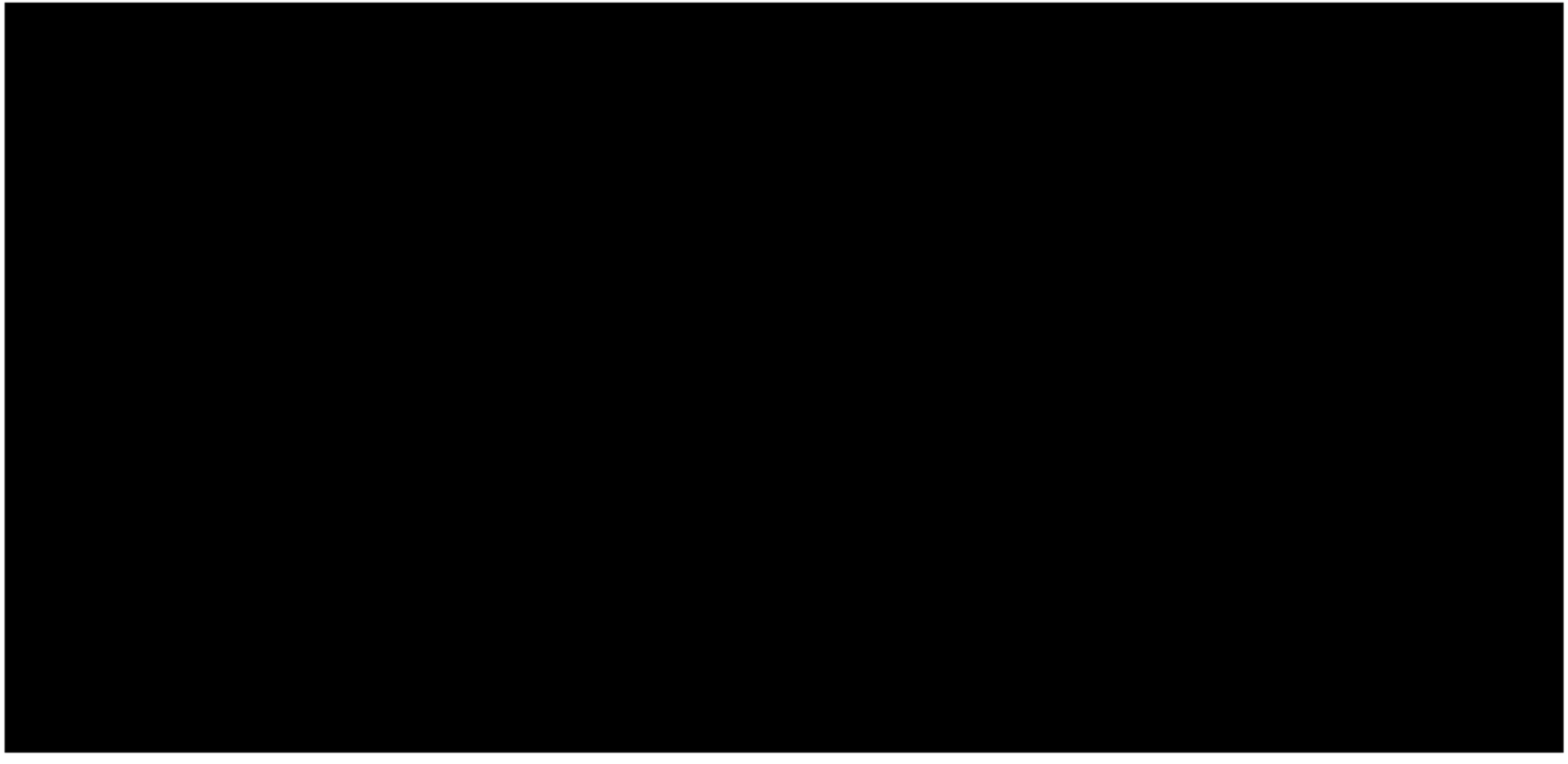

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION AT CINCINNATI

Kimberly Jeffery-Wolfert [redacted] **Plaintiff,** **vs.** **UC Health** **234 Goodman Avenue** **Cincinnati, OH 45219** **Also Serve:** **GH & R Business Services, Inc.** **511 Walnut Street, Suite 1900** **Cincinnati, OH 45202** **Defendants.**	**Case No.** **Judge** **COMPLAINT FOR MONEY DAMAGES (JURY TRIAL DEMANDED)**

Plaintiff Kimberly Jeffery-Wolfert, for her *Complaint for Money Damages (Jury Trial Demanded)* (the "**Complaint**") against Defendant UC Health, states and alleges as follows:

I. NATURE OF ACTION.

1. This is an action brought pursuant to Title VII of the Civil Rights Act of 1964 (Pub. L. 88-352), 42 U.S.C. §§2000e, *et seq.* ("**Title VII**"), 42 U.S.C §1981,("**1981**") and the Ohio Civil Rights Act, ORC §§4112.01, *et seq.* (the "**Act**"), for:

i. Retaliation pursuant to Title VII,

ii. Retaliation pursuant to 42 U.S.C §1981,

iii. Retaliation pursuant to ORC Chapter 4112,

iv. Retalitaion in violation of public policy/unsafe workplace,

v. Retaliation in violation of Ohio Public policy/unsafe treatment environment

I. PARTIES.

1. Ms. Wolfert is a female of legal age and a citizen of the United States of America and the State of Ohio, [redacted] within this judicial district. At all pertinent times, Ms. Wolfert was an "employee" of Defendant within the meaning of 42 U.S.C. §2000e(f), 42 U.S.C. §1981, ORC §4112, and other applicable law.

2. UC Health is a limited liability company organinzed under the laws of the State of Ohio with its princpal place of business located at 234 Goodman Avenue, Cincinnati, Ohio 45219 ("**Defendant**") within this judicial district. At all pertinent times, Defendant was an "employer" within the meaning of 42 U.S.C. §2000e(b), ORC §4112(A)(2), and other applicable law.

III. JURISDICTION AND VENUE.

4. This Court has subject matter jurisdiction over the claims and causes of action asserted by Ms. Wolfert against defendnat pursuant to 28 U.S.C. §1331, 42 U.S.C §2000e-5(f) and 42 U.S.C. §1981, as this action involves federal questions arising under Title VII and 42 U.S.C. §1981. This Court has subject matter jurisdiction over Ms. Wolfert's claims and causes of action against Defendant arising under the Act pursuant to 28 U.S.C. §1367(a).

5. This Court has personal jurisdiction over Defendant because it transacts business within the State of Ohio, its principal place of business is within this State, and most of the unlawful employment practices perpetrated by Defendant occurred within this State.

6. Venue of this action is proper in this District under 28 U.S.C. §1391(b) and (c), 42 U.S.C §2000e-5(f) and 42 U.S.C. §1981 because defedant committed unlawful employment practices against Ms. Wolfert within this District, Defendant transacts substantial business within this District, and Ms. Wolfert would have worked within this Distrct but for Defendant's unlawful employment practices.

IV. PROCEDURAL PREREQUISITES.

7. On March 10, 2016 Ms. Wolfert filed a charge of hostile work environment and retaliation against Defendant with the Equal Employment Opportunity Commission ("EEOC").

8. More than sixty days have elapsed since Ms. Wolfert filed her charge with the EEOC.

9. Ms. Wolfert received a right to sue letter from the EEOC, dated April 29, 2016, and fewer than 90 days have elapsed since she received same.

V. FACTS.

10. Ms. Wolfert began employment as an Infection Preventionist at Drake/UC Health approximately March, 2013 and in approximately December, 2013 to January, 2014 she was recurited by Madhuri M. Sopirala, MD, MPH, FACP to transfer over to the main campus, which she did in approximately April, 2014, where she cantinued to act as an Infection Preventionist.

11. Ms. Wolfert is a registered nurse (RN) with a Bachelor of Science Degree in nursing (BSN).

12. As part of Ms. Wolfert's responsibilities at UC Health, it was her job to oversee issues relating to infection prevention and outbreak investigations. This would include

concerns regarding incidents of infection relating to disinfection or sterilization procedures for hospital instrumentation used during patient procedures.

13. In May of 2015 it was brought to the attention of infection control by associates in the neuro-intensive care unit (NSICU) that they were experiencing an increase in hospital acquired multi-drug resistant *Stenotrophomonas* cases.

14. In May of 2015 the lab had confirmed the fourth case of the month.

15. At the request and direction of Ms. Wolfert's supervisor, Madhuri M. Sopirala, MD, MPH, FACP, the medical director of Infection Control and Antimicrobial Stewardship at UC Health, Ms. Wolfert began a comprehensive investigation of the infection outbreak.

16. A review of the recent NSICU cases from January 2015 to May 2015 showed a significant increase in *Stenotrophomonas* cases.

17. A review of other intensive care units within the hospital showed a slight increase in *Stenotrophomonas* cases.

18. From January, 2015 thru the end of May, 2015 between the four main intensive care units, neuro-intensive care unit (NSICU), medical intensive care unit (MICU), surgical intensive care unit (SICU) and the cardiovascular intensive care unit (CVICU), there were a total of thirty-six case. Thirteen of the cases were community acquired and twenty-three were hospital acquired.

19. Most of these cases involved bronchoscopy procedures and were culture-positive on or after this procedure.

20. Only five of the cases did not involve a bronchoscopy at UC Health.

21. All cultures were obtained from respiratory sources from either sputum or bronchial alveolar lavage (BAL) specimens.

22. The infection control department began collecting information regarding the infections.

23. The data included some of the following: patient information, location of patient, patient intubation history, patient ventilator dependence, ventilator/patient travel, bronchoscopy procedures and staff assignment to patients.

24. Interviews of hospital associates were conducted, in particular, respiratory therapists working in the NSICU.

25. Concerns were raised regarding the bronchoscopy cleaning process and travel ventilator contamination.

26. Site visits of the intensive care units were conducted.

27. Particular attention was given to compliance with isolation procedures, hand hygiene and the cleaning and storage of equipment.

28. Because of the infection concerns a heightened awareness campaign was launched in the NSICU.

29. The staff was cognizant of the need for proper hand hygiene and would indicate to other associates when non-compliant hand hygiene was observed.

30. Posters were placed to remind staff of proper hygiene and the concerns were discussed at staff meetings and huddles.

31. The nursing director and manager of the NSICU attempted to create dedicated staff assignments to patients in order to limit staff cross contamination.

32. Further scrutiny and enforcement of diligent equipment cleaning was enforced throughout the department and extra cleaning of rooms and ancillary areas was requested of the environmental services department.

33. Further investigation identified that several of the infected patients had undergone bronchoscopy procedures with many showing culture positive results on a bronchiole alveolar lavage specimen on the same day of the procedure.

34. Further investigation determined there were twenty-three dedicated intensive care scopes and these scopes were often shared between different units.

35. One particular scope (Scope 11924) was identified as having been used in seven of the cases involving infection.

36. This scope had already undergone routine high level disinfection and was then cultured.

37. Further investigation was done to observe bronchoscopy procedures in their entirety, to observe the cleaning and processing of the bronchoscopy scope, to learn more about the travel ventilator units and their maintenance and cleaning, and to consider environmental cultures of bronchoscopy scopes and towers and travel ventilators. All other environmental cultures returned negative.

38. From these further studies and investigations it came to light that at least one scope, Scope 11924, had cultured positive for *Stenotrophomonas* MDR on or about June 9, 2015.

39. Risk management was advised and updated on the situation.

40. Process improvement plans were implemented in the high level disinfection procedures.

41. As part of Ms. Wolfert's investigation, in addition to the above identified information, she requested information regarding procedures performed at the hospital including a request to observe procedures, initiate cultures to be performed on the

bronchoscopes to check for the presence of bacteria and even contact the manufacturer of the bronchoscopes to get guidance regarding best practice.

42. In June of 2015 when one of the scopes tested positive for the same bacteria infecting many of the patients, despite having undergone the standard high level disinfection process, the scope was returned to the manufacturer and they were notified of the ongoing investigation.

43. Every aspect of quality and utilization for these particular scopes was explored with the manufacturing company (STORZ), which was cooperative and equally concerned about this contaminated scope.

44. While certain steps by individuals were taken to address the infection concerns among many of the patients, Ms. Wolfert was concerned that not enough was being done to protect patients from exposure.

45. Despite these numerous improvements, new cases kept evolving at an alarming rate. As of September, 2015 a second scope tested positive indicating there was still a very serious problem and patient safety threat to patients undergoing bronchoscopy procedures at UC Health.

46. As the primary investigator and person in charge of spearheading the investigation, Ms. Wolfert became increasingly concerned with the lack of progress in stopping the spread of infection to patients.

47. Ms. Wolfert was concerned that UC Health had an obligation to ensure management personnel within the hospital were fully aware of the outbreak of reported infections including risk management and Leadership.

48. Ms. Wolfert further believed that the infection outbreak had reached the point that UC Health had an obligation to report the issue to the local health department and

inform the FDA since there was a connection between the spread of infection and the bronchoscopy scopes.

49. Despite Ms. Wolfert's recommendations, only a portion of the information was being reported to key hospital personnel, and the seriousness of the issue was downplayed when discussed.

50. During Ms. Wolfert's initial investigation her supervisor, Dr. Madhuri Sopirala, was helpful and cooperative. Deficiencies and corrective action plans were identified by Ms. Wolfert and shared and approved by Dr. Sopirala at every step of Ms. Wolfert's investigation.

51. When Ms. Wolfert began expressing her concerns about safety and getting assistance from an outside agency in September, 2015 Dr. Sopirala began treating Ms. Wolfert differently.

52. Dr. Sopirala was adamant and firmly reprimanded Ms. Wolfert not to report any of her concerns in fear it could result in a hospital audit.

53. Shortly after Dr. Sopirala advised Ms. Wolfert not to report her findings, Ms. Wolfert was removed from her role as investigator of the infection outbreak.

54. At this time the office environment became extremely uncomfortable for Ms. Wolfert.

55. During this period of time Ms. Wolfert utilized every internal resource that she knew about in order to insure the safety and well-being of the patients.

56. Ms. Wolfert discussed her ethical dilemma and concerns with employee advocates, human resources and even the chief of nursing. Thereafter her situation only worsened.

57. The hostility towards her became evident in emails to her and in her performance evaluation.

58. Ms. Wolfert always had stellar performance evaluations at UC Health and she has had a consistent exemplary work history with her previous employers having received numerous career awards and being one of only a few select individuals to receive the 'Civilian of the Year in Safety" by the Army Surgeon General in 2011".

59. After advising her superiors of her concerns about the safety of the patients and the need to report her findings to outside agencies she was not only removed from her role as investigator, she began receiving very negative evaluations, many of which clearly contradicted her earlier evaluations and were not true reflections of her performance.

60. Ms. Wolfert was even reprimanded for looking up her own medical records on the hospital's computer system and was "counseled" and advised that if there were any further issues she would be terminated.

61. At this point Ms. Wolfert felt she was being set up.

62. Despite the increasing number of patients becoming infected and continued safety risks – Ms. Wolfert was being shut down and ignored by the very people who could help address the problems she identified. Key leadership personnel were now aware of the situation and they too, apparently, did not want it reported to an outside agency. There was no sign of support displayed.

63. In fact, the next guidance given in response to the outbreak was for the department to stop culturing suspected scopes therefore there would be no need to report to outside agencies since there would be no more positive cultures linked to the bronchoscopy scopes.

64. As a result of Ms. Wolfert actually doing her job and making correct observations and recommendations, she was singled out because certain individuals were fearful of the negative effects of her findings regarding numerous patients being exposed to serious infections.

65. At UC Health there was clearly an apathetic attitude towards responding quickly and attempting to stop the further spread of a multi-drug resistant bacteria by taking the best form of action to address the issue. Specifically, there was a failure to take appropriate steps in sterilizing equipment, despite having knowledge and even receiving recommendations from the manufacturers of the equipment. Additionally, there was a failure to protect Ms. Wolfert, the employee that, in performing her job duties, tried to raise an issue in the name of patient safety.

66. As a direct result of Ms. Wolfert doing her job and trying to protect UC Health's patients and the public in general, Ms. Wolfert was placed in a hostile work environment with constant fear of retaliation for doing what was right for the patients, other employees and the public in general.

67. Eventually, Ms. Wolfert was forced out of her job rather than continue to face the continued hostility and degradation of her character.

VI. CAUSES OF ACTION.

Count One – Retaliation

68. Ms. Wolfert incorporates by reference each of the preceding paragraphs of her Complaint, the same as if repeated verbatim.

69. On multiple occasions, Ms. Wolfert, in performing her job duties as an Infection Preventionist, reported her concerns about what was causing the infections and

suggested several courses of action to take to address the infection outbreak at UC Health.

70. In response to performing her job duties, Ms. Wolfert was removed from the infection outbreak investigation, she began getting poor performance evaluations and she was threatened with termination for looking up her own medical records because UC Health was fearful of an adverse affect the revelation of the infection outbreak would have on UC Health.

71. Ms. Wolfert, in performing her job duties, took steps internally to address not only her concerns about the patients, employees and the public in general, but her concerns for her job based on the increased level of hostility she faced at work.

72. Ms. Wolfert raised these concerns not only to employee advocates but also with the human resources department, risk management the head of nursing and Leadership.

73. No action by any hospital personnel was taken in response to Ms. Wolfert's reported concerns about the patients, other employees, the public in general or her job security.

74. The removal of Ms. Wolfert from investigating the infection outbreak, the poor performance evaluations, the threats of termination and general hostility of Ms. Wolfert's workplace environment was a direct and proximate result of UC Health's retaliation against Ms. Wolfert for suggesting that the hospital report the infection outbreak and as well as the findings of her investigation to outside agencies including the local public health department and the FDA.

75. As a direct result of UC Health's actions, Ms. Wolfert suffered lost wages, benefits, great embarrassment, humiliation, and mental and physical anguish for which Defendant is liable.

Count Two – Hostile Work Environment

76. Ms. Wolfert incorporates by reference each of the preceding paragraphs of her Complaint, the same as if repeated verbatim.

77. Despite performing her job as an Infection Preventionist and making recommendations that sought to benefit the health and well-being of the patients at UC Health, Ms. Wolfert was removed from her role as investigator and placed in an environment hostile towards her despite doing the very duties she was instructed to do.

78. Ms. Wolfert was not only repeatedly reprimanded by her immediate supervisor, Dr. Madhuri Sopirala, when she took appropriate steps to consult with employee advocates, human resources, risk management and nursing management, she was shut down, ignored and expected to keep quiet.

79. Ms. Wolfert, who consistently had stellar performance evaluations in 2014, before the infection outbreak and was recognized for being "reliable and honest", "delivers on her commitments", "works really well as a team with the members of the department" and being "passionate about her work" was now being reported as having "misplaced enthusiasm" and being "abrasive and belittling" and "disrespectful with departments" in October 2015.

80. Such everyday criticism and hostility created an abusive work environment for Ms. Wolfert.

81. As a direct result of UC Health's actions, Ms. Wolfert suffered lost wages, benefits, great embarrassment, humiliation, and mental and physical anguish for which Defendant is liable.

VII. JURY TRIAL DEMAND.

Plaintiff Kimberly Jeffery-Wolfert demands trial by jury on all issues so triable.

VIII. PRAYER FOR RELIEF.

WHEREFORE, Plaintiff Kimberly Jeffery-Wolfert demands judgment against Defendant UC Health as follows:

A. back pay;

B. reinstatement, or in the alternative, front pay;

C. other compensatory damages;

D. attorneys fees and costs;

E. trial by jury on all issues so triable; and

F. for such other and further relief to which Ms. Wolfert may appear entitled.

Respectfully submitted,

/s/ Benjamin M. Maraan II
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