3/28/11

Memorandum to the File
Administrative Closure Report
(Project No. 2010-03888-HI-0361)

Alleged Mold Issues Impacting Employee and Patient Safety at the
Clement J. Zablocki VA Medical Center
Milwaukee, Wisconsin

Purpose:

At the request of Russell Feingold, former United States Senator from Wisconsin, the VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding mold at the Clement J. Zablocki VA Medical Center, (medical center) in Milwaukee, WI. The complainant alleged that mold was found in Building 111 in the community living center (CLC) and the spinal cord injury (SCI) unit, in an office on the 6th floor, the basement of Building 6, and Building 2.

Background:

The Clement J. Zablocki VA Medical Center is located in Milwaukee, WI. The medical center delivers primary, secondary, and tertiary medical care in 185 acute care beds, while providing over 630,000 outpatient visits annually. The CLC long-term care unit has 113 operating beds, and the domiciliary unit has 366 beds.

During the week of July 21, 2010, heavy rains caused flooding in the CLC located on the 9th floor of Building 111 and the file room located in the north side of the basement of Building 6. Senator Feingold contacted the medical center Director and requested information regarding the mold, remedial efforts, and monitoring of the effects on staff or patients. Additionally, the Director received a Notice of Alleged Safety or Health Hazards from the Occupational Safety and Health Administration (OSHA) concerning mold in several areas of the medical center causing health issues for employees.

Prior to our site visit the medical center Director responded to both the Senator and OSHAs' requests by submitting corrective actions taken regarding the mold remediation.

Methodology and Results:

We conducted a site visit on November 8–10, 2010. We interviewed medical center senior managers, the CLC, SCI, and safety program managers; the Industrial Hygienist; and other knowledgeable staff. We reviewed Veterans Health Administration and local policies. We toured Buildings 111 and 6 and

observed the outside of vacant Building 2. We reviewed medical records, work orders, time and attendance logs, meeting minutes, and other pertinent documents. We also conducted telephone interviews with additional relevant staff following our site visit.

We substantiated that mold was found in Buildings 111 (the CLC), 2, and 6. Building 2 was closed prior to the heavy rains due to other structural issues. We did not substantiate that mold was found in an office on the 6th floor of Building 111 or in the SCI Unit.

Medical center staff confirmed that mold was found in multiple residents' rooms around the windows in the CLC. Residents were removed from their rooms while the mold was abated. At the request of senior managers a physician conducted a one-time chart review for CLC residents to assess if their respiratory illnesses were a result of the mold. The results of the chart reviews were not documented in the patients' electronic medical records. The physician conducting the reviews informed us during an interview that none of the patient's current illnesses were related to or affected by the mold issues.

File room employees reported experiencing respiratory related illnesses such as shortness of breath, coughing, and headaches immediately after the flood. Supervisors encouraged all of the employees to report to Employee Health for evaluation. We interviewed the Employee Health staff and reviewed documents that confirmed six employees from the basement file room and six employees from the first floor had experienced respiratory related health issues after the flood. Employee Health staff completed the initial screenings and encouraged all employees to follow up with their private health care providers. Supervisors informed us that some employees used more sick leave than usual for these alleged mold-related illnesses. However, during our review of employees' sick leave documents, we were unable to determine if employee sick leave usage was excessive.

We discussed our findings and concerns with the medical center Director and senior managers during the exit briefing. Prior to our visit, the medical center Director had responded to both the former Senator and OHSAs' requests, completed most of the mold mediations, and continued to take action to ensure employee safety. Therefore, we closed this review without any recommendations.

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Date: March 21, 2011

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