's suite.

- The former Director unnecessarily purchased a $40,000 fish tank for the Medical Center lobby.

- Management authorized a rear entrance construction project despite warnings from the contractor that the design was not safe and would result in cracks in the structure.

- Management poorly renovated the psychiatric ward and painted the walls a dismal blue, which depressed patients.

Contracts and Services Allegations

- The former Director hired a consultant and inappropriately paid the person $800 daily for program analyst services.

- The former Director spent scarce funds on a maintenance contract to care for the fish tank while employees were facing layoffs, and anesthesia machines were not covered by service agreements.

- The former Director estimated a $2.9 million shortfall in funding as an excuse to contract out services and initiate a Reduction In Force (RIF).

- The former Director misused permanent change of station (PCS) funds by including a friend's household goods in his contract to move to another facility.

- Management wasted money by spending $3,000 for conference facilities at the Wild Dunes West resort.

- Management authorized nonessential landscaping services and redirected the old landscaping items to an employee's residence.

- The former Director and current Associate Director violated Federal and VA acquisition regulations when the medical center's contracting officer terminated a contract.

- The ***(b)(6)*** inappropriately hired a cleaning firm without a formal solicitation to seek competition, and he harassed his employees.

Personnel-Related Allegations

- The former Director engaged in inappropriate personnel actions to reward his associates and friends.

- The former Director created a nonessential GS-***(b)(6)*** position.

- Management inappropriately placed two employees in new respiratory therapy positions without seeking competition.

- Prosthetic Service management required an employee to work 3,000 hours of overtime without compensation.

- Management forced a physician to quit without just cause.

- Management created a contract specialist position for the friend of the ***(b)(6)***, and did not permit other staff to compete for the job.

Scheduling/Staffing Allegations

- Management violated their own policies by requiring respiratory therapists to work without backup in the intensive care unit during the evening hours.

- There was a shortage of nursing staff to provide quality patient care.

- Management closed the medical center at night and inappropriately turned away veterans seeking emergency care.

Reprisal for Whistleblowing Allegation

We received several complaints from congressional staff that VAMC management reprised against an employee. We took sworn, taped testimony from management and several employees on whether a ***(b)(6)*** suffered reprisal for whistleblowing to the OIG, and whether the supervisor of the section acted inappropriately. We found that management misinformed the OIG on actions taken to resolve disclosures made by staff, and supervisors reprised against one employee for whistleblowing to the OIG. The reprisal issues and recommendations are discussed in a separate report "Alleged Reprisal For Whistleblowing, Ralph H. Johnson VA Medical Center, Charleston, South Carolina," Report No. 7PR-G02-028, dated January 10, 1997.

Other Related Issues

We are continuing to review several other allegations received from congressional staff, VA employees and other concerned Charleston residents. The issues presented to the OIG conveyed similar concerns such as alleged personnel irregularities and mismanagement. We are continuing to review these issues with Veterans Health Administration (VHA) officials on a case-by-case basis.

RESULTS AND RECOMMENDATIONS

Construction and Renovation Allegations

Allegation 1: The former Director took action to renovate Ward 4A into a Nursing Home Care Unit (NHCU) and never used the space for this purpose.

Discussion: This allegation is substantiated. Ward 4A of the Medical Center was completely renovated into a 38-bed NHCU at a reported cost of $571,831. Construction was completed in February 1994, but the renovated space was never used as a NHCU. Instead, the space has been in nearly continuous use as "swing space" for specialty clinics displaced by other construction projects in the Medical Center.

The former Director, Mr. Billik, indicated that space was at a premium in the Medical Center and that he believed he had no choice but to use the renovated NHCU space as swing space while many of the Medical Center's specialty clinics were undergoing renovation. In his opinion, the only other choice would be to close or significantly curtail these clinics' services to veterans while the clinics were undergoing renovation. He did not believe that was a viable alternative.

The former Director expected that the NHCU would be used as swing space until at least June 1997. He stated that the use of the NHCU as swing space was coordinated with and approved by the VISN 7 Network Director's Office in Atlanta, Georgia, in March 1996.

The former Director stated that there was a strong demand for nursing home care beds in the Charleston area and he could fill the 38 NHCU beds almost immediately if the decision was made to open the NHCU. His assessment of the need for nursing home beds was supported by comments we received from staff in Congressman Sanford's office and the fact that there are 33 active nursing home care contracts for Charleston area veterans. The Charleston area has a large elderly veteran population. The closest VA nursing home care beds are in Columbia, South Carolina, which is over 110 miles from Charleston.

The former Director told us he did not like the idea of having a NHCU intermingled with patient treatment areas in the Medical Center. The NHCU was planned and approved before he became Director; therefore, he did not have any input into the planning for the NHCU. He also thought the NHCU would be costly for the Medical Center to operate. Furthermore, he stated that the decision on which facilities in VISN 7 should be providing

long term care was still "up in the air" and he was not sure if Ward 4A would ever be used as a NHCU.

While the former Director had some ideas for future uses of the NHCU space for non-NHCU activities, we did not believe there was a well defined long-term plan for the most effective use of the NHCU space. We were concerned about this issue especially in view of the significant funds that have been spent to renovate the Ward 4A space into a NHCU and the need for nursing home care beds in the Charleston area.

In early September 1996, we discussed the need for a more well defined plan for the NHCU space with the VISN 7 Director and the Acting Medical Center Director (Mr. Billik had been reassigned from the VAMC). In late September 1996, VISN 7 staff contacted VAMC Charleston on this issue and asked for additional information on the NHCU. In October 1996, letters were exchanged between the VISN and the Medical Center on this issue and telephone calls were also made to clarify the information provided in the letters.

On October 23, 1996, a final decision was made to open the NHCU in July 1997. In the meantime, the NHCU will continue to be used as swing space until the completion of the Ambulatory Care, Phase III Project.

Conclusion: We are satisfied that the timely action taken by the VISN 7 Director and the Medical Center in response to our inquiry will resolve the NHCU issue. In view of the money that had been spent on renovating the NHCU and the need for nursing home beds in the Charleston area, we believe the October 23, 1996 decision to open the NHCU was the right decision.

Allegation 2:	**There was an unnecessary cost overrun of $489,000 on the Ward 4A NHCU project.**

Discussion: This allegation is unsubstantiated. The Architect and Engineering firm estimated that the renovation of Ward 4A into a NHCU would cost $669,927. The reported cost to renovate Ward 4A into a NHCU was $571,832. There was no other evidence brought to our attention to support an alleged cost overrun on this project.

Allegation 3:	**Three grandfather clocks and a treadmill purchased for the Ward 4A NHCU were missing from the Medical Center.**

Discussion: This allegation is unsubstantiated. As part of the activation funding for the NHCU, the Medical Center purchased equipment during Fiscal Year 1995 valued at $174,807 for the NHCU. The equipment was purchased even though the NHCU was never activated. The equipment purchased included items appropriate for a NHCU, such as electrical beds, defibrillators, nurse call systems, and items that appeared nonessential, such as grandfather clocks, treadmill, and a piano.

The equipment purchased for the NHCU has been dispersed throughout the Medical Center and the items we checked were in use along side other Medical Center equipment. We searched the Medical Center with a management official and located the two grandfather clocks (two were purchased, not three as alleged) in Ward 4A, and the treadmill was located in the prosthetic's clinic. We found the piano in the main auditorium. We received every indication from staff that the equipment purchased for the NHCU was used to supplement other Medical Center equipment mostly in the patient treatment areas, but there was no comprehensive record of where this equipment was located.

Recommendation 1:

We recommend the Medical Center Director ensure that all the equipment purchased for the NHCU in Fiscal Year 1995 be accounted for so that it can be reconstituted in the NHCU once it is opened.

Medical Center Director's Comments:

As of December 2, 1996, our A&MM [Acquisition and Materiel Management] Service has accounted for all equipment items purchased for the NHCU. Those appropriate items will [be] transferred to the NHCU once it becomes operational.

Office of Inspector General Comments:

The Medical Center Director's comments are responsive to the recommendation, and we consider the issue resolved.

Allegation 4:	**Management received activation funding for the Ward 4A NHCU project even though the NHCU was never opened.**

Discussion: The allegation is substantiated. The activation funding provided the Medical Center in Fiscal Year 1995 totaled $1,528,337. The funding was for both equipment purchases (discussed above) and for the salaries and benefits (about $1,350,000) for 32.9 full-time employees (FTE) to staff the NHCU. Since the NHCU was not activated, the salaries and benefits portion of the activation funding in Fiscal Year 1995 was used to support general operational needs in the Medical Center. The $1.35 million then became part of the Medical Center's base amount for future (1996 and beyond) budget years.

Since the decision has been made to activate the NHCU, the Medical Center may be faced with the need to request additional funds to pay the salaries and benefits of NHCU staff or make reductions in current Medical Center services to activate the NHCU. Some preliminary estimates we were provided showed that an additional $379,000 may be needed to activate the NHCU. In today's austere budget climate, there is no assurance this additional funding would be available.

The OIG issued a nationwide audit report (6D2-D02-007) on activation funding in March 1996. This report contained VHA-wide recommendations for improving the management and control of activation funds. Since the findings in the recent nationwide report were similar to the events at VAMC Charleston, we are not making any additional recommendations; however, VHA top management should be aware of the potential funding problems they face now that the decision has been made to activate the NHCU.

Allegation 5:	**The former Director renovated his suite without advance approval from VA Central Office on the renovation costs.**

Discussion: The allegation is substantiated. In March 1993, the Deputy Secretary issued a letter to Administration Heads, Assistant Secretaries, Other Key Officials and Deputy Assistant Secretaries requiring his approval on all renovations and furniture purchases for Directors' offices. The policy applied to all Central Office and field facilities, and there was no expiration date for the policy.

In accordance with this policy, on December 29, 1994, the former Medical Center Director submitted a request through the Director, Southern Region, to the Deputy Secretary requesting approval for the purchase of office furniture and the renovation of

3,100 square feet for the Director's suite. The request was approved on January 5, 1995, by the Southern Regional Director and forwarded to Facilities Management in Central Office.

No further documentation of the approval process could be found. We interviewed the former VHA Associate Chief Medical Director for Operations who stated he was positive that he also did not have the opportunity to approve or disapprove this request. Responsible officials in the Office of Facilities Management could not recall this project. We contacted the Deputy Secretary's Office and confirmed that they never reviewed the request.

·***(b)(6)***·····, the individual who was responsible for coordinating the project for the former Director, indicated that ·***(b)(6)***· and the former Director thought the project was approved based on ·***(b)(6)***· telephone conversation with an individual in the Office of Facilities, who indicated that the project had been approved by VHA officials. The individual ·***(b)(6)***····· talked with is no longer a VA employee and could not be contacted to verify what information ·***(b)(6)***· provided to ·***(b)(6)***····· or the basis for her telling ·***(b)(6)***····· the project was approved.

Since the policy requiring the Deputy Secretary's approval on furniture purchases and renovations was more than 3 years old at the time of our review, we asked the Deputy Secretary's Special Assistant if the Deputy Secretary still wanted to approve these types of requests. We also told him we were aware of a number of cases, including VAMC Charleston, where the existing policy was not being followed. The Special Assistant informed us the Deputy Secretary still wanted to be involved in the approval process. After our contact with the Deputy Secretary's Office, the Chief of Staff issued a reminder on August 13, 1996 to all Administration Heads, Assistant Secretaries, and Other Key Officials. The reminder stated that the March 1993 policy requiring the Deputy Secretary's approval for furniture purchases and renovations was still in effect and should be complied with.

Conclusion: We are not making any recommendations to the Medical Center on this issue. We advised the Deputy Secretary's Office of the unapproved project at this Medical Center. The Chief of Staff's recent guidance on this issue should correct the non-reporting problem.

Allegation 6:	**The former Director's suite was unusually plush, with expensive wallpaper, gold plated bathroom fixtures, unnecessary audio- visual equipment, and expensive carpet. Also, the former Director replaced the carpet twice in one week.**

Discussion: This allegation is not substantiated. We did not find the Director's suite to be inordinately plush; however, we did find that carpet for part of the suite was ordered twice.

Approximately 3,100 square feet of Medical Center space was renovated for the Director's suite. The renovated space provided offices for 12 individuals: the Director, Associate Director, Chief of Staff, Chief Nurse, two special assistants, an administrative assistant, and five secretaries. The renovated space also included a conference room, bathroom, and a closet.

We were shown photographs of the old Director's suite, and we discussed the condition of the suite with responsible officials both at the Medical Center and the VISN. It appeared that prior to the renovation, little had been done to the space since the Medical Center had opened in 1968. We concluded that the space needed to be renovated. Medical Center records indicate the renovations cost $58,357. Management used local funds for the renovations.

In conjunction with the renovation of the Director's suite, staff also purchased new furniture and equipment totaling $139,254. According to responsible Medical Center officials, much of the furniture that was replaced was more than 25 years old, mismatched and not functional for a modern automated office. The new furniture and equipment purchases were made from the General Services Administration (GSA) schedule. The new furniture is mostly veneer and not unlike that found in other executive office suites.

With respect to the specific items mentioned in the allegations, we found the following.

a) Wallpaper — The wallpaper purchased by the Medical Center was actually a high quality wall covering (woven yarn with an acrylic backing). According to the sales representative for the manufacturer of the wall covering, this 54 inch wide wall covering retails for $24.50 per linear yard, but they sold it to the Medical Center for the discounted price of $9.79 per linear yard. The Medical Center purchased 310 linear yards at a total cost of $3,035.

This wall covering was not on the GSA schedule. The sales representative said that her company had vinyl wallpapers on the GSA schedule, but they were of a lower quality than the woven yarn with acrylic backing wall covering. The company did offer vinyl wallpapers on the GSA schedule at a cost of about $5 to $6 per linear yard.

The wall covering purchased by the Medical Center was more upscale than one may find in many Federal offices. According to the manufacturer's representative, this type of wall covering should last longer and wear better than lower quality wallpaper. If the representations made by the manufacturer are valid, then we would not view the wallpaper purchase as wasteful.

b) Gold-Plated Fixtures — The gold fixtures (one set in the bathroom and one set in the break closet) were actually polished brass and the type generally stocked by a local hardware store. The Medical Center paid $337 for the faucets and a Kohler sink in the bathroom and $205 for the faucet and sink in the break closet. We did not view these expenditures as lavish or wasteful.

c) Audio-Visual Equipment — The $30,861 spent for audio-visual equipment was to fully equip not only the Director's conference room but also the main auditorium with state-of-the-art ceiling mounted projection equipment with remote controls. The two systems (one in the Director's office and one in the auditorium) are wired together so that the same briefing could be shown simultaneously in both areas. This type of equipment certainly adds to the professionalism of presentations made by management officials and should aid them in disseminating information to the Medical Center staff. We did not find the audio-visual equipment purchases out of line with the type of equipment purchased for modern conference rooms and auditoriums.

d) Expensive Carpet — As a part of the renovation project for the Director's suite, the Medical Center purchased 74 square yards of carpet from the GSA Schedule for selected rooms in the Director's suite. The carpet cost $18.77 per square yard, and the total cost of the carpet purchased was $1,389. This carpet had a black background and, when it arrived, Medical Center officials decided that it would not be suitable for the Director's suite because it would show dirt and lint too easily. Some of this carpet was later installed in other parts of the Medical Center and the remainder was stored in the warehouse for future use. According to management officials, the black carpet was never actually installed in the Director's suite.

After rejecting the black carpet, the Medical Center then ordered 300 square yards of green carpet from the GSA Schedule at a cost of $18.77 per square yard. This was enough carpet to cover the entire Director's suite. The total cost of this second carpet purchase was $5,631.

Medical Center officials admitted it was a mistake to have purchased the black carpet because this color of carpet is so difficult to keep clean. The Medical Center has used some of this carpet in other parts of the Medical Center where appearance of the carpet is not so critical. The second purchase of carpet appears reasonable and the price is not out of line with carpet purchased for other Federal offices.

Conclusion: In summary, we did not find the renovations made to the Director's suite to be overly plush or the furniture and equipment purchased to be unnecessary (except for the black carpet discussed above). As a part of our Special Inquiries work, we visit a number of Director's suites in Medical Centers and we found the VAMC Charleston suite to be in line with many other Medical Center Director's suites.

We believe the complaints about the renovations, furniture and equipment purchased for the Director's suite stemmed from the timing of the event. The renovations were completed almost immediately after the second Federal employee furlough and only about two months before the former Director made it known to the staff that there was a large potential funding shortfall in the Medical Center's Fiscal Year 1996 budget. A number of employees thought that their jobs were being threatened by both furloughs and budget cuts. These employees believed the renovation of the Director's suite was given a high priority by the former Director when his highest priority should have been to preserve funds to meet the employee payroll.

With respect to the former Director's actions, the renovations and purchases were planned long before any Federal furloughs or shortages of Fiscal Year 1996 funds. The former Director could not have predicted these two events (furlough and fund shortage).

Allegation 7:	**The former Director inappropriately discarded a well-known local artist's paintings as a part of the renovation of the Director's suite.**

Discussion: This allegation is partially substantiated. There was no inventory of paintings in the old Director's suite; therefore, we could not determine how many paintings were destroyed. Also, there was no way for us to place a value, if any, on these items. However, a management official admitted he discarded at least one of the paintings because it looked like a "piece of trash" to him. The fate of the remaining paintings could not be determined. Therefore, we made no recommendations.

Allegation 8:	**The former Director unnecessarily purchased a $40,000 fish tank for the Medical Center lobby.**

Discussion: This allegation is partially substantiated. As a part of the construction project to renovate the ambulatory care area, a large saltwater fish tank was built into a wall in the center of the main lobby/waiting room for ambulatory care patients. According to Medical Center records, the aquarium cost $26,119, not $40,000 as alleged in the complaint. The construction project that included the fish tank was completed in February 1996.

A fish tank is obviously not a necessity for the successful operation of a Medical Center; therefore, this part of the allegation is substantiated. The project also came at a time when employees were faced with furloughs and potential budget cuts, which heightened concern that management was not adequately prioritizing the expenditure of resources.

However, there is no question that the fish tank makes a charming lobby centerpiece and many veterans enjoy viewing the fish while they are waiting for their medical care. We observed a number of veterans walking up to the tank for a close-up view of the fish. Management officials stated that the fish in the tank have a therapeutic effect on the patients in the waiting room, many of whom have to spend time in the lobby waiting to see a physician. Furthermore, since it is now built into the lobby wall, it would be an expensive project to remove the tank and its associated plumbing and wiring.

Conclusion: In summary, we believe some employees perceived the former Director as placing priority on nonessential amenities such as the fish tank at the a time when employees' jobs were being threatened by a shortage of funds. A number of employees used the fish tank as a symbol of what they believed was the former Director's unsympathetic attitude towards the employees who may be subject to the RIF process or other adverse personnel actions due to the fund shortages.

Recommendation 2:

The Medical Center Director should carefully evaluate the options regarding the fish tank and determine whether continued use of the tank is in the best interests of the Medical Center.

Medical Center Director's Comments:

The Medical Center Director determined that it would cost approximately $27,394 to remove the fish tank from its present location in the front lobby. The Director stated that due to the nature of the initial construction, removing the fish tank would destroy the

interior design and uniformity of the lobby. The Medical Center Director stated they have received numerous positive comments from patients, family members, and the general public on the lobby and fish tank. They supported keeping the fish tank as part of the lobby. The full text of the comments are shown in the Appendix of the report.

Office of the Inspector General Comments:

The Medical Center Director's actions met the intent of the recommendation. We consider the recommendation resolved.

Allegation 9:	**Management authorized a rear entrance construction project, despite warnings from the contractor that the design was not safe and would result in cracks in the structure.**

Discussion: This allegation is unsubstantiated. Our discussion with the Acting Chief Engineer indicated that his staff were not aware of any problems with the rear entrance until cracks appeared in the wall about one year after construction was complete. We also discussed this issue with the President of the contracting firm for the project and he said that no one suspected that the rear entrance wall would crack like it did. His firm did not warn Medical Center staff of any potential problems regarding cracks in the rear entrance wall.

We found that a planter, which was connected to a wall leading into the rear entrance, was built on fill dirt without the proper supporting structure. As a result, the planter began to sink, causing the wall to crack. The Medical Center determined that it was a faulty design problem by the Architect and Engineer (A&E) firm. The general contractor, who followed the A&E firm's design in building the wall and planter, was not at fault on the project.

The Medical Center issued a modification in May 1996 for $9,084 to the general contractor to provide a proper foundation for the planter and repair the wall around the crack. The Acting Chief, Engineering Service, informed us he did not consult Regional Counsel on whether to try to seek reimbursement from the A&E firm for the additional work. He said the issue was discussed with his engineers. They determined that had the original specifications required a reinforcing foundation, the cost of the project would have increased about $6,000 anyway. The Acting Chief Engineering believed that it would cost more than the remaining $3,000 to legally pursue the A&E firm for the difference, and there would be no assurances that VA would win a judgment against the firm. Therefore, management elected not to pursue the issue further. At the time of our visit, the problems with the rear entrance had been corrected.

Allegation 10:	**Management poorly renovated the psychiatric ward and painted the walls a dismal blue, which depressed patients.**

Discussion: This allegation is unsubstantiated. Management officials informed us that the interior designer on loan from VAMC Columbia had plans to paint the psychiatric ward rooms purple. This plan was discussed with physicians and nurses on the psychiatric ward, and they vetoed painting the rooms purple.

It was the clinical staff that suggested the walls be painted a sky blue color. The psychiatric ward staff's suggestion was followed and the walls are indeed sky blue. We trust the psychiatric staff's judgment on this issue.

The psychiatric ward is scheduled for a complete renovation in the near future. Management officials indicated that they will again discuss the color of the paint with psychiatric staff and they will paint the walls whatever color they suggest. We therefore made no recommendations.

Contracts and Services Allegations

Allegation 11:	**The former Director hired a consultant and inappropriately paid the person $800 daily for program analyst services.**

Discussion: The allegation is substantiated. We received an allegation that the former Director inappropriately hired a consultant and paid the person $800 daily for program analyst services that have been provided by VA staff.

We found that the former Director hired a management consultant, ***(b)(6)***, beginning in Fiscal Year 1995. The former Director told us that ***(b)(6)*** was a former employee of a firm that had a contract with VA to establish a Quality Improvement Program nationwide. ***(b)(6)*** left the firm and began his own company, ***(b)(6)***. The former Director hired ***(b)(6)*** as a management consultant, and continued using his services at the VA Medical Center after the national contract expired.

(b)(6) received $1,200 per day plus expenses from the Medical Center and worked 4 days per month at the time of the review. According to the Chief, Fiscal Service, the Medical Center paid ***(b)(6)*** $87,750 in Fiscal Year 1995, and $90,117 in Fiscal Year 1996. The former Director used 48 - Code of Federal Regulation (CFR) 670- 3 as his

authority to contract with the consultant. According to the Chief, Fiscal Service, this authority did not require the medical center to obtain approval from the Veterans Integrated Service Network (VISN) or VA Central Office, Washington, DC.

We found that management incorrectly approved this contract using the CFR [1] to authorize funds. This regulation delegates "fee basis" authority to the Chief of Staff and Chief, Medical Administration Service to execute authorizations for medical, dental, and ancillary services under $10,000 per authorization when such services are not available from existing contracts or agreements. The regulation made no provision for management consultant services or other administrative functions.

Management should have followed the procedures for obtaining consultant services prescribed in CFR 837.2. [2] The regulation prescribes that consultant services will normally be obtained only on an intermittent or temporary basis; repeated or extended arrangements are not to be entered into except under extraordinary circumstances. The regulation also prescribes that a competitive solicitation is the preferred method of obtaining consulting services and should be used to ensure that costs are reasonable. Sole-source contracts for consulting services resulting from unsolicited proposals are generally not appropriate. According to the regulation, contracts such as these require the approval of the Secretary, regardless of the amount.

On July 8, 1992, VA issued Circular 00-92-15 to mitigate the effort associated with the formal submission of documentation required. The Circular provided for "concept approval" procedures to secure advisory and assistance services. Although the Circular was rescinded on July 1, 1993, acquisition policy staff considered the procedures effective until further notice. All advisory and assistance service contracts over $25,000 require the approval of the Secretary. VA staff informed us that they anticipate this ceiling will be raised to $250,000. The concept request should be a memorandum signed by the appropriate Assistant Secretary or Administration Head and should be transmitted through the Assistant Secretary for Acquisition and Facilities to the Secretary for approval.

The former Director should have developed a concept proposal for advisory and assistance services as prescribed by the Circular to include:

- a brief description of the services contemplated;

[1] *48 Code of Federal Regulations, Chapter 8, Subpart 670.3*
[2] *48 Code of Federal Regulations, Chapter 8 Subpart 837.2*

- a signed statement, by the appropriate contracting officer, certifying that the requirement is for advisory and assistance services as defined by Federal Acquisition Regulation 37.201; and

- a justification of need and certification that such services do not unnecessarily duplicate any previously performed work or services.

After the proposed acquisition was approved "in concept," the former Director should then have completed a procurement request package. All procurement request packages are approved by an official one level above the requesting activity. The former Director did not follow this policy or its requirements.

We found that the former Director did not specifically define ***(b)(6)***'s management consultant duties. Essentially, ***(b)(6)*** carried out special projects assigned by the former Director. We asked management to develop a list of the consultant's accomplishments during the past fiscal year. We were informed that one of his projects was to consult with the former Director and his staff to develop a Medical Center strategic plan. He also assisted in developing a proposal for a consolidated mail-out pharmacy and met with staff on quality improvement program issues. He also provided training on quality management issues and worked with the Medical Center's Quality Management Coordinator. At the time of our inquiry, the Medical Center's contract for services with ***(b)(6)*** continued without any specific work statements or fixed periods of service.

A number of employees we interviewed believed that the hiring of the consultant was just another example of the former Director's lack of concern about them. The employees believed that the former Director paid the consultant to perform work that could have been done by VA program analysts in the Director's Office and in the Medical Center's Quality Management Section. They pointed out that the former Director seemed to have enough money to pay his consultant (i.e., $90,117 yearly working about 4 days per month), yet at the same time he was telling the staff assigned patient care and support responsibilities that he may not have enough money to pay them.

Recommendation 3:

We recommend the Director, Veterans Integrated Service Network No. 7 take action to ensure that the former Director, and current management at the VA medical center are aware of the appropriate procedures to follow when requesting advisory and assistance services.

Director, Veterans Integrated Service Network No. 7 Comments:

The Director, Veterans Integrated Service Network No. 7 stated "The former Director at Charleston VAMC no longer works in this VISN. Accordingly, I have no line of authority over him. The newly appointed Director at Charleston is aware of the appropriate procedures to follow when requesting consultative services and has terminated the present contract effective 12-31-96."

Office of Inspector General Comments:

We will forward a copy of the final report to the former Director's current supervisor for review and action as warranted. Action to terminate the contract was responsive to the recommendation, and we consider the issue resolved.

Recommendation 4:

We recommend the Medical Center Director take action to:

a. Discontinue using the fee basis authority to pay for the management consultant's services, and reevaluate whether advisory and assistance work continues to be needed at the medical center.

b. Develop the required "concept approval" documents and submit an official request for the consultant's services to the VISN if it is determined that these services are still needed.

Medical Center Director's Comments:

The Medical Center Director stated "The consultant in question, ***(b)(6)***·····, will be terminated as a consultant as of 12/31/96. In the future if a consultant's services are deemed necessary, the procedures outlined in Circular 00-92-15 will be followed."

Office of Inspector General Comments:

The Medical Center Director's comments are responsive to the recommendations. The cancellation of the contract will permit the Medical Center to use the much needed funds ($90,000 plus expenses) for other health care priorities. We consider the issue resolved.

Allegation 12:	**The former Director spent scarce funds on a maintenance contract for the fish tank while employees were facing layoffs, and anesthesia machines were not covered by service agreements.**

Discussion: This allegation is substantiated. On February 12, 1996, the Medical Center issued a purchase order for maintenance of the fish tank. The maintenance contract cost $650 per month for an annual cost of $7,800. The contract included stocking the tank with salt water fish, feeding the fish, cleaning the tank, and replacing dead fish.

On March 13, 1996 (one month after the fish tank maintenance contract was issued), the Chief of Fiscal Service developed budget status documents that showed a projected shortfall in the Fiscal Year 1996 budget of $2.9 million. One of the scenarios developed by the Chief of Fiscal Service to meet this budget shortfall was to RIF employees in the Environmental Management Service and Dietetics Service. This information about the RIFs was later shared with the Medical Center employees, which caused them to become very concerned about the possible loss of their jobs. Eventually the Medical Center was provided more funding by the VISN, which negated the need to RIF employees. However, a number of the other "belt tightening" measures suggested by the Chief of Fiscal Service were implemented.

In an environment where employees' jobs were threatened, the expenditure of scarce funds on the construction and maintenance of the fish tank became a "lightening rod" for attracting complaints about what some employees viewed as the former Director's misplaced sense of priorities. We suspect the construction of an aquarium for the lobby might have brought compliments from employees about its therapeutic value had significant funding shortages for the Medical Center not been an issue.

It is true that the anesthesia machines no longer have a maintenance contract. Medical Center officials explained that the anesthesia machines have not had a maintenance contract for a number of years because of a management decision that the maintenance of these machines could be accomplished more effectively by the Medical Center's biomedical staff. We could find no evidence of any problems with the in-house maintenance services for the anesthesia machines. Therefore, we did not review this issue further.

Recommendation 5:

We recommend the Medical Center Director consider the cost of the annual maintenance contract for the fish tank in her deliberations on the options related to the future of the fish tank.

Medical Center Director's Comments:

The Medical Center Director stated that the current maintenance contract for the fish tank runs through September 30, 2000. He stated that the monthly fee of approximately $650 covered both the lease of the tank, fish and equipment, as well as on-going maintenance. The Medical Center Director noted that when the contract was sent out for bid, there were 5 inquiries. However, the Medical Center only received 2 bids. The bid not chosen was approximately double ($1,500) the current rate. The Medical Center Director made the decision to keep the fish tank and associated maintenance contract. The full text of the comments are shown in Appendix A of the report.

Office of Inspector General Comments:

The Medical Center Director's comments met the intent of the recommendation. We consider the issue resolved.

Allegation 13:	**The former Director estimated a $2.9 million shortfall in funding as an excuse to contract out services and initiate a Reduction In Force (RIF).**

Discussion: This allegation is unsubstantiated. In March 1996, the Chief of Fiscal Service prepared a comprehensive budget status document that clearly showed a projected shortfall of $2,988,801 in the Medical Center's Fiscal Year 1996 funding.

As an attachment to the budget shortfall document, the Chief of Fiscal Service proposed 13 budget scenarios to deal with the funding shortfall. These scenarios ranged from proposals for smaller savings, such as eliminating the nighttime urgent care coverage ($41,000), reducing overtime and night differentials ($116,000), reducing fee basis costs ($75,000), to proposals for larger savings, such as implementing an employment freeze ($300,000), initiating an across-the-board furlough ($740,000), and conducting a RIF of employees in Environmental Service and Dietetics Service (savings undetermined).

There is no question that the $2.9 million projected shortfall at mid-year in Fiscal Year 1996 was real. We believe the Chief of Fiscal Service did a good job of presenting the former Director with options to help ease the shortfall. The former Director took action to implement some of these options. He also used a "town hall" type forum to inform the staff about the shortfall and its consequences on Medical Center employees.

As a part of the process of searching for cost savings ideas, a proposal was developed to contract out many of the remaining Environmental Management Service functions (some Medical Center Environmental Management functions were already contracted out). We

reviewed this proposal, which projected savings in the first two years of more than $600,000 from contracting out these services. We did not see any evidence of fraud or misrepresentation in the proposal. Some of the figures naturally were estimates, but they did not seem out of line.

This proposal was submitted to VHA Central Office for consideration. It was disapproved at that level for reasons entirely unrelated to the accuracy of the cost estimates.

Allegation 14:	**The former Director misused permanent change of station (PCS) funds by including a friend's household goods in his contract to move to another facility.**

Discussion: We did not substantiate the allegation. We found that the former Director's date of transfer was September 1, 1996. We interviewed the contracting officer, ***(b)(6)*** and found that the former Director's PCS move was performed by Lawrence Transportation Company. We contacted the company and spoke with the employee that visited the former Director's residence and calculated the number of boxes and truck space needed to complete the PCS move.

We asked the contractor whether the former Director indicated he was moving anyone else's household goods. The contractor informed us that the former Director asked the company to estimate the cost of moving ***(b)(6)*** from ***(b)(6)*** apartment to Texas. The contractor said the former Director asked whether they could include ***(b)(6)*** household goods on the same truck, and pay for ***(b)(6)*** portion of the move separately.

The contractor informed us that the former Director said that he needed to pay for ***(b)(6)***s move separately because it was not covered under VA contract. The contractor said that he visited the former Director's residence to estimate the cost of the move and did not notice any ***(b)(6)*** clothing in any of the closets or anything else to indicate he was moving more than one residence. The contractor said he provided the former Director a separate estimate for moving the household goods in ***(b)(6)***'s apartment. The contractor informed us that the former Director contacted him a few days later and said they were going to make other arrangements to move the items using U-Haul transportation.

The Acting Director confirmed that the former Director made a request to the Medical Center contracting officer to include ***(b)(6)***'s household goods on the same truck. The contracting officer informed us that the former Director asked her whether he could pay for ***(b)(6)***'s portion of the move separately from the VA contract. She contacted the Acting Director for advise. The Acting Director said she disapproved of the idea because of the appearance it might give employees, and asked the former Director to seek other alternatives. The contractor provided us documents which showed that the former Director's move was within 7 percent of the original estimate. The estimated weight was 9,100 pounds and the actual weight was 9,760 pounds.

We contacted the former Director and asked him to clarify this issue. The former Director denied combining ***(b)(6)***s household goods with his move. He said that ***(b)(6)*** used a Rider Truck Company in ***(b)(6)*** to move to ***(b)(6)***, and ***(b)(6)*** parents helped ***(b)(6)*** move. ***(b)(6)***s move is a matter of record at the Rider Truck Company. The former Director said he recognized that even if he had paid for ***(b)(6)***'s portion of the move using his own funds, someone at the Medical Center would probably have complained about it given the current climate at the Medical Center.

Allegation 15:	**Management wasted money by spending $3,000 for a conference at the Wild Dunes West resort.**

Discussion: This allegation is unsubstantiated. On July 9 and 10, 1996, the Medical Center held an administrative conference at the Wild Dunes West resort in Mt. Pleasant, South Carolina, a suburb of Charleston. The Medical Center paid the Wild Dunes West resort $950 for space and supplies for the conference. About 35 senior staff members attended the conference. Temporary duty costs were not an issue because the attendees did not stay overnight.

The primary purpose of the conference was to exchange ideas about the development of a strategic plan for the Medical Center. Strategic planning is a subject that is receiving considerable Congressional and Office of management and Budget (OMB) attention and all activities are required to develop such plans. We were shown a copy of the plan that was eventually developed.

Senior managers throughout VA conduct business off site from time to time where they can concentrate on important issues without the daily interruptions of the workplace. Therefore, we considered the expenditure within management's discretion.

Allegation 16:	**Management authorized nonessential landscaping services and redirected the old landscaping items to an employee's residence.**

Discussion: This allegation is partially substantiated. The Medical Center has a very small campus and according to the former Director and others, it was poorly landscaped. The former Director essentially said to his staff "landscape it right or pave it over." Managers elected to improve the landscaping.

The Medical Center has a contract with Fast Eddies Landscaping Company for maintenance of the grounds to include sweeping the parking lots and street around the Center. The contract was awarded on a competitive basis and Fast Eddies was the low bidder at $17,988 annually.

The Medical Center also has two current construction projects that include landscaping services. Both of these contracts are for repairing the parking lots and handicapped access to the Medical Center. The small areas around the parking lots and the handicapped access areas will be landscaped by these contractors. Once the landscaping is installed, Fast Eddies will be responsible for maintaining the landscaping.

With the amount of exterior construction projects either recently completed or still underway, we could see how some employees may have the impression that constant changes are being made to the landscaping. We did not see any evidence of wasteful spending in this area. The Medical Center's landscaping is attractive, but not overly lavish when compared with other VA medical centers.

With respect to the issue of the diversion of old plants to employees, management officials indicated that some time ago an employee had taken some old plants home with him. Staff were reminded that the old plants were Government property and were to be disposed of and not given to employees. A memorandum was issued to employees regarding removing excess and scrap Government property from the facility. Management's actions seemed to have corrected the situation and we are not aware of any other problems in this area. We therefore made no recommendations.

Allegation 17:	The former Director and current Associate Director violated Federal and VA acquisition regulations when the Medical Center's contracting officer terminated a contract.

Discussion: This issue is in the appropriate administrative and judicial forum for resolution. The complainant made serious allegations regarding the former Director's and current Associate Director's involvement in contract irregularities and the improper termination of his contract with the Medical Center. The allegations and related documents have been filed with the Board of Contract Appeals (BCA). We submitted the post-hearing briefs filed by VA and the contractor to our legal staff and the information revealed substantial disagreements and disputes about the facts of the case.

Our legal staff found that a hearing has already been held before BCA. We found that the contractor's arguments made to the OIG are identical to the arguments made by the contractors legal representative in his submissions to the BCA.

Our legal staff took the position that it would be inappropriate for the OIG to become involved in the dispute under these circumstances. They based their decision on the fact that the disputed matters are already in the appropriate administrative and judicial forum for their resolution. This incident was interpreted by some employees as another example of the former Director's mismanagement of Medical Center operations.

Allegation 18:	The ***(b)(6)*** **inappropriately hired a cleaning firm without a formal solicitation to seek competition, and harassed his employees.**

Discussion: We did not substantiate that the private cleaning firm's contract was inappropriately awarded, but found that some employees believe they are harassed by management. We found that ***(b)(6)*** entered into a 7-week contract with a small business cleaning service to provide floor care prior to a Joint Commission on Accreditation of Healthcare Organizations external review on September 15, 1995. The Medical Center awarded the contract pursuant to Section 8(a) of the Small Business Act [15 U.S.C. 637(a)] and anticipated services would begin on September 15, 1995. The contract received prior approval from the Small Business Administration and was estimated to cost VA $24,000.

On September 10, 1995, Medical Center staff requested the Small Business Administration to approve the same company to supplement janitorial services for the Medical Center. The services were requested for one year with a one year option. The estimated cost of this contract totaled $101,000. The Small Business Administration approved the agreement for the period October 1, 1995 through September 30, 1996, for $92,284, and approved the option year beginning October 1, 1996, through September 30, 1997, at a cost of $94,561. VA staff followed small business set aside contracting procedures.

We also interviewed ***(b)(6)*** employees who informed us that ***(b)(6)*** harasses them on a routine basis, and continually threatens them with the prospect of fully contracting out their jobs to the private cleaning firm. They expressed concerns that the private contractor uses their supplies and locks up VA equipment making it unavailable for VA staff to complete their assignments during other shifts. They also said that they have to clean the areas the private contractor is responsible for because the work is not always done properly.

The ***(b)(6)*** disagreed that supplies and equipment are unavailable to his VA staff or that the private contractor's work is inferior. He acknowledged that he is direct and forthright with his employees and believes that some of them are lazy, abuse sick leave, and are accident prone. The ***(b)(6)*** is an advocate of contracting out for services and said he has met with staff in general meetings to alert them of the trend in this area. The ***(b)(6)*** said that he has taken a no nonsense approach with his employees and admits that his style of management is not always tactful or sensitive.

Employees we spoke with were uncertain of their retention rights and were unsure of their future employment at the Medical Center. These concerns have been heightened by ***(b)(6)*** management style, and discussions with his staff concerning the private cleaning service's work. This increasing uncertainty contributed to the overall belief that the former Director, and management in general, are unsympathetic to the employees at the Medical Center, and staff speculations that they will lose their jobs.

Recommendation 6:

The Medical Center Director should take appropriate action to ensure that the ***(b)(6)*** employees are appropriately advised of their employment rights as they pertain to the current and future plans for retaining private cleaning services at the Medical Center.

Medical Center Director's Comments:

The Medical Center Director communicated to ***(b)(6)*** that he needs to improve interaction with ***(b)(6)*** employees in keeping them informed of the current contract for private cleaning services, in addition to their rights as federal employees in these situations. The Director informed us that this would be done at ***(b)(6)*** staff meetings. Any information communicated at these meetings will be coordinated through Human Resources Management. The Medical Center Director noted that all ***(b)(6)*** employees have the opportunity to speak separately with ***(b)(6)*** as well as Human Resources staff concerning this and any other issues. The full text of the Medical Director's comments is shown in Appendix A of the report.

Office of Inspector General Comments:

The Medical Center Director's comments met the intent of the recommendation, and we consider the issue resolved.

Personnel-Related Allegations

Allegation 19:	**The former Director engaged in inappropriate personnel actions to reward his associates and friends.**

Discussion: This allegation is unsubstantiated. The complainant alleged that the former Director inappropriately promoted several of his associates and friends without competition, e.g. ***(b)(6)*** ***(b)(6)*** ***(b)(6)*** ***(b)(6)*** and ***(b)(6)*** The former Director allegedly rewarded those employees who became his personal friends or who covered up for him for some improper action at the Medical Center. The complainants also alleged that the former Director promoted staff he had a personal relationship with, and those who would willingly go along with any managerial action no matter how inappropriate it was for the Medical Center.

All five of the people named in the allegation were promoted noncompetitively to a higher grade and in two cases ***(b)(6)*** and ***(b)(6)***), promoted twice noncompetitively. Noncompetitive promotions are authorized by personnel regulations and the use of this method of promotion process in lieu of the competitive process is a management decision.

Three of the five individuals (***(b)(6)*** ***(b)(6)*** and ***(b)(6)*** were ***(b)(6)*** and the remaining two individuals were ***(b)(6)*** office. The former Director was the approving official on all of these promotions.

We found no evidence that these individuals were not qualified for the higher graded positions. The promotions were processed through the Medical Center's Human Resources Management Service and the Chief certified that the positions met the higher classification grade and that the individuals were qualified for the higher graded position.

We found the use of noncompetitive promotions for these individuals was a subject of concern among employees. The staff promoted were known friends and associates of the former Director. This fact undoubtedly gave rise to the allegation that the promotions were made more on the basis of friendship than merit. There is no indication even if the competitive process had been used for filling these positions, that these individuals would not have been selected. However by foregoing the competitive process no one else at this Medical Center, or any other VHA facility, had the opportunity to be considered for the positions.

Also, the timing on the promotions to GS-***(b)(6)*** for the two ***(b)(6)*** raised further questions from employees. The two promotions were made in April 1996, at the same time the former Director was announcing to the staff serious funding shortages, possible RIFs and other cutbacks in funding. This gave the staff the appearance that the "front" office was exempt from these budget cuts, while everybody else in the Medical Center was subject to the potential RIFs or other reductions. We received a number of complaints about the appropriateness of the promotions of these two ***(b)(6)*** so it was apparent the staff was upset by what appeared to them to be favoritism.

While we could not validate the allegation that these promotions were based on anything other than merit, the former Director's use of noncompetitive promotions for these individuals to the exclusion of others sent the wrong message to the staff and increased the tension between rank and file employees and top management.

Allegation 20:	**The former Director created a nonessential GS-*(b)(6)* position.**

Discussion: This allegation is unsubstantiated. The former Director did create a GS-***(b)(6)*** position in 1993. The former Director believed that with the numerous renovation projects underway or planned for VAMC Charleston, an in ***(b)(6)*** was necessary. Prior to that time, the Medical Center had borrowed the services of an ***(b)(6)*** assigned to VAMC Columbia, South Carolina.

According to Medical Center officials, that arrangement did not prove to be entirely satisfactory. Accordingly, ***(b)(6)*** was hired to fill the ***(b)(6)*** position at the GS-***(b)(6)*** level. ***(b)(6)*** was promoted to the GS-***(b)(6)*** level in August 1994, and ***(b)(6)*** recently transferred to another VA facility. With the current budget limitations, there are no plans at this time to hire a new ***(b)(6)***

We believe it was management's decision whether or not to hire an in-house ***(b)(6)*** There is nothing necessarily wasteful about that decision. A number of VA medical facilities have an ***(b)(6)*** on their staff and others contract for ***(b)(6)*** services. It is a valid Medical Center function, especially for those VAMCs undergoing extensive renovation.

Allegation 21:	**Management inappropriately placed two employees in new respiratory therapy positions without seeking competition.**

Discussion: The allegation is not substantiated. The Chief, Human Resource Management Service, informed us that the two positions in question were not subject to promotion consideration or change in position description. Two respiratory therapy employees were laterally assigned to the duties.

Allegation 22:	**Prosthetic Service management required an employee to work 3,000 hours of overtime without compensation.**

Discussion: The issue is pending resolution. The complainant alleged that management required her to work after hours, weekends and holidays. According to the complainant, she continued to work the hours until the pace became so exhausting that she became ill. She eventually suffered a work-related injury. We reviewed this issue with the Chief, Human Resources Management Service and found that the complainant has sought legal assistance in pursuing and EEO complaint and reimbursement of the overtime hours worked. VA management had made an offer to the complainant to settle the dispute, but it was rejected by the employee. The legal process continues. We took the position that it would be inappropriate for the OIG to become involved in this matter further because the matter is already in the appropriate administrative and judicial forum for resolution.

Allegation 23:	**Management forced a physician to quit without just cause.**

Discussion: A settlement was reached with the physician. The physician settled with the VA and affiliation and left the Medical Center to enter a private practice. The complainant alleged that management inappropriately forced him to resign from his position in ***(b)(6)*** According to the physician, the problems began after a controversy over the dosage he prescribed patients on anti-anxiety medications. During the physician's vacation, one of his patients on a trycyclic antidepressant was given another drug and had a toxic reaction. The patient had severe

side effects and was hospitalized. This began a series of disagreements between the physician and a new ***(b)(6)***.

The physician informed us during a telephone interview that he accepted a settlement agreement from the VA and the University Medical School affiliation, prior to entering private practice. At that time, all parties were in agreement with the settlement. The physician contacted the congressional office because he was now asking for additional considerations beyond the original agreement, and wanted to inform the OIG of the poor management practices of the Medical Center. We took the position that it would be inappropriate for the OIG to become involved in a matter that was settled by an official agreement signed by the complainant, and that the physician could continue to pursue these issues through the appropriate legal processes.

Allegation 24:	**Management created a contract specialist position for the friend of the *(b)(6)*, and did not permit other staff to compete for the job.**

Discussion: The allegation is not substantiated. The contract specialist position noted in the complaint was subject to competition by other employees at the Medical Center. The ***(b)(6)***, announced a program analyst position in October 1995. We found that the position was posted from October 12 through October 23, 1995, wherein employees at the Medical Center had an opportunity to compete for the position. There was no other evidence to suggest that the personnel process was inappropriately followed.

Scheduling/Staffing Allegations

Allegation 25:	**Management violated their own policies by requiring respiratory therapists to work without backup in the intensive care unit during the evening hours.**

Discussion: The allegation was partially substantiated. We found that management did require respiratory therapists to work alone in the intensive care unit during the evening hours because of a declining inpatient workload at the Medical Center. Management

informed us that in the event another respiratory therapist would be needed, the employee on duty could obtain assistance from the respiratory therapist working in the sleep laboratory. Respiratory therapy staff expressed concern that the employee in the sleep laboratory could not leave a patient undergoing a study unattended.

We noted however, this practice was not consistent with the existing policy as alleged by the complainant. Management took action to change the policy during this review after it became the subject of a union complaint. The new policy was consistent with the practice of only retaining one full-time respiratory therapist on duty at night. We discussed the changes with our health care inspection staff, and were informed that the new policies were consistent with other VA medical centers experiencing inpatient workload reductions. The new policy provides alternative sources for backup if needed by the respiratory therapist on duty at the time. We, therefore, made no recommendations.

Allegation 26: There was a shortage of nursing staff to provide quality patient care.

Discussion: We could not substantiate a correlation between nursing staffing reductions and quality of care. Nursing staff we interviewed stated that the RIFs by management in the Service have caused a severe shortage in the wards and they believed that this will effect patient care if the trend continues. However, we noted that the inpatient workload dropped at a rate far exceeding the drop in inpatient nurses.

The Chief, Nursing Service reported that since 1994, the overall number of registered nurses, licensed nurse practitioners (LPNs), and nursing assistants declined by about 3 percent (283 to 275). During the same period, nursing inpatient assignments declined about 14 percent (248 to 215). However, the average number of daily inpatients dropped by about 32 percent (184 to 124). The percentages have been rounded. The Chief, Nursing Service acknowledged that some nursing positions were realigned to primary care functions.

We found that 23 registered nurses separated from service between October 1, 1995, and September 30, 1996; or a turnover of registered nurses totaling 14 percent. We also found that 23 LPN's and nursing assistants were separated during the same period; a turnover rate of 23 percent. Management did not believe the turnover rate for registered nurses was atypical from prior years, but did agree that overall nursing turnover rates have increased over the past fiscal year and need to be evaluated.

We noted that from September 1994 to October 25, 1996, there were 111 nursing staff separations. Of the 111 separations, Human Resource Management Service provided us documentation on 40 exit interviews. The two main reasons given by nursing staff for

leaving the VA were that they were short of help, and they had problems with supervision. Nursing staff also indicated they left VA because training was not offered, their skills were not being used, or they took higher paying jobs. Other nursing staff retired, left because of family illness, or relocated to another area.

This information was discussed with the VISN Director to alert him to the concerns expressed to us by the nursing staff. The Chief, Human Resource Management Service also informed us that his staff would give more attention to ensure that exit interviews are completed during the separation process. We therefore made no additional recommendations.

Allegation 27:	**Management closed the Medical Center at night and inappropriately turned away veterans seeking emergency care.**

Discussion: We did not substantiate that VA patients seeking emergency care were inappropriately turned away and not treated. The complainant expressed concern with a memorandum issued by the Medical Center's Chief of Police that instructed officers to lock down the facility after 9:00 p.m. each night. The complainant believed that veterans seeking emergency care were being inappropriately turned away.

The complainant perceived this to be the case because of the instructions issued to VA staff. The Police Chief's memorandum dated July 1, 1996, informed staff that police officers would take up their post in the ambulatory care area at 9:00 p.m. each night and would lock the doors to the facility. The emergency room doors were to be locked at 10:00 p.m. each night. From 10:00 p.m. until 8:00 p.m. all persons seeking medical treatment would be referred to the nearby Charleston Memorial Hospital (CMH). The memorandum stated that

> "If a patient claims to be having a heart attack or collapses at the door, the AOD [Administrative Officer of the Day] will call 911 for assistance. Coding/Mayday of a patient in distress is not an option at this time. Signs will be posted at the doors directing patients to CMH. In the event that officers are called away to an emergency on 5BN or elsewhere in the facility persons who present at the door which require admission to the facility will just have to wait. MAS [Medical Administration Staff] staff will under no circumstances unlock the door….All persons provided with access to the facility will be documented in the Journal indicating who entered, why entered, where they went. This to track potential abuses."

The Acting Director informed us that the Medical Center was not certified to provide emergency care, and workload in the evenings was steadily declining. Because of these reasons, management entered into a contract with nearby CMH which agreed to accept all evening emergency patients on their behalf. The CMH is approximately one block from the VA Medical Center. The Acting Director said that the veteran patients seeking emergency care are provided quality emergency health care at CMH under contract, and are later transferred to the VA Medical Center once stabilized. The contract with CMH permits management to reallocate VA staff to other functions.

The Acting Director agreed that the Chief of Police's instructions could be misinterpreted and informed us she would speak with the Chief of Police on this issue. Therefore, no additional recommendations were made. Employees interviewed believed that these instructions were one more example of management's insensitivity toward patients and employees.

Director, VA Medical Center Comments

DEPARTMENT OF VETERANS AFFAIRS
Ralph H. Johnson Medical Center
109 Bee Street
Charleston SC 29401-5799

18 DEC 1996.

In Reply Refer To:

Mr. Michael Staley
Director, Hotline and Special Inquiries Division (53E)
Office of the Inspector General
Washington, DC 20420

Dear Mr. Staley:

Pursuant to your draft report dated November 18, 1996, below are our responses to the IG's recommendations:

Recommendation 1 - The Acting Director ensure that all equipment purchased for the NHCU in FY95 be accounted for so that all can be reconstituted in the NHCU once it is opened.

Response: As of December 2, 1996, our A&MM Service has accounted for all equipment items purchased for the NHCU. Those appropriate items will transferred to the NHCU once it becomes operational.

Recommendation 2 - The Acting Director should carefully evaluate the options regarding the fish tank and determine whether continued use of the tank is in the best interest of the medical center.

Response: After conferring with our Engineering Service, it has been determined that it would cost approximately $27,394 to remove the fish tank from its present location in our front lobby. In addition, due to the nature of initial construction (i.e. mixing of grout, rock, coloring, etc.), it would be virtually impossible to remix any replacement ingredients to match the existing tile color scheme. Therefore, any attempt at removing the fish tank would destroy the interior design uniformity of the lobby.

Since the installation of the fish tank, Management has received numerous positive comments from patients, family members, staff, and the general public. It remains the focal point of the newly renovated lobby and we feel strongly that it provides a positive diversion for those in the lobby waiting on prescriptions or who have other business at the medical center. Therefore, Management will support keeping the fish tank a part of our lobby.

Recommendation 3 - Response to be prepared by VISN 7 Network Director.

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Mr. Michael Staley

Recommendation 4 - We recommend the Acting Director take action to:

a. Discontinue using the fee basis authority to pay for the top management consultant's services, and reevaluate whether advisory and assistance work continues to be needed at the medical center.

b. Develop the required "concept approval" documents and submit an official request for the consultant's services to the VISN if it is determined that these services are still needed.

(b)(6) **Response:** The consultant in question, [redacted] will be terminated as a consultant as of 12/31/96. In the future if a consultant's services are deemed necessary, the procedures outlined in Circular 00-92-15 will be followed.

Recommendation 5 - The Acting Director consider the cost of the annual maintenance contract for the fish tank in her deliberations on the options related to the future of the fish tank.

Response: The current maintenance contract for the fish tank runs through September 30, 2000. The monthly fee of approximately $650 covers both the lease of the tank, fish, and equipment, as well as on-going maintenance. When the contract was sent out for bid, we initially had 5 inquiries, but actually received only 2 bids. As a point of information, the other bid received was approximately double ($1500) the current rate. As stated above, it is Management's decision to keep the fish tank and associated maintenance contract.

(b)(6) Recommendation 6 - The Acting Director should take appropriate action to ensure that [redacted] employees are appropriately advised of their employment rights as they pertain to the current and future plans for retaining private cleaning services at the medical center.

(b)(6) **Response:** It has been communicated to the [redacted] that he needs to improve interaction with [redacted] employees in keeping them informed of the current contract for private cleaning services, in addition to their rights as federal employees in these situations. At a minimum, this should take place at [redacted] staff meetings. Any information communicated at these meetings will be coordinated through Human Resources Management. All [redacted] employees always have the opportunity to
(b)(6) speak separately with [redacted], as well as Human Resources staff concerning this and any other issues.

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If you have any further questions regarding these responses, please do not hesitate to contact me at 803-577-5011, ext. 7200.

Sincerely,

R. J. VOGEL
Director

Director, Veterans Integrated Service Network No. 7 Comments

DEPARTMENT OF VETERANS AFFAIRS
Veterans Integrated Service Network #7
2200 Century Parkway
Suite 260
Atlanta, GA 30345

December 20, 1996 In Reply Refer To: 10N7

Mr. Michael L. Staley
Director, Hotline and Special Inquiries Division (53E)
Office of the Inspector General
Washington, DC 20420

Dear Mr. Staley:

This is in response to your letter of November 18, 1996, concerning the draft report on the Charleston VAMC Special Inquiry. In your letter, you asked that I respond to Recommendation 3 on page 18 of that report. My response to that recommendation follows:

> **Recommendation 3 - We recommend the Veterans Integrated Service Network Director take action to ensure that the former Director, and management at the VA medical center are aware of the appropriate procedures to follow when requesting advisory services.**
>
> **Response:** The former Director at the Charleston VAMC no longer works in this VISN. Accordingly, I have no line authority over him. The newly appointed Director at Charleston is aware of the appropriate procedures to follow when requesting consultative services and has terminated the present contract effective 12-31-96.

If you have any questions regarding this response, please call me at 404-728-4101.

Sincerely,

Larry K. Deal
Director, Atlanta Network

Monetary Impact
In Accordance with IG Act Amendments

Report Title: **Special Inquiry, Alleged Mismanagement, Ralph H. Johnson VA Medical Center, Charleston, SC**

Report Number: **7PR-G02-029**

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
4.	**Improved Use of Resources.** Amount of funds that can be reallocated to other activities.	$90,117	-0-
	TOTALS	$90,117	-0-

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