



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20420



October 13, 2026

MEMORANDUM

TO: John Figueroa, Acting Under Secretary for Health,
Veterans Health Administration (10)

FROM: Dr. David Krulak, Assistant Inspector General for Healthcare Inspections, Office
of Healthcare Inspections, VA Office of Inspector General (54)

SUBJECT: Discontinuation of the *Review of Community Living Center Admissions and
Treatment Planning for Veterans with Mental Health Conditions and Associated
Distressed Behaviors* (MCI# 2023-00221-HI-1396)

This memorandum is to inform the Department of Veterans Affairs that the Office of Inspector General (OIG) is concluding its national review of community living center admission and treatment processes. This review evaluated how staff ensure the safety of veterans with mental health conditions and associated distressed behaviors who are admitted and treated in community living centers as well as identify any risks or areas of concern requiring additional VA action.

During the course of the review, the OIG received and analyzed the results of VA's own study, *Community Living Center – Mental Health Integration in the Veterans Health Administration: Evaluation of Practice Patterns*, which corroborated the OIG's initial observations and preliminary findings.¹

As VA's study provides sufficient confirmation of the issues originally identified, the OIG has determined that further inspection is not necessary. The OIG is taking no additional steps as the

- VA's study aligns with and confirms OIG's preliminary findings,
- OIG gathered no evidence indicating a need for further review, and
- VA is already positioned to act, as appropriate, based on its internal study.

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¹ Kim Curyto et al., "Community Living Center – Mental Health Integration in the Veterans Health Administration: Evaluation of Practice Patterns," *Psychological Services*, 23, no.3 (March 30, 2026): 462-478, <https://doi.org/10.1037/ser0001029>.