DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Failure of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota

HEALTHCARE INSPECTION | REPORT #22-00514-108 | MAY 2, 2023

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review the response by facility leaders and staff to allegations of sexual harassment of a patient at the VA Black Hills Health Care System (facility) in Fort Meade and Hot Springs, South Dakota.[1]

In January 2021, the OIG received complaints alleging inappropriate behavior within the facility's mental health service. The former Facility Director convened an administrative investigation board (AIB) to review the allegations.[2]

The OIG focused this review on the administrative and clinical staff response to the patient's allegation of sexual harassment that was initially identified, but not addressed, in the AIB report.[3] The patient alleged being sexually harassed for several months by a Nutrition and Food Service (food service) coworker through social media messages that were sent after work hours.

The patient was in their 50s with a history of major depressive disorder, anxiety, alcohol use disorder, posttraumatic stress disorder (PTSD), military sexual trauma, and a suicide attempt in

[1] VHA Directive 1124, *Equal Employment Opportunity*, February 6, 2015, rescinded and replaced with VHA Directive 1124, *Equal Employment Opportunity*, August 12, 2021. The directives contain similar language defining sexual harassment. VHA defines sexual harassment as "unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature." This includes when "the conduct creates an intimidating, hostile or offensive working environment."

[2] VA Directive 0700, *Administrative Investigations*, March 25, 2002, rescinded and replaced by VA Directive 0700, *Administrative Investigation Boards and FactFindings*, August 10, 2021. These directives contain similar language defining an administrative investigation board. An administrative investigative board is a type of administrative investigation that can be developed for a specific need to identify and correct any individual or systemic deficiency.

[3] The VA Office of Inspector General reviewed the administrative investigation board report in a separate report. VA OIG, *Issues Related to an Administrative Investigation Board at VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota*, Report No. 22-00540-107, May 2, 2023, https://www.va.gov/oig/pubs/VAOIG-22-00540-107.pdf.

2016.[4] In 2017, the patient requested admission to the Mental Health Residential Rehabilitation Treatment Program (MH RRTP) for treatment of alcohol use.[5] Through participation in the MH RRTP, the patient was referred to the Compensated Work Therapy program and was assigned to work in food service.[6] Later, the patient transitioned from the domiciliary to the Transitional Residence program.[7] However, the patient violated the Transitional Residence program sobriety and curfew rules while on a pass and was discharged from the Transitional Residence house and the Compensated Work Therapy program. In late spring, the patient was readmitted to the MH RRTP for residential PTSD treatment.

After completing residential PTSD treatment in early summer, the patient began Compensated Work Therapy placement in food service again. Shortly after, the patient moved into a

[4] Mayo Clinic Patient Care and Health Information, "Major Depressive Disorder," accessed January 8, 2020, https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007. Depression is "a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems." National Institute of Mental Health, National Institutes of Health, "Anxiety," accessed May 22, 2019, https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml. Anxiety disorders "involve more than temporary worry or fear. For people with an anxiety disorder, the anxiety does not go away and can get worse over time. The symptoms can interfere with daily activities such as job performance, schoolwork, and relationships." U.S. National Library of Medicine, National Institutes of Health, "Alcohol Use Disorder," accessed December 13, 2019, https://ghr.nlm.nih.gov/condition/alcohol-use-disorder. Alcohol use disorder is "a diagnosis made when an individual has severe problems related to drinking alcohol. Alcohol use disorder can cause major health, social, and economic problems and can endanger affected individuals and others through behaviors prompted by impaired decision-making and lowered inhibitions, such as aggression, unprotected sex, or driving while intoxicated." Mayo Clinic Patient Care and Health Information, "Post-Traumatic Stress Disorder," accessed August 31, 2022, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967. "Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event." The OIG uses the singular form of they (their) in this instance for privacy purposes.

[5] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010, rescinded and replaced by VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019, that contains similar language. MH RRTPs, or domiciliaries, offer a residential therapeutic setting for veterans with mental health and addictive disorders who require additional structure and support due to psychosocial challenges including homelessness and unemployment. The OIG uses MH RRTP and domiciliary interchangeably throughout this report. While VHA refers to individuals residing at MH RRTPs as residents, for consistency in this report, the OIG uses the term patient.

[6] VHA Handbook 1163.02, *Therapeutic and Supported Employment Services Program*, July 1, 2011, rescinded and replaced with VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019. The handbook and directive contain similar language defining the Compensated Work Therapy program. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. Compensated Work Therapy programs are located at all VA medical centers and provide vocational rehabilitation services that are recovery-oriented in nature.

[7] VHA Handbook 1162.02; VHA Directive 1162.02. The handbook and directive contain similar language defining Transitional Residence. The Transitional Residence program is paired with the Compensated Work Therapy program and provides housing for patients whose rehabilitative focus is occupational and who are working towards independent community living. Although Transitional Residences are located both on and off VA medical center campuses, Transitional Residence houses are owned and operated by the VA.

Transitional Residence house located on the Hot Springs campus. In 2018, the patient was hired into a permanent food service position as a facility employee, while continuing to reside in the Transitional Residence house.

In early spring 2018, the patient reported being sexually harassed by a food service coworker to a Transitional Residence staff member, the work site supervisor, and a human resources specialist. Over several months, during treatment encounters, the patient worked with mental health staff regarding feelings of frustration, betrayal, anger, and anxiety from the sexual harassment and facility leaders' apparent lack of response.

In early fall 2018, the patient, who was intoxicated, arrived at the facility's urgent care center, and was admitted into the inpatient mental health unit. The following morning, once sober, the patient denied suicidal ideation or intention. During admission to the inpatient mental health unit, the patient mentioned being sexually harassed by a VA employee to a mental health nurse. The mental health nurse reported the patient's allegations to the VA police. The VA police interviewed the patient about the sexual harassment. Per the police report, the patient reported that the sexual harassment began in 2017 and provided social media messages dated from mid-fall 2017 through early spring 2018. During this time frame, the patient was in the Transitional Residence program, Compensated Work Therapy program, and transitioned to being a permanent facility employee.

In early fall 2018, the patient pursued elevating the report of sexual harassment by submitting a White House complaint and working with a union representative and the former Veterans Integrated Service Network (VISN) Equal Employment Opportunity (EEO) Lead. The next month, a psychiatric nurse practitioner documented that the patient continued to experience occasional thoughts of suicide related to feeling let down and not listened to about being sexually harassed. In late fall, a third party contacted the Veterans Crisis Line expressing concern about the patient's suicidal thoughts. The Hot Springs Police Department was sent to do a welfare check, but while enroute, received a phone call from the third party reporting a gunshot. Upon arrival, the police found the patient dead by suicide.

Inspection Results

The OIG reviewed the administrative and clinical responses to the patient's allegations of being sexually harassed while working in food service.

Failures in the Administrative Response to the Patient's Report of Sexual Harassment

The OIG determined that a human resources specialist, the chief of food service, and the former Facility Director did not take administrative actions that aligned with policy when the patient reported being sexually harassed. Interviews with the above staff revealed that the general

understanding was that since the interactions occurred after hours, off VA property, and between two employees, no administrative action could be taken.

Veterans Health Administration (VHA) and facility policies describe zero tolerance for sexual harassment.[8] In addition, facility policy states that "Employees are not allowed to engage in any type of personal transactions or relationships, including sexual relationships with patients." The policies outline expected responsibilities and actions for supervisors and VA leaders. The facility's boundaries policy specifically identifies that upon being informed of an inappropriate relationship, the supervisor will notify the service line chief. The service line chief will develop a written plan to ensure the patient's rights are respected and follow up on each complaint to determine if the harassment has stopped.[9]

In early spring 2018, as recommended by the Transitional Residence staff member, the patient reached out to a human resources specialist who, in turn, contacted the chief of food service about the patient's allegations. The OIG found that the chief of food service took some action to address the sexual harassment allegations by meeting with the patient and the food service coworker individually, providing the food service coworker with the facility boundaries policy, and discussing expectations for professional behavior. Using scheduling rotations, the chief of food service also attempted to eliminate or minimize when both parties would be working in the same area at the same time.

Upon learning of the allegation in early spring 2018, the chief of food service sought guidance from the human resources specialist. According to the chief of food service, the human resources specialist advised that no formal disciplinary action could be taken against the food service coworker based on the determination that the sexual harassment occurred between two employees, off facility property, and not during work time. The human resources specialist deemed that the jurisdiction of discipline and action was limited to occurrences on campus and during tours of duty. Based on the guidance provided by the human resources specialist, the food service leaders took no further action.

The OIG found the chief of food service failed to follow facility policy by not following up with the patient to determine if the sexual harassment had stopped and the patient felt the work environment was no longer hostile.

The OIG found that the patient also reported being sexually harassed to a union representative. In an interview, the union representative stated bringing the patient's concern to the former Facility Director and reiterating that the person reporting the sexual harassment was a patient when the harassment began. The union representative reported to the OIG that the former Facility Director

[8] VHA Directive 1124. Facility Policy DIR-09, *Prevention of Workplace and Sexual Harassment*, April 27, 2016.

[9] Facility Policy, DIR-05, Boundaries-Relationships Between Employees and Patients, Former Patients, and Patients Families, September 2016.

responded that no further action would be taken because the harassment occurred after hours and off campus.

In early fall 2018, after the patient reported being sexually harassed to the VA police, the VA police documented that the inappropriate messages were a violation of the facility's boundaries policy, and forwarded the findings to the former Facility Director, privacy officer, and EEO manager. In an interview, the former Facility Director could not recall having a discussion with the VA police about the patient's allegation of being sexually harassed. In addition, the former Facility Director reported not being aware of the patient being in the Transitional Residence program until the AIB was completed in mid-2021.

The OIG found that even when facility leaders were presented with this additional information from the VA police indicating that the inappropriate messages began when the patient was a participant in the Compensated Work Therapy program, the guidance from facility leaders remained unchanged, and no action was taken because the sexual harassment occurred off campus and after hours. The patient continued to voice dissatisfaction to a union representative, a mental health counselor, and the VISN EEO Lead with the decision by the human resources specialist and facility leaders, and felt the harassment was still an active issue that was having a negative impact. The union representative and the VISN EEO Lead attempted to take action and advocate on behalf of the patient with facility leaders through discussion and possible mediation. Despite these efforts, the OIG could find no documented evidence that facility leaders took further actions aligning with policy, considering the sexual harassment occurred while the employee was a patient and residing on campus.

The OIG found that the Compensated Work Therapy and Transitional Residence program manager (program manager) failed to take action when informed of the patient's sexual harassment.

In early spring 2018, during an unscheduled appointment, the patient reported being sexually harassed by a food service coworker to a Transitional Residence staff member. In response, the Transitional Residence staff member referred the patient to the work site supervisor and to human resources. The Transitional Residence staff member also notified the program manager through an electronic health record (EHR) progress note. The program manager acknowledged the EHR progress note through electronic signature two days later. In an interview with the OIG, the program manager acknowledged being responsible for the safety of each work site environment and being aware of the patient's allegation. Based on policy review and the interviews conducted, the OIG would have expected the program manager to have taken an active interest in the patient's case and, at minimum, spoken with the patient about the sexual harassment allegations. In addition, the program manager should have ensured that the patient's supervisor or the chief of food service were aware that a report of sexual harassment had been made. However, the OIG found no documented evidence that this occurred, and the program

manager could not recall discussing the patient's case with the Transitional Residence staff member or speaking with the patient.

Clinical Response to the Patient's Report of Sexual Harassment

The OIG determined that the Transitional Residence staff member and the patient's counselor provided clinical support when the patient reported being sexually harassed by a food service coworker.

The OIG made three recommendations to the Facility Director to review the sexual harassment policy to ensure that leaders and supervisors can identify, thoroughly investigate, and respond to sexual harassment allegations; to review the actions of the program manager related to the identified patient's case, and take action as needed; and to ensure that facility policy addresses the safety and rights of patients who are both VA employees and participants in the Transitional Residence program.

VA Comments and OIG Response

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

AIB	administrative investigation board
EEO	Equal Employment Opportunity
EHR	electronic health record
MH RRTP	mental health residential rehabilitation treatment program
OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review the response by facility leaders and staff to allegations of sexual harassment of a patient at the VA Black Hills Health Care System (facility) in South Dakota.

Background

The facility is part of Veterans Integrated Service Network (VISN) 23 and has two campuses located in Fort Meade and Hot Springs, South Dakota. In addition, the facility has nine community-based outpatient clinics.[1] The facility provides primary, surgical, and mental health care, including mental health residential rehabilitation treatment programs (MH RRTPs).[2] From October 1, 2021, through September 30, 2022, the facility served 20,754 patients. The Veterans Health Administration (VHA) classifies the facility as a Level 3—low complexity.[3]

The Fort Meade campus is located in Meade County with a reported county population of just under 30,000. The Fort Meade campus employs 790 staff members and is comprised of 65 operational beds encompassing inpatient services for medicine, psychiatry, surgery, and a community living center.

The Hot Springs campus is located in Fall River County with a reported county population of just under 7,000. The Hot Springs campus employs 364 staff members and has 77 operational beds encompassing services for inpatient medicine, a community living center, and a domiciliary that provides residential rehabilitation services.

Sexual Harassment

VHA defines sexual harassment as "unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature." This includes "when the conduct creates an

[1] The facility provides outpatient services in Nebraska: Gordon and Scottsbluff; South Dakota: McLaughlin, Mission, Pierre, Pine Ridge, Rapid City, and Winner; and Wyoming: Newcastle.

[2] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010, rescinded and replaced by VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019, that contains similar language. MH RRTPs, or domiciliaries, offer a residential therapeutic setting for veterans with mental health and addictive disorders who require additional structure and support due to psychosocial challenges including homelessness and unemployment. The OIG uses MH RRTP and domiciliary interchangeably throughout this report. While VHA refers to individuals residing at MH RRTPs as residents, for consistency in this report, the OIG uses the term patient.

[3] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2 or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

intimidating, hostile or offensive working environment."[4] On February 12, 2015, in response to VA's goal of a harassment-free environment, VA established the Anti-Harassment Office whose mission is to "ensure allegations of harassment receive a prompt, thorough, and impartial investigation; and that VA takes immediate and appropriate corrective action when it determines harassment has occurred."[5]

A Government Accountability Office report published in 2020 found that an estimated 21 percent of females and 9 percent of males experienced sexual harassment in the federal workplace.[6]

Compensated Work Therapy and Transitional Residence Programs

The Compensated Work Therapy program is available at all VA medical centers and provides vocational rehabilitation services that are recovery-oriented in nature.[7] The mission of Compensated Work Therapy "is to find employment opportunities that match the skills, abilities and preferences for the Veterans." Transitional Residence housing, paired with the Compensated Work Therapy program, provides housing for patients whose rehabilitative focus is occupational and who are working towards independent community living. The program is based on the goals and objectives in the patient's rehabilitation plan. Although residences are located both on and off medical center campuses, Transitional Residence housing is owned and operated by the VA.[8]

The Compensated Work Therapy and Transitional Residence programs are separate and independent programs. Patients enrolled in Compensated Work Therapy are not required to participate in the Transitional Residence program. However, VHA states that patients must be enrolled in a Compensated Work Therapy employment program to be admitted to the Transitional Residence program. Patients may continue to reside in a Transitional Residence house after obtaining permanent employment as determined necessary to meet the goals of the established rehabilitation plan. This typically does not exceed 12 months.[9]

---

[4] VHA Directive 1124, *Equal Employment Opportunity*, February 6, 2015, rescinded and replaced with VHA Directive 1124, *Equal Employment Opportunity*, August 12, 2021. The directives contain similar language in defining sexual harassment.

[5] VA Memorandum, "Establishment of Anti-Harassment Office," February 12, 2015.

[6] US Government Accountability Office, *Workplace Sexual Harassment*, September 2020, https://www.gao.gov/assets/gao-20-564.pdf.

[7] VHA Handbook 1163.02, *Therapeutic and Supported Employment Services Program*, July 1, 2011, rescinded and replaced with VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019. The handbook and directive contain similar language about the Compensated Work Therapy program. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[8] VHA Handbook 1162.02; VHA Directive 1162.02.

[9] VHA Handbook 1162.02; VHA Directive 1162.02.

Concerns

In January 2021, the OIG received complaints alleging inappropriate behavior within the facility's mental health service. The former Facility Director convened an administrative investigation board (AIB) to review the allegations.[10] The OIG reviewed the AIB report and identified concerns with how facility leaders and staff responded to the allegations.[11]

The OIG focused this review on the administrative and clinical response to the patient's allegation of sexual harassment that was initially identified, but not addressed, in the AIB report. The patient alleged being sexually harassed for several months by a Nutrition and Food Service (food service) coworker through social media messages that were sent after work hours.

Scope and Methodology

The OIG initiated the inspection on March 7, 2022, and conducted a site visit April 19–21, 2022.

The OIG interviewed the former Facility Director, VISN leaders and staff, and facility leaders and staff.[12] The OIG was unable to interview several staff who had retired or left VA employment.

The OIG reviewed relevant VHA and facility policies and procedures; a police report and supporting evidentiary attachments; a fact-finding; the AIB report; organizational charts for Mental Health and Food Service; staff training records; human resources information; and the patient's electronic health record (EHR).

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations

[10] VA Directive 0700, *Administrative Investigations*, March 25, 2002, rescinded and replaced by VA Directive 0700, *Administrative Investigation Boards and FactFindings*, August 10, 2021. These Directives contain similar language defining an administrative investigation board. An administrative investigation board is a type of administrative investigation that can be developed for a specific need to identify and correct any individual or systemic deficiency.

[11] The VA Office of Inspector General reviewed the administrative investigation board report in a separate report. VA OIG, *Issues Related to an Administrative Investigation Board at VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota*, Report No. 22-00540-107, May 2, 2023, https://www.va.gov/oig/pubs/VAOIG-22-00540-107.pdf.

[12] From the VISN, the OIG interviewed the Network Homeless Coordinator and a human resources specialist. From the facility, the OIG interviewed the Facility Director; director of quality, safety, and value; deputy chief of police; Equal Employment Opportunity (EEO) manager; a primary care provider; Compensated Work Therapy and Transitional Residence program manager and staff; chief of food service and staff; and former union president.

to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summary

The following information was obtained from documentation contained in the patient's EHR.

The patient was in their 50s with a history of major depressive disorder, anxiety, alcohol use disorder, and a suicide attempt in 2016.[13] In mid-winter 2017, the patient requested admission to the MH RRTP for treatment of alcohol use and was subsequently admitted 15 days later. An initial mental health assessment and a suicide prevention safety plan were completed by a social worker the next day. Five days later, a psychiatric nurse practitioner documented the patient as having stable major depressive disorder, alcohol use, and identified homelessness and lack of current employment as stressors. In early spring 2017, staff referred the patient to the Compensated Work Therapy program. The patient's mood improved over the course of treatment and the psychiatric nurse practitioner described the patient's depression as "in remission." The next month, the patient began Compensated Work Therapy classes and was assigned to food service for therapeutic employment. After two weeks in the Compensated Work Therapy program, a mental health counselor documented that the patient reported doing well and enjoying the structure of the Compensated Work Therapy placement.

In mid-spring, the patient described experiencing sexual trauma to the psychiatric nurse practitioner. While a reservist, an officer threatened denial of promotion opportunities if the patient did not engage in a sexual relationship with the officer. The patient conceded because of the power differential. The patient reported experiencing intrusive memories and psychological

[13] Mayo Clinic Patient Care and Health Information, "Major Depressive Disorder," accessed January 8, 2020, https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007. Depression is "a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems." National Institute of Mental Health, National Institutes of Health, "Anxiety," accessed May 22, 2019, https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml. Anxiety disorders "involve more than temporary worry or fear. For people with an anxiety disorder, the anxiety does not go away and can get worse over time. The symptoms can interfere with daily activities such as job performance, schoolwork, and relationships." U.S. National Library of Medicine, National Institutes of Health, "Alcohol Use Disorder," accessed December 13, 2019, https://ghr.nlm.nih.gov/condition/alcohol-use-disorder. Alcohol use disorder is "a diagnosis made when an individual has severe problems related to drinking alcohol. Alcohol use disorder can cause major health, social, and economic problems and can endanger affected individuals and others through behaviors prompted by impaired decision-making and lowered inhibitions, such as aggression, unprotected sex, or driving while intoxicated." The OIG uses the singular form of they (their) in this instance for privacy purposes.

distress related to the encounter. The psychiatric nurse practitioner diagnosed the patient with posttraumatic stress disorder (PTSD) related to the military sexual trauma.[14]

Two weeks later, the patient transitioned from the domiciliary to a Transitional Residence house and while on a pass, the patient violated the Transitional Residence program sobriety and curfew rules. The next day, the patient was discharged from the Transitional Residence house and Compensated Work Therapy program, and then readmitted to the domiciliary. Between late spring and early summer, the patient participated in the residential PTSD program at the domiciliary. In early summer, the patient began Compensated Work Therapy placement in food service again while living in the domiciliary. The next month, the patient was admitted into a Transitional Residence house located on the Hot Springs campus.

In mid-winter 2018, the patient was hired into a permanent food service position as a facility employee. The patient continued in mental health treatment and worked on processing the history of military sexual trauma.

In early spring 2018, the patient met with Transitional Residence staff for an unscheduled appointment and reported being sexually harassed by a food service coworker.[15] The patient reported the harassment to the work site supervisor. The Transitional Residence staff referred the patient to a human resources specialist because the patient was a permanent facility employee and no longer in the Compensated Work Therapy program. Three days later, the Transitional Residence staff documented the patient's suicide risk assessment as low. Five days later, the patient told the psychiatric nurse practitioner that the sexual harassment "activated allot [*sic*] of the feeling of anger, anxiety, shame, embarrassment, that [the patient] felt when [the patient] experienced the sexual trauma in the military." The next month, the psychiatric nurse practitioner completed paperwork for reasonable accommodations related to the patient's PTSD.[16]

In late spring, the patient's counselor documented that the patient expressed ongoing frustration and a sense of betrayal with the facility's response to the sexual harassment allegation. The patient filed a complaint with the former Facility Director but felt the complaint had been ignored. The patient reported experiencing increased anger, anxiety, and depression but denied suicidal ideation.

---

[14] Mayo Clinic Patient Care and Health Information, "Post-Traumatic Stress Disorder," accessed August 31, 2022, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967. "Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event."

[15] The Transitional Residence staff was also known as a vocational rehabilitation specialist.

[16] U.S. Department of Labor, Title I of the Americans with Disabilities Act, "Accommodation," accessed January 9, 2023, www.dol.gov/agencies/odep/program-areas/employers/accommodations. "A reasonable accommodation is a modification or adjustment to a job, the work environment, or the way things are usually done during the hiring process."

Four days later, the patient was discharged from the Transitional Residence house and moved into independent living. The next month, the patient began working in the domiciliary as a social services assistant. In mid-summer, the counselor documented that the patient reported alcohol relapse due to worsening anger and sadness related to the sexual harassment.

In early fall, the patient arrived at the facility's urgent care center. The patient, who was intoxicated, expressed frustration with the facility leaders' response to sexual harassment and verbalized thoughts of suicide. The patient was admitted into the inpatient mental health unit. The following morning, once sober, the patient denied suicidal ideation or intention. The patient completed a suicide prevention safety plan and denied access to firearms or other lethal weapons; a high risk for suicide flag was initiated. During admission to the inpatient mental health unit, the patient mentioned being sexually harassed by a VA employee to a mental health nurse. The mental health nurse reported the patient's allegations to the VA police. While on the inpatient mental health unit, the VA police interviewed the patient about the sexual harassment.

The next week, the patient denied thoughts of suicide to the suicide prevention team and noted there was some movement on the sexual harassment case. Eleven days later, the patient told the psychiatric nurse practitioner about feeling "let down, not listened to," and said that if the patient "cannot get the support from the VA, [the patient] has option of suicide." The psychiatric nurse practitioner documented the patient's first appointment with a non-VA psychologist was scheduled for three days later, and notified the suicide prevention team.

The patient continued to experience occasional thoughts of suicide related to current stressors. In mid-fall, the patient had multiple contacts with the suicide prevention team during which the patient repeatedly endorsed, and then denied, thoughts of suicide; eventually the patient agreed to meet for safety planning. Eleven days later, the suicide prevention case manager documented the patient had a moderate risk of suicide and completed an updated suicide prevention safety plan in which the patient denied access to lethal means. The patient told the suicide prevention case manager about suicidal thoughts and potential plans but felt too scared to act on the plans. The patient expressed ongoing frustration with previous employment and the inability to return to the facility MH RRTP for treatment. The suicide prevention case manager urged the patient to consider other treatment options.

In late fall, a third party contacted the Veterans Crisis Line expressing concern about the patient's suicidal thoughts. The Hot Springs Police Department was sent to do a welfare check, but while enroute, received a phone call from the third party reporting a gunshot. The police found the patient dead by suicide.

Inspection Results

The OIG reviewed the administrative and clinical responses to the patient's allegations of being sexually harassed while working in food service.

1. Failures in the Administrative Response to the Patient's Report of Sexual Harassment

The OIG determined that a human resources specialist, the chief of food service, and the former Facility Director did not take administrative actions that aligned with policy when the patient reported being sexually harassed. The OIG also found that the Compensated Work Therapy and Transitional Residence program manager (program manager) failed to provide an administrative response when informed of the patient's sexual harassment.

Human Resources Specialist's, Chief of Food Service's, and Former Facility Director's Responses

VHA and facility policies describe zero tolerance for sexual harassment.[17] The policies also outline expected responsibilities and actions for supervisors and VA leaders. Facility policy further states that facility leaders and supervisors will:

- "Take immediate action to correct a problem when brought to their attention, including informing employees engaging in harassing activities, including sexual, that may be subject to appropriate disciplinary action."
- "Assist employees in resolving complaints of harassment by encouraging employees to report such incidents to the EEO [Equal Employment Opportunity] Manager, HR [Human Resources] Chief, union representative or the Office of Resolution Management (ORM)."
- "Follow-up on each complaint to determine if the harassment has stopped."
- "Cooperate fully with on-going investigations of harassment incidents."

Facility policy also states that sexual comments or conduct may create an intimidating, offensive, or hostile work environment that can interfere with an individual's work performance.[18]

The facility boundaries policy specifically identifies that upon being informed of an inappropriate relationship, the supervisor will notify the service line chief. The service line chief will develop a written plan to ensure the patient's rights are respected.[19]

In early spring 2018, the patient initially reported being sexually harassed to a Transitional Residence staff member during an unscheduled visit. Advising the patient as an employee, the Transitional Residence staff member recommended that the patient follow up with the work site supervisor and a human resources specialist.

[17] VHA Directive 1124. Facility Policy DIR-09, *Prevention of Workplace and Sexual Harassment*, April 27, 2016.

[18] Facility Policy DIR-09.

[19] Facility Policy DIR-05, Boundaries-Relationships Between Employees and Patients, Former Patients, and Patients Families, September 2016.

Human Resources Specialist and Chief of Food Service

After being contacted by the patient, the human resources specialist contacted the chief of food service about the patient's allegations. Since the patient had transitioned to a VA employee at the time the report of sexual harassment was made, the chief of food service and the human resources specialist based actions on the premise that the alleged sexual harassment occurred between two employees. In response to the allegations, the chief of food service met with both parties individually and documented through handwritten notes what transpired in the service after the sexual harassment was reported. The chief of food service provided the food service coworker with the facility boundaries policy and discussed expectations for professional behavior. Using scheduling rotations, the chief of food service attempted to eliminate or minimize when both parties would be working in the same area at the same time. The chief of food service reported that based on the human resources specialist's determination that the sexual harassment occurred after hours, off campus, and between two employees, no formal disciplinary actions against the food service coworker could be taken. Neither the chief of food service nor the human resources specialist noted that the patient was a participant in the Transitional Residence program at the time of the reported sexual harassment. Facility leaders failed to consider that the patient was in the Transitional Residence program and should have been considered a patient at the time of the sexual harassment.

The OIG found that the chief of food service took action when notified of the sexual harassment allegations by speaking individually with both employees, obtaining guidance from a human resources specialist, and altering the employees' work schedules to try to limit interaction at work. The OIG found no documented evidence that the chief of food service re-evaluated the situation to determine if the harassment had stopped and if the employee felt the work environment was no longer hostile. By not re-evaluating the situation, the chief of food service did not fully comply with facility policy.

Former Facility Director

In an interview, a union representative stated the patient reported being sexually harassed by a food service coworker while participating in the Compensated Work Therapy program. The union representative reported bringing the patient's concern to the former Facility Director and reiterated that the person reporting the sexual harassment was a patient when the harassment began. The union representative further stated that the former Facility Director responded that no further action would be taken because the harassment occurred after hours and off campus. In an interview, the former Facility Director reported not being aware of the patient being in the Transitional Residence program until the completion of the AIB in mid-2021.

During interviews with the OIG, facility leaders and human resources staff told the OIG that if an incident occurs off campus and after hours, there can be no action taken by the facility. The chief of food service reported to the OIG that a human resources specialist explained that the

jurisdiction of discipline and action was limited to occurrences on campus and during tours of duty. This information was disseminated to the food service leader and resulted in no additional action being taken.

Although facility leaders reported to the OIG that Transitional Residence houses are considered VA property, and that sexual harassment could create a hostile work environment, the OIG found that no action was taken because of the human resources specialist's guidance.

In early fall 2018, the patient made additional reports to the VA police and a White House complaint. When meeting with the VA police, the patient reported that the sexual harassment began when the patient was a participant in the Compensated Work Therapy program and that the sexual harassment occurred mainly through social media. The patient provided to the VA police copies of the social media messages between the patient and the food service coworker. The messages were dated from mid-fall 2017 through early spring 2018, when the patient was a Compensated Work Therapy participant and a resident of a Transitional Residence house, and later transitioned to being a permanent facility employee. Therefore, the VA police documented that the inappropriate messages were a violation of the boundaries policy and forwarded the findings to the former Facility Director, privacy officer, and EEO manager. The OIG found no documented evidence that facility leaders reconsidered the patient's case or took into consideration that the patient was in the Compensated Work Therapy program and, per policy, was considered a patient when the sexual harassment began. In an interview, the former Facility Director could not recall having a discussion with the VA police about the patient's allegation of being sexually harassed. The former Facility Director further reported that after receiving the AIB in mid-2021, working with the OIG to determine if criminal activity occurred. Once it was determined that no criminal activity occurred, the former Facility Director forwarded the patient's case to the Office of General Counsel to determine what action could be taken. The former Facility Director retired before a decision was made.

After being notified of a White House complaint, the VISN EEO Lead contacted the patient on multiple occasions. The VISN EEO Lead was unable to provide any resolution but offered to schedule mediation. The patient completed suicide in late fall 2018 before mediation could be scheduled.

The Compensated Work Therapy Patient Handbook provides patients with strategies to resolve job related issues independently and, if needed, several external options are provided.[20] The OIG found that the patient sought assistance from all avenues recommended in the Compensated Work Therapy Patient Handbook as well as those noted through interviews. The patient asked

[20] Facility Handbook, *Compensated Work Therapy Handbook*, Revised December 3, 2015. Compensated Work Therapy patients are advised to use the following model to work through issues on the job site: speak with the person directly involved in the situation; address with the work supervisor; speak with the care coordinator, treatment team, or Compensated Work Therapy staff; and be aware of the availability of the patient advocate.

the coworker to stop sending sexual messages, spoke to the work site supervisor and the chief of food service, discussed with the assigned Transitional Residence staff member, and met with a union representative and a human resources specialist.

The OIG concluded that the chief of food service took action to address the patient's report of being sexually harassed by a food service coworker. However, the OIG found no documented evidence that the chief of food service followed up with the patient to ensure that the sexual harassment ended and there was no longer a hostile work environment. From early spring through late fall 2018, the patient reported being sexually harassed by a food service coworker to multiple staff and leaders throughout VHA. The patient continued to voice dissatisfaction with the outcomes of the reports, and felt the harassment was still an active issue that was negatively impacting the patient. The union representative and the VISN EEO Lead attempted to take action and advocate on behalf of the patient with facility leaders. VA police reviewed the patient's case and determined that a boundaries policy violation did occur and notified facility leaders. Despite these efforts and information provided to facility leaders and a human resources specialist, the guidance remained unchanged, and no action was taken because the sexual harassment occurred between two employees, off campus, and after hours. The OIG concluded that facility leaders and a human resources specialist failed to consider that the patient was in the Transitional Residence and Compensated Work Therapy program when the sexual harassment began. As a result, facility leaders failed to follow the sexual harassment policy, failed to ensure that the patient was treated with dignity and respect, and failed to ensure that the patient was able to work in a hostile-free environment.

Compensated Work Therapy and Transitional Residence Program Manager's Response

VHA and the facility define sexual harassment as unwanted "sexual advances, requests for sexual favors, and other" unwanted "verbal or physical conduct of a sexual nature" generally in, but not limited to, a workplace environment.[21] Facility policy also states that "Employees are not allowed to engage in any type of personal transactions or relationships, including sexual relationships, with patients…. All employees are expected to treat [patients with] dignity and respect."[22]

In early spring 2018, the patient's assigned Transitional Residence staff member documented that the patient reported receiving inappropriate messages from a food service coworker which caused the patient to recall past military sexual trauma. The Transitional Residence staff member documented advising the patient to report all "unwanted sexual advances" to the work site

[21] VHA Directive 1124. Facility Handbook, *Hot Springs Transitional Residence, CWT-TR Program*, March 29, 2018, and replaced by Facility Handbook, *Hot Springs Transitional Residence, CWT-TR Program*, January 28, 2022. The handbooks contain similar language defining sexual harassment.

[22] Facility Handbook, *Hot Springs Transitional Residence*, CWT-TR Program.

supervisor. Since the patient was now a facility employee, the Transitional Residence staff member referred the patient to a human resources specialist.

Through interviews with the program manager and staff, the OIG found that patients who are participating in the Transitional Residence program, who are also facility employees, are typically referred to both staff and patient resources. The Compensated Work Therapy and Transitional Residence staff and leader stated that if a Transitional Residence patient, who was also a facility employee, reported experiencing sexual harassment while on the job, the Transitional Residence patient would be advised to speak with the work site supervisor and a human resources specialist. The OIG found that in considering the patient an employee of the facility, the Transitional Residence staff member took appropriate steps by recommending that the patient speak with the work site supervisor and report the harassment to a human resources specialist.

Since the patient was in the Transitional Residence program, the Transitional Residence staff member also notified the program manager through an EHR progress note that the patient reported being sexually harassed by a food service coworker. The program manager acknowledged the EHR progress note through electronic signature two days later.

VHA policy states that Compensated Work Therapy and Transitional Residence program managers provide oversight of a highly complex program including administrative, financial, clinical, and supervisory functions.[23] In an interview with the OIG, the program manager reported being responsible for the safety of each work site environment.

In an interview, the VISN 23 Network Homeless Coordinator reported an expectation that the Transitional Residence staff member immediately reach out to key staff, including the program manager, who would consult with experts for advice on managing the situation. Based on interviews conducted, the OIG would have expected the program manager to have taken an active interest in the patient's case and, at minimum, spoken with the patient about the sexual harassment allegations. In addition, the program manager should have ensured that the patient's supervisor or the chief of food service were aware that a report of sexual harassment had been made. However, the OIG found no documented evidence that this occurred. In an interview with the OIG, the program manager admitted being aware of the patient's allegation but could not recall discussing the patient's case with the Transitional Residence staff member or speaking directly with the patient.

The OIG concluded that the Transitional Residence staff member took action when the patient reported being sexually harassed by advising the patient to notify the work site supervisor and a human resources specialist. The Transitional Residence staff member included the program

[23] VHA Handbook 1163.02; VHA Directive 1163. VHA Handbook 1162.02; VHA Directive 1162.02. The handbooks and directives contain similar language regarding the responsibilities of the Compensated Work Therapy and Transitional Residence program manager.

manager as an additional signer to the early spring 2018 progress note. The OIG acknowledges the confusion caused by the patient being considered both a Transitional Residence patient and a facility employee. The Transitional Residence staff member and the program manager were aware that the patient was participating in the Transitional Residence program. Due to this awareness and understanding of policy, the OIG would have expected the program manager to have taken steps to address the patient's report of sexual harassment.

2. Clinical Response to the Patient's Report of Sexual Harassment

The OIG determined that the Transitional Residence staff member and the patient's counselor provided clinical support when the patient reported being sexually harassed by a food service coworker.

On two separate days in early spring 2018, the patient reported being sexually harassed by a food service coworker to the Transitional Residence staff member. The patient reported meeting with the work site supervisor, a union representative, and a human resources specialist in an effort to resolve the issue. The Transitional Residence staff member completed a suicide risk assessment that identified the patient as low risk for suicide. The following week, the patient reported to the same Transitional Residence staff member feeling stressed out by "all the stuff going on in the kitchen" and expressed appreciation for being able to discuss these concerns.

Between mid-spring and mid-summer, the patient met with a counselor for mental health therapy. The therapy focused on the patient's crisis of sexual harassment by a food service coworker and history of military sexual trauma. The counselor documented that the patient's recovery was impacted by having to work closely with the food service coworker.

The OIG concluded that the patient received supportive services through the Transitional Residence staff member and clinical support from the counselor.

Conclusion

The OIG concluded that a human resources specialist, the chief of food service, and the former Facility Director did not take administrative actions that aligned with policy when the patient reported being sexually harassed. While the chief of food service took steps to address the patient's report of being sexually harassed by a food service coworker, the OIG found no documented evidence that the chief of food service followed up with the patient to ensure that the sexual harassment ended and there was no longer a hostile work environment. The patient reportedly felt betrayed by the former Facility Director's and a human resources specialist's response that no action could be taken because the sexual harassment occurred between two employees, after hours, and off campus. In response, the patient elevated the reports of sexual harassment by contacting the VA police, submitting a White House complaint, and continuing to work with the union representative. The VA police reviewed the patient's case and determined

that a boundaries policy violation occurred because the patient was a Compensated Work Therapy patient and notified facility leaders. The union representative and the VISN EEO Lead attempted to take action and advocate on behalf of the patient with facility leaders. Despite these efforts and information provided to facility leaders and a human resources specialist, the OIG found that the guidance remained unchanged, and no action was taken because the sexual harassment occurred between two employees, off campus, and after hours. The former Facility Director reported not knowing of the patient's work or residential status until after the completion of the AIB in mid-2021. Once known, the former Facility Director reportedly reached out to the OIG to confirm that criminal activity had not occurred and then to the Office of General Counsel to determine what actions could be taken.

The OIG concluded that the Transitional Residence staff member took action when the patient reported being sexually harassed by a food service coworker. Because the patient was a facility employee, the Transitional Residence staff member referred the patient to the work site supervisor and a human resources specialist. Since the patient was also a participant in the Transitional Residence program, the Transitional Residence staff member also notified the program manager of the sexual harassment allegations. The program manager could not recall having discussed the patient's allegations with either the Transitional Residence staff member or the patient. The OIG acknowledges the confusion caused by the patient being considered both a facility employee and a patient. However, the OIG would have expected the program manager to understand the complexity of the situation and, at minimum, speak with the patient and ensure that the patient's supervisor and the chief of food service were informed of the allegations. The OIG found no documented evidence that the program manager took action with regards to the patient's sexual harassment allegations.

The OIG concluded that the Transitional Residence staff member and the patient's counselor provided clinical support when the patient reported being sexually harassed by a food service coworker.

Recommendations 1–3

1. The VA Black Hills Health Care System Director reviews the sexual harassment policy to ensure that leaders and supervisors can identify, thoroughly investigate, and respond to sexual harassment allegations.

2. The VA Black Hills Health Care System Director reviews the actions of the Compensated Work Therapy and Transitional Residence program manager related to the identified patient's case and takes action as needed.

3. The VA Black Hills Health Care System Director ensures that facility policy addresses the safety and rights of patients who are both VA employees and participants in the Transitional Residence program.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 24, 2023

From: Director, VA Midwest Health Care Network (10N23)

Subj: Healthcare Inspection—Failure of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota

To: Director, Office of Healthcare Inspections (54HL08)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed the attached documentation related to the OIG report number 2022-00514-HI-1225.

2. This was a tragic event for all who knew or cared for this Veteran at VA Black Hills.

3. I fully concur with the OIG recommendations, with the Facility Director's response, and her expression of support and concern for the Veteran's family and VA Black Hills staff. Please feel free to contact us should you have additional questions.

(*Original signed by:*)

Robert P. McDivitt, FACHE
Executive Director
VA Midwest Healthcare Network (VISN 23)

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 22, 2023

From: Director, VA Black Hills Health Care System—Fort Meade Campus (568/00)

Subj: Healthcare Inspection—Failure of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota

To: Director, VA Midwest Health Care Network (10N23)

1. I acknowledge this as a tragic event that happened at the Black Hills VA Health Care System and empathize regarding the impact this has had on the Veteran's family and the staff within the health care system who are very passionate about the care, they provide Veterans.

2. This memorandum is being provided to convey transmittal of the Facility Director response to VAOIG DRAFT REPORT—Failure of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Healthcare System (HCS) response to OIG Hotline Case Referral No. 2022-00514-HI-1225/VA Medical Center, Fort Meade, SD.

3. VA Black Hills HCS received notification of an OIG draft report and is submitting response to the recommendations in accordance with VA OIG request.

(*Original signed by*:)

Lisa R. Curnes
Director
VA Black Hills Healthcare System

Facility Director Response

Recommendation 1

The VA Black Hills Health Care System Director reviews the sexual harassment policy to ensure that leaders and supervisors can identify, thoroughly investigate, and respond to sexual harassment allegations.

Concur.

Target date for completion: April 2022

Director Comments

I acknowledge this as a tragic event that happened at the Black Hills VA Health Care System (HCS) and empathize regarding the impact this has had on the Veteran's family and the staff within the health care system who are very passionate about the care, they provide Veterans. VA Black Hills HCS follows VHA Directive 5979, dated December 8, 2020, *Harassment Prevention Policy* to ensure allegations or concerns of harassment of any kind, are addressed appropriately and in a timely manner and staff receive *Harassment Prevention & Accountability Training* annually. A live training was provided to all Mental Health staff on February 16, 2022, by the VISN 23 Mental Health Program leadership regarding Harassment prevention and dual relationships with employee/Veteran patients. Additional training was provided during Education Day on March 9, 2022, and all VA Black Hills staff were invited. Facility Leadership received training December 13, 2021, about the Compensated Work Therapy (CWT) training program and all the CWT program staff received this updated training on December 30, 2021. This training includes content regarding staff not engaging in sexual behaviors, language, harassment, etc. with any CWT or Transitional Residence (TR) participants. This training was developed into a Talent Management System (TMS) module and assigned to all facility staff on March 21, 2022 and has been added to the annual mandatory all-staff TMS learning plan. Additionally, Human Resources initiated Employee Relations/Labor Relations Lunch and Learn sessions for all staff on processes for addressing allegations brought to supervisors. These ongoing sessions occur every fourth Thursday of the month beginning January 7, 2022.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The VA Black Hills Health Care System Director reviews the actions of the Compensated Work Therapy and Transitional Residence program manager related to the identified patient's case and takes action as needed.

Concur.

Target date for completion: March 30, 2023

Director Comments

VA Black Hills is conducting a further review of the actions taken in 2018, at the time of the care identified in this report. Upon completion of the review, and in consultation with Human Resources guidance, appropriate action will be taken, if warranted in accordance with Human Resources Management regulations.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The VA Black Hills Health Care System Director ensures that facility policy addresses the safety and rights of patients who are both VA employees and participants in the Transitional Residence program.

Concur.

Target date for completion: May 10, 2022

Director Comments

VA Black Hills HCS enacted an updated medical center policy *Boundaries-Relationships Between Employees and Patients, Former Patients, and Patient's Families* May 10, 2022. Staff also receive training on *Ethics and Professionalism: Ethical Boundaries in the Patient-Provider Relationship* and *BHH Enhanced Transitional Work Program (CWT)* to reinforce the policy expectations regarding Veteran patient and Veteran staff distinctions. These trainings are assigned to all staff annually, along with new employees during their initial orientation.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Joanne Wasko, MSW, LCSW, Director Shelby Assad, LCSW Debbie Davis, JD Hanna Lin, LCSW Sheena Mesa, MSN, RN Elizabeth Winter, MD
Other Contributors	Sherry Becker, MSN-Ed, RN-BC Karen Berthiaume, RPh, BS Limin Clegg, PhD Natalie Sadow, MBA Zaire Smith, LCSW Erica Taylor, MSW, LICSW Erika Terrazas, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Midwest Health Care Network (10N23)
Director, VA Black Hills Health Care System Fort Meade Campus (568/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Nebraska: Deb Fischer, Pete Ricketts
South Dakota: Mike Rounds, John Thune
Wyoming: John Barrasso, Cynthia M. Lummis
U.S. House of Representatives:
Nebraska: Don Bacon, Mike Flood, Adrian Smith
South Dakota: Dusty Johnson
Wyoming: Harriet Hageman

OIG reports are available at www.va.gov/oig.