US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Minneapolis VA Health Care System in Minnesota

Healthcare Facility Inspection	24-03416-237	November 19, 2025

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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Executive Summary

The Office of Inspector General's (OIG's) mission is to conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors. Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the Minneapolis VA Health Care System (facility) from October 29 through 31, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders identified the COVID-19 pandemic as a significant system shock for the facility. During the pandemic, leaders used expedited hiring practices, sign-on bonuses, and retention incentives to optimize staffing. However, once these programs ended, the leaders became more strategic about which positions to fill. A leader said the Medical Center Director conducted employee forums to explain these changes to hiring and other personnel matters.

To further improve transparency and engage staff, executive leaders stated they communicate through several mechanisms, such as online educational videos that are accessible on the facility's website, town halls, and visits to employees in their work areas.

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

Leaders also shared that patient advocates inform them of trends in veterans' concerns, such as scheduling delays and communication difficulties with care teams.[2] Leaders reported meeting with veterans service organization representatives on a regular basis to share information.[3] The Associate Director said representatives also work closely with patient advocates to help resolve the issues.

Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

The OIG found the main entrance welcoming and well-lit, and the area contained an information desk and a patient library. Overall, the facility was clean and well-maintained. However, the OIG found it difficult to navigate through the facility because the signs identifying buildings used letters and numbers and not descriptive names. Since leaders were aware and planned to improve the signs, the OIG did not make a recommendation.

During the physical inspection, the OIG noted restrooms did not have feminine hygiene products available, as required. Further, the OIG found unsecured medications in the pneumatic tube system used to transport medications in the intensive care unit, medical unit, and emergency department; in unlocked coolers outside of the specialty clinic's medication room; and in unsecured medication rooms in the intensive care and medical units.

The OIG made associated recommendations. In response, the Director said staff had identified restrooms that needed dispensers and supplies and are installing them. The Director also reported that leaders reminded clinical staff to properly secure medications and store vaccines in locked medication rooms. They also installed badge readers on inpatient medication room doors and planning to add keypad-access doors to pneumatic tube stations (used to transport items) in inpatient areas (see OIG Recommendations and VA Responses).

The OIG also found cardiac monitors in the intensive care unit and emergency department did not have dated stickers to indicate when staff completed preventive maintenance. Although staff

[2] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[3] Veterans service organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

provided documentation showing the maintenance had been performed timely, VHA requires facilities to ensure clinical staff are confident patient care equipment is safe and functional.[4]

The OIG made a related recommendation. The Director responded to the recommendation and reported that leaders implemented and sustained corrective actions, and the OIG now considers this recommendation closed (see OIG Recommendations and VA Responses).

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG determined the facility had processes to communicate abnormal results to providers who order tests using alerts in the electronic health record system. Informatics staff work with newly hired primary care providers to configure their alerts to make it easier for them to quickly review and act on test results. The OIG found that providers communicate most non-critical test results to patients through their automated process, which sends patients a letter within seven days.[5]

The OIG evaluated patient safety reports and results from surveys and reviews for the past three years and found no open recommendations. Through interviews, the OIG learned quality management staff work with executive leaders and senior service chiefs to determine staff responsible for developing action plans for each recommendation and monitor changes to ensure sustained improvement.

The OIG also found leaders to be focused on process improvement. Quality management staff shared an example of the actions they took to correct deficiencies with staff cleaning medical equipment. An external survey identified that nursing staff did not properly clean equipment as recommended by the manufacturer. Nursing staff received training on how to properly clean equipment. Then, nurse managers observed staff demonstrate how to properly clean the equipment at random times to ensure they sustained improvement.

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson

[4] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[5] The automated process does not include some tests, such as those for sexually transmitted diseases. Additionally, patients receive radiologists' summaries instead of radiology reports.

Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected primary care delivery structure and new patient appointment wait times.[6]

The OIG reviewed facility documents and found staffing vacancies among providers, nurses, and medical support assistants. Primary care leaders addressed these vacancies through recruitment and retention incentives, which included increased salary rates for current and newly hired providers. They also partnered with local nursing programs to recruit recent graduates.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The homeless program increased staffing and outreach efforts to identify homeless veterans and enroll them in the programs.

Program staff work at the facility's Community Resource and Referral Center, which allows homeless veterans to use showers, laundry facilities, and a computer lab and provides them with meals, clothing, and toiletries. A primary care team dedicated to serving homeless veterans provides health care services at the center and in the community through the program's mobile medical unit.[7]

Housing and Urban Development–Veterans Affairs Supportive Housing program staff reported multiple challenges finding permanent housing for homeless veterans, including lack of affordable lodging and difficulty locating accommodations for veterans with criminal backgrounds, poor rental histories, or complex medical needs. Staff collaborated with community partners to find solutions, saying they worked with organizations that purchased properties for veterans with significant housing barriers. There were 122 units available with an additional 98 in development.

[6] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[7] Staff explained the program was one of 25 across the nation with a mobile medical unit, which is a vehicle equipped with a private exam room, exam table, and storage area for medical equipment and refrigerated medications. Mobile medical unit staff provide healthcare assessments, preventive care, wound care, and first aid to homeless veterans in the community.

What the OIG Recommended

The OIG made three recommendations.

1. The Associate Director ensures staff make feminine hygiene products available in public women's and unisex restrooms.
2. The Medical Center Director ensures staff implement processes to secure medications from unauthorized access.
3. Biomedical staff indicate inspection dates on all equipment.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with our findings and recommendations and provided acceptable action plans (see appendixes D and E). Based on the information provided, the OIG considers recommendation 3 closed. For the remaining open recommendations, leaders are implementing corrective actions (see OIG Recommendations and VA Responses), the OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VSO	veterans service organization

FACILITY IN CONTEXT

Minneapolis VA Health Care System
Minneapolis, Minnesota
Level 1a-High Complexity
Hennepin County
Hospital Referral Region: Minneapolis

Description of Community

POPULATION

Female **2,701,732**	Male **2,690,525**
Veteran Female **25,267**	Veteran Male **262,257**

Homeless - State **7,917**
Homeless Veteran - State **290**

MEDIAN INCOME

$62,750

EDUCATION

93% Completed High School
68% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **117**

SUBSTANCE USE

30.8% Driving Deaths Involving Alcohol
24.4% Excessive Drinking
1,096 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	2,110,646
Work at Home	237,211
Carpool	219,639
Public Transportation	86,096
Walk to Work	72,555
Other Means	42,981

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**37 Minutes, 33 Miles**
Specialty Care	**84 Minutes, 80 Miles**
Tertiary Care	**114 Minutes, 113 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **31,782**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	35%
<65 without Health Insurance	9%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

20,920

411 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.05 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
18	30

Health of the Facility

UNIQUE PATIENTS

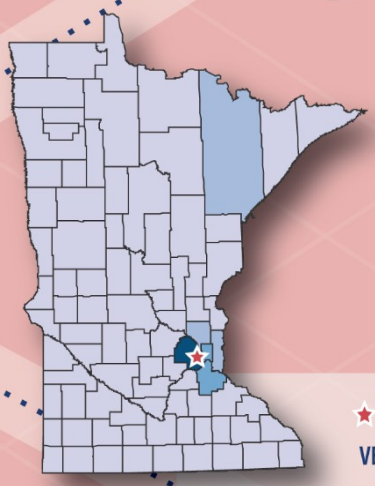
Unique Patients VA and Non-VA Care	102K
Unique Patients VA Care	96K
Unique Patients Non-VA Care	45K

COMMUNITY CARE COSTS

Unique Patient $33,703	Outpatient Visit $386
Line Item $2,925	Bed Day of Care $301

STAFF RETENTION

Onboard Employees Stay <1 Yr	8.94%
Facility Total Loss Rate	9.93%
Facility Retire Rate	2.59%
Facility Quit Rate	6.51%
Facility Termination Rate	0.83%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.08% 3.46% 6.83% 10.21% 13.58% 16.94%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

Contents

Background and Vision

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection cyclical review program to help accomplish its mission. Inspection teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.

Figure 1. *VHA's high reliability organization framework. Source: Department of Veterans Affairs (VA), "VHA's Journey to High Reliability."*

Healthcare Facility Inspection reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

[1] "About VHA," Department of Veterans Affairs, accessed May 29, 2024, https://www.va.gov/health/aboutvha.

High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]

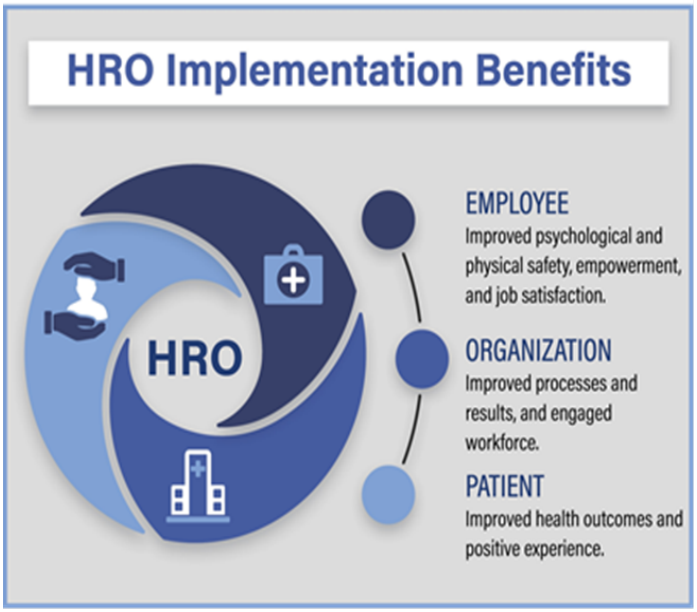


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG inspectors observed how facility leaders incorporated high reliability principles into their operations.

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Veazie, Peterson, and Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[5] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

[6] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

[7] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety 18*, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

Content Domains

Figure 3. *Healthcare Facility Inspection's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The Minneapolis VA Health Care System (facility) is a level 1a complexity, affiliated teaching and research hospital that began caring for veterans in 1921.[13] In fiscal year (FY) 2024, the facility's budget was approximately $1.4 billion, with more than 106,000 enrolled veterans. The facility had 221 hospital and 80 community living center beds.[14]

The OIG inspected the facility from October 29 through 31, 2024. The executive team consisted of the Medical Center Director (Director), Chief of Staff, Associate Director Patient Care Services/Nurse Executive, Associate Director/Chief Experience Officer, and Acting Associate Director. A staff member stated the Director had been in place since June 2013. The Acting Associate Director was the newest member of the executive team, joining in June 2024 after the previous Associate Director retired.

A 2019 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a

[13] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "Facility Complexity Level Model Fact Sheet," October 1, 2017. "An academic affiliate is an educational institution" that fosters education and training through a relationship with a VA medical facility. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed December 2, 2024, https://www.va.gov/Geriatrics/CLC/VA.asp.

[15] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[16] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[18] By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[19] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks.

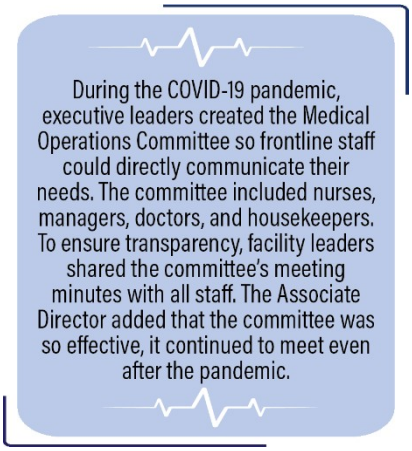


Figure 4. *Addressing a system shock.*
Source: OIG interviews.

Executive leaders identified the COVID-19 pandemic's effect on staffing levels as a system shock. One of the leaders stated that during the pandemic, VA authorized the use of expedited hiring practices and incentives, such as sign-on bonuses and retention incentives, to onboard staff as quickly as possible and retain existing ones. Leaders explained that when they could no longer offer some of the incentives, they had to be more strategic with hiring decisions, which caused staff to question their actions. Leaders stated that staff asked about their decisions to hire in specific areas and only offer incentives for certain positions. According to OIG questionnaire responses and discussions with facility leaders, staff experienced a system shock related to what they perceived to be a hiring freeze. A leader reported that to increase transparency, the Director held forums to discuss changes to hiring and other personnel matters.

[17] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

[18] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies."

[19] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies"; Department of Veterans Affairs, *VHA HRO Framework*.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[21] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[22] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[23]

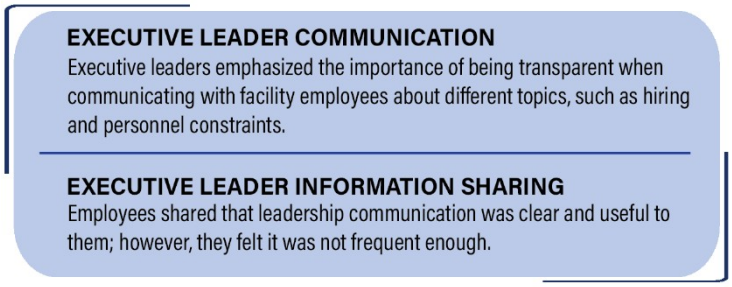


Figure 5. *Leader communication with employees.*
Source: All Employee Survey data and OIG interviews with facility leaders.

Executive leaders said they communicate with employees through several mechanisms that include video communications about operation or policy changes posted to the facility's website; employee town halls, which are recorded and uploaded to the site; and visits to employees in their work areas. A leader stated that, prior to the visits, they send employees a questionnaire so they can share safety concerns and current needs. The leaders then discuss the questionnaire responses to make the visits more meaningful.

[20] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

[21] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[22] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

[23] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[24] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[25] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

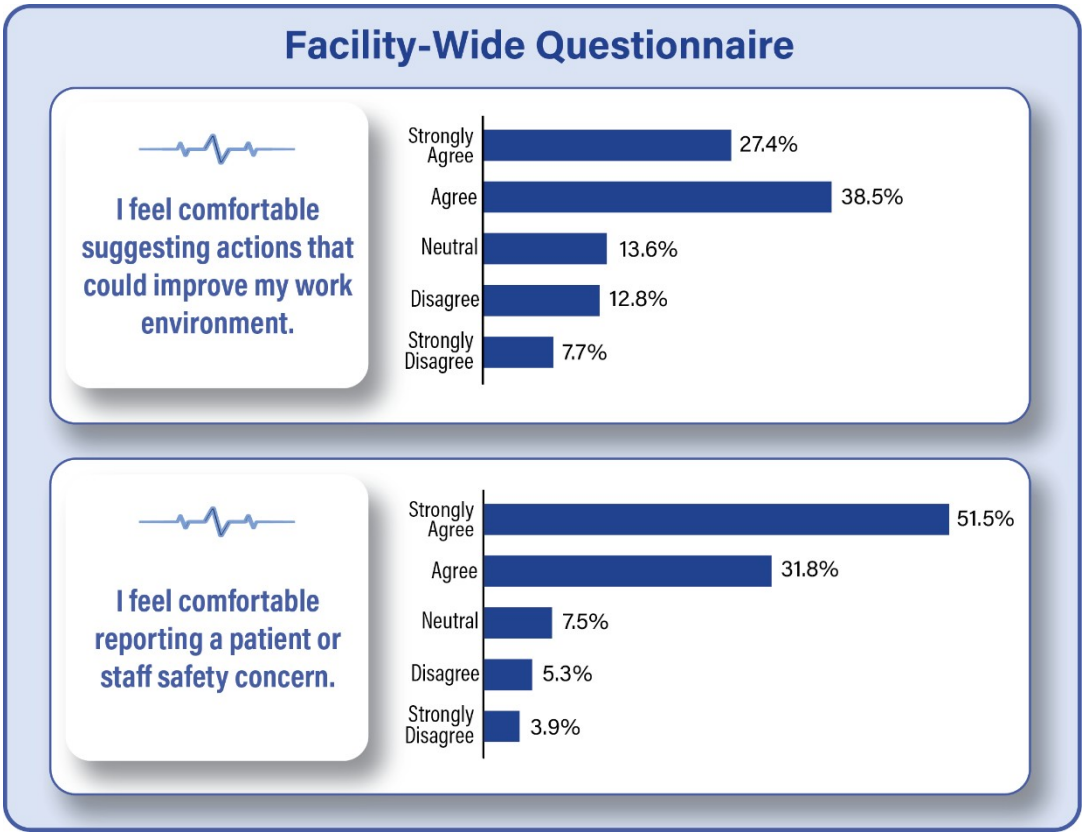


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

Executive leaders stated that while they could always improve psychological safety, survey scores showed employees have very little fear of reprisal for reporting concerns. However, they

[24] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[25] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

also acknowledged psychological trust starts with leaders, and since some employees may feel unheard, they need to do a better job of informing employees that it is safe to communicate issues. Leaders also said Quality, Safety, Value Department employees trained other employees on how to improve psychological safety.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[26] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[27] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.[28]

During an interview with executive leaders, the Director reported meeting with VSO representatives on a regular basis. Leaders stated that local VSO representatives support the facility and communicate what is working well and what needs improvement. The Associate Director added that VSO representatives work closely with patient advocates to address veterans' concerns.

Additionally, leaders said patient advocates inform them of trends in veterans' concerns monthly, such as delays in scheduling and difficulties communicating with care teams, and reach out to service leaders to help resolve these problems. Leaders also said that because the patient advocates promptly resolve issues, they are often unaware of the concerns until they receive the data. According to one leader, patient advocates also proactively learned about benefits enrollment, the PACT Act, and travel reimbursement so they could assist veterans as needed.

[26] "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[27] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

[28] Although the OIG sent questionnaires to VSO representatives, none of them responded.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[29] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 7. *Facility photo.*
Source: "Minneapolis VA Medical Center," Department of Veterans Affairs, accessed December 10, 2024, https://www.va.gov/minneapolis-health-care/locations/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[30] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[31]

[29] VHA Directive 1608(1).

[30] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

[31] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

The ease with which a veteran can reach the facility's location is part of the healthcare experience. The OIG expects the facility to have sufficient transit and parking options to meet veterans' individual needs.

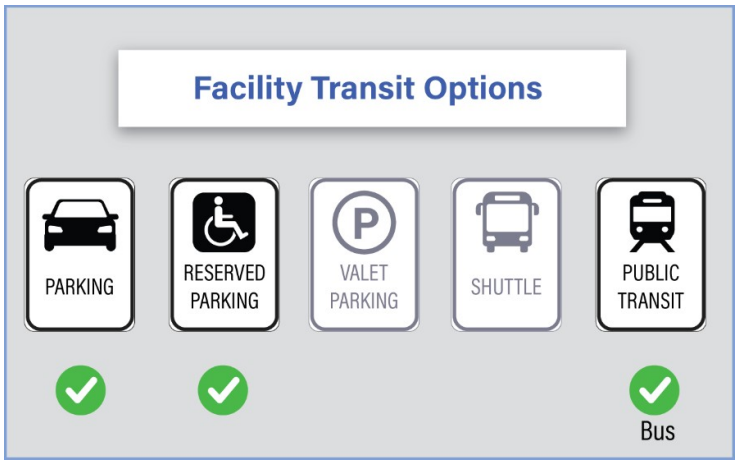


Figure 8. *Transit options for arriving at the facility.*
Source: OIG review of documents and observations.

The OIG used the navigation application link found on the facility's web page to obtain directions, which took the team to the main entrance. The OIG observed the veterans' parking garage, located immediately to the right of the main entrance, had parking accessible to those with disabilities, a covered route to the main entrance that was easy to follow, adequate lighting, and emergency call boxes for safety. Public transportation stopped at the main entrance, and there were additional covered stops throughout the site.

Main Entrance

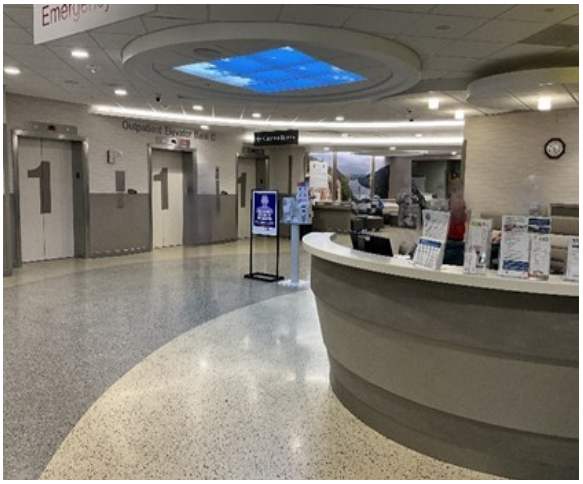


Figure 9. *Facility front entrance.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[32]

The OIG observed a welcoming and well-lit main entrance with an information desk, a seating area, and a library (see appendix C, figure C.1). The library had a full-time staff member, computers, places to read, and staff to assist veterans with benefits, toxic exposure information, and My HealtheVet (a secure messaging system veterans can use to communicate with clinic staff).[33]

[32] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

[33] "Manage Your Health Care with My HealtheVet," Department of Veterans Affairs, accessed July 15, 2025, https://www.va.gov/health-care/manage-health/.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[34]

The OIG observed staff and volunteers at the information desk directing or escorting veterans to their appointments. Information desk staff also supplied veterans with printed maps, and the OIG noted additional maps displayed on walls throughout the facility. However, the OIG found it challenging to navigate the facility because the signs used letters and numbers to mark the different building sections and did not include the corresponding descriptive area names. Facility leaders are aware of this problem and plan to develop a better system that includes an internet navigation application; therefore, the OIG did not make a recommendation.

Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG review of documents and observations.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[35] The OIG did not find any complaints from veterans with sensory impairments made to the patient advocate's office. While on site, the OIG confirmed the availability of sign language interpretation services, and noted written captions on information monitors, braille on elevator signs, and audible commands in elevators throughout the facility.

[34] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

[35] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[36]

An OIG questionnaire respondent indicated the facility had only one toxic exposure screening navigator, but the Chief of Staff said all providers and administrative staff are responsible for the program. The OIG noted toxic exposure screening information in the library, and the librarian could direct veterans to administrative staff for additional information. While VA recommends two toxic exposure screening navigators, the OIG found the facility had no unresolved screenings and therefore did not make a recommendation.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[37] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues. Finally, the OIG reviewed recommendations from previous Joint Commission inspections related to the environment of care.

The OIG found all prior recommendations closed and no repeat issues from those reports and did not note any areas of concern. The OIG also found the facility's environment of care team identified trends in their deficiencies and completed action plans for improvement.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

Overall, the facility was clean and well-maintained. However, restrooms did not have feminine hygiene products available. VHA requires public women's and unisex restrooms to have

[36] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

[37] Department of Veterans Affairs, *VHA HRO Framework*.

feminine hygiene products available at no charge.[38] The Chief of Environmental Management Services was unaware the dispensers had not been installed.

The OIG recommended the Associate Director ensures staff make feminine hygiene products available in public women's and unisex restrooms. In response to the recommendation, the Director reported they identified restrooms that needed dispensers and supplies and are now installing them (see OIG Recommendations and VA Responses).

The OIG found three instances where staff did not limit medication access to approved individuals. First, the OIG observed unsecured medications in the pneumatic tube system in common areas of the intensive care unit, medical unit, and emergency department.[39] The nursing staff said they did not realize leaving medications in the unsecured tube receiving area made them vulnerable to unauthorized access (see appendix C, figure C.2). Second, the OIG found two small, unlocked coolers containing vaccines outside of the specialty clinic's locked medication room. Nursing staff explained they keep the vaccines in a convenient location due to the high volume of immunizations given each day. Finally, the OIG noted two unsecured medication rooms in the intensive care and medical units. When the OIG asked nurse managers why the medication room doors were unlocked, they explained there is only one key for each room, and therefore, nursing staff left them unlocked so they have access.[40]

VHA requires facilities to limit access to medications to approved staff.[41] Failure to secure medications could lead to patient harm. When the OIG informed leaders about the unsecured medications, the Associate Director Patient Care Services/Nurse Executive immediately emailed all clinical staff about the need to safeguard them. Further, the Associate Director Patient Care Services/Nurse Executive secured additional keys and implemented a checkout process, so nurse managers can track them from shift to shift.

The OIG recommended the Director ensures staff implement processes to secure medications from unauthorized access. In response, the Director reported leaders improved medication safety by reminding clinical staff to properly secure medications and store specialty clinic vaccines in locked medication rooms. They also installed badge readers on inpatient medication room doors and are planning to add keypad-access doors to pneumatic tube stations in inpatient areas (see OIG Recommendations and VA Responses).

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[38] VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023.

[39] A pneumatic tube system uses a dispatch tube to send small objects from place to place using air pressure. *Merriam-Webster*, "Pneumatic Tube," accessed December 17, 2024, https://www.merriam-webster.com/dictionary/pneumatictube.

[40] Staff in the intensive care unit used tape to prevent the door from latching. Staff in the medical unit kept the key in an unsecured drawer.

[41] VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

The OIG also observed cardiac monitors in the intensive care unit and emergency department that lacked dated stickers indicating staff had completed routine equipment maintenance. VHA requires facilities to have a method for clinical staff to ensure patient care equipment is safe and functional.[42] The Chief of Biomedical Engineering said they were unaware cardiac monitors lacked stickers and provided the OIG with evidence of current preventive maintenance.

The OIG recommended biomedical staff indicate inspection dates on all equipment.[43] In response, the Director reviewed the process with staff and ensured equipment had up-to-date stickers that showed staff completed the maintenance. Staff monitored this process and maintained compliance at 90 percent or higher over six months. The OIG now considers this recommendation closed (see OIG Recommendations and VA Responses).

The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[44] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[45] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG determined the facility had processes to communicate abnormal test results to ordering providers via alerts in the electronic health record system, identify a surrogate provider when an ordering provider was unavailable or had left the facility, and communicate results outside regular clinic hours. The Chief of Informatics said staff meet with all newly hired primary care

[42] VHA Directive 1608(1); VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*.

[43] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

[44] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[45] Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

providers to optimize their alerts, which makes it easier for them to review and act quickly. In an interview, the Chief of Staff and the Chief of Informatics explained the facility's process for sending automated notification letters to patients for most non-critical test results via mail within seven days.[46]

Action Plan Implementation and Sustainability

Figure 11. *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[47] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG evaluated patient safety reports and results from surveys and reviews for the past three years and found no open recommendations. In an interview, quality management and patient safety staff explained their process to ensure staff implement action plans and sustain improvement. The process starts with quality management staff working with executive leaders and senior service chiefs to determine staff responsible for developing action plans for each recommendation, tracking action plans until they complete all steps, and identifying similar vulnerabilities. Once staff complete an action plan, quality management staff monitor the changes to ensure improvement and update executive leaders and staff through councils and committees.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[48] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[49] The OIG examined the

[46] The automated process does not include some tests, such as those for sexually transmitted diseases. Additionally, patients receive radiologists' summaries instead of radiology reports.

[47] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

[48] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.

[49] VHA Directive 1050.01(1).

facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The OIG found the facility's committee structure, which included an Executive Leadership Board and various facility- and unit-based councils and committees created to govern and oversee operations, to be focused on process improvement. Each group was responsible for ensuring communication flowed up, down, and across the committees.

Quality management staff also provided the OIG with an example of a process improvement initiative that staff recently implemented to correct deficiencies in the medical equipment disinfection process. An external survey identified that nursing staff did not properly clean equipment as recommended by the manufacturer. In response, leaders ensured nursing staff received training on how to properly clean the equipment. Staff then created a poster for the equipment room to remind them of the process. Leaders also implemented a process in which the nurse manager observed staff cleaning equipment to ensure they followed procedures correctly. They also observed staff at random intervals to verify they continued to use the correct cleaning process. Quality management staff said they use an audit tool during environment of care inspections to monitor the improvement effort and track the results.

In addition to the required emergency equipment, the OIG found that staff assembled fall stretchers and placed them throughout the facility (see appendix C, figure C.3). Each stretcher is equipped with a backboard, neck brace, blanket, nasal canula, and oxygen. In the event of a fall, they use the stretcher to stabilize and transport the patient to a treatment location.

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[50] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[51] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

[50] VHA Directive 1406(2); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[51] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

staffing shortages in FY 2023.[52] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

After reviewing documents provided by facility staff, the OIG learned that primary care teams had several vacancies in provider, nurse, and medical support assistant positions. Primary care managers shared that some staff retired or resigned to accept telework positions. The managers said they approved biannual pay raises for primary care providers and offered incentives to licensed practical nurses and medical support assistants to increase retention. Managers and facility leaders also increased the initial salary offer for providers. The OIG found that average appointment wait times for new patients did not exceed VHA's target of 20 days from quarter one through quarter three of FY 2024.[53]

The managers also said the number of graduating licensed practical nurses had decreased in the area, which resulted in fewer applicants. The Chief Nurse of Primary Care and Specialty Care Integrated Clinical Community said the facility had recently established academic affiliations with local licensed practical nursing programs and had since hired several full-time nurses through these partnerships.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[54] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[55]

The OIG found that some primary care team panel sizes exceeded 100 percent of VHA's expected baseline capacity of 1,200 patients from January 2023 through June 2024.[56] During interviews, primary care staff said covering for staff's absences added to their workload, but leaders addressed this by hiring rovers (providers who fill in when needed) to lend additional support. Primary care leaders also told the OIG they meet regularly as a team to review staffing and balance panels as needed. Primary care providers agreed that leaders communicate and update staff on hiring actions and coverage plans during team meetings.

[52] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, Report No. 23-00659-186, August 22, 2023.

[53] Assistant Under Secretary for Health, Office of Integrated Veteran Care (IVC) (16), "Veteran Appointment Scheduling and Community Care Wait Time Eligibility (VIEWS#08891707)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) Medical Center Directors (00), November 18, 2022.

[54] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[55] VHA Directive 1406(2).

[56] VHA Directive 1406(2).

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[57] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Both primary care leaders and staff told the OIG that responding to secure messages (private communications from patients to their health care team), addressing alerts, and completing lengthy clinical reminders (preventive health assessments) significantly affected workflow efficiency. Primary care leaders said they removed non-mandatory clinical reminders and employed a team approach to responding to secure messages to distribute the workload among staff. Primary care staff also explained that rovers addressed some of the alerts for the absent providers.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found the facility did not experience an increase in enrollment following PACT Act implementation.

Primary care leaders and staff told the OIG that screening veterans for toxic exposure added additional time to appointments, which disrupted clinic workflows. The staff said they did not receive training prior to beginning screenings and had to overcome a learning curve. However, they eventually received training and became more comfortable with their added responsibilities over time.

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG analyzed enrollment and performance data and interviewed program staff.

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if

[57] VHA Handbook 1101.10(2).

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[58]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[59] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[60]

The program did not meet the HCHV5 target for FY 2023 but did meet it for quarters one through three in FY 2024. Program staff said they hired additional staff during FY 2023, which contributed to the program's success in FY 2024.

Program staff said they conduct outreach to homeless veterans at homeless shelters, encampments, libraries, drop-in centers, and stand downs.[61] They meet weekly with community partners to receive referrals, then conduct targeted outreach to those homeless veterans. The facility's Community Resource and Referral Center, located in downtown Minneapolis near the largest homeless shelter in the city, assists homeless veterans with permanent housing, medical and mental health care, and career development. Program staff, community partners, and other staff, including the Director, participated in the last point-in-time count and identified homeless veterans in the community to enroll in the program.

The Minnesota Homeless Veteran Registry is a statewide database that HCHV program staff used to identify and track progress for homeless veterans. Community partners added homeless individuals to the registry when contact occurred. Program staff used the list in biweekly case conferencing meetings with community partners and updated the registry in real time, which allowed staff to find different resources to assist veterans in locating housing. Staff tracked when veterans entered the program, how long it took to get permanent housing, if housing was declined, and what barriers were present.

Figure 12. *Minnesota Homeless Veteran Registry.*
Source: OIG interviews.

[58] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[59] VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022.

[60] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

[61] "Stand Downs are an outreach strategy to engage homeless Veterans and present them with longer-term treatment and housing opportunities. The 1- to 3-day events provide homeless Veterans a temporary refuge where they can obtain food, housing assistance, supplies and a range of community and VA assistance." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[62] VHA tracks data for these metrics for veterans discharged from Contract Emergency Residential Services (community-based agencies that contract with local VA medical centers to provide short-term residential treatment) and Low Demand Safe Haven programs (staffed transitional residencies for those chronically homeless with mental illness) as they transition to other programs or permanent housing.[63]

The program met the HCHV1 target for FY 2023 but did not meet it during the first three quarters of FY 2024. The program missed the HCHV2 target for FY 2023 through quarter three of FY 2024. In an interview, staff asserted they took appropriate actions to meet veterans' needs despite missing targets. For example, veterans with mental health and substance use issues may enter treatment facilities, which are not considered permanent housing.

Program staff shared that veterans can use the facility's Community Resource and Referral Center's showers, laundry facilities, and computer lab and obtain meals, clothing, and toiletries. The facility also has a primary care team dedicated to serving homeless veterans that is located at the center and staffed with nurses each weekday and primary care providers twice a week.

Additionally, program staff explained that the program was one of 25 across the nation with a mobile medical unit, which is a vehicle equipped with a private exam room, an extendable exam table, and storage area for medical equipment and refrigerated medications. Mobile medical unit staff provide healthcare assessments, preventive care, wound care, and first aid to homeless veterans in the community.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for

[62] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[63] "HCHV CRS [Contract Residential Services] programs target and prioritize Veterans transitioning from literal street homelessness…[who] require safe and stable living arrangements." There are two models for Contract Residential Services programs. Under the Contract Emergency Residential Services model veterans can usually stay in housing from 30 to 90 days. Under the other model, Low Demand Safe Havens, veterans can typically stay in housing between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[64] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[65]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[66] The OIG found that despite staff's outreach efforts, the program did not meet the target for FY 2022 through quarter three of FY 2024. Program staff attributed this to lack of available housing and difficulty locating housing for veterans with significant barriers to permanent housing, such as criminal backgrounds, poor rental histories, and complex medical conditions that may require assisted living accommodations.

Program staff said they helped develop the Veteran Core Collaborative in 2018 in which veteran organizations meet regularly to identify barriers and create strategies to improve housing options.[67] The collaborative succeeded in building partnerships with landlords to increase access to housing and purchase buildings specifically for veterans with housing barriers. For example, at the time of the site visit in October 2024, this housing included 122 units on 12 properties. Nine more properties, with 98 additional units, were in various stages of development. Staff anticipate this additional housing will improve their ability to meet the performance target.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[68] The program met the target for FYs 2022 and 2023, but not for the first three quarters of FY 2024. Program staff attributed missing the target to staff not entering information correctly into the national database. They educated staff to ensure they capture accurate information.

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[64] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[65] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[66] VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[67] Program staff explained the Veteran Core Collaborative includes the Supportive Services for Veteran Families, Minnesota Assistance Council for Veterans, and Minnesota Department of Veterans Affairs.

[68] VHA sets the VASH3 target at the national level. For FY 2023, the target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[69] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[70]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[71] The facility met the target for FY 2023 but did not meet it for quarters two and three of FY 2024.

Program outreach staff said they identify and enroll veterans through community outreach and referrals from jails, prisons, courts, and facility staff. However, program enrollment decreased because the Health Care for Re-entry Veterans Specialist, who also enrolls veterans into the program, was on unexpected leave for over three months.

Staff described actions they took to increase program enrollment. They educated facility staff on the program through various presentations. They also created cards with QR (quick response) codes that, when scanned, list multiple VA resources, including the Veterans Justice Program. Staff distributed the cards to law enforcement personnel so they refer veterans to the program when in custody. Staff anticipate the cards will increase enrollment.

The Minnesota Veterans Restorative Justice Act, passed in 2021, is unique to Minnesota and the Veterans Justice Program. For jurisdictions without a veterans treatment court, the act provides a specialized sentencing structure for veterans found to have committed criminal offenses related to conditions resulting from military service. Veterans who complete all recommended treatment and abide by the conditions of their probation can avoid a criminal conviction and jail time. Program staff help veterans access and complete the program.

Figure 13. *Veterans Restorative Justice Act.*
Source: OIG review of documents and interviews.

Meeting Veteran Needs

To help veterans complete their individual goals, program staff work closely with

- prisons;
- community agencies;

[69] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report.*

[70] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[71] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

- facility substance use and mental health programs;
- VSOs; and
- treatment courts, which help veterans with substance use and mental health disorders get treatment, lessen or eliminate veterans' jail time, and reduce or dismiss veterans' charges when they graduate from the program.[72]

Program staff said they use early intervention to help veterans avoid the justice system whenever possible. They also monitor veterans released from prison for three months to ensure the transition process is successful and help prevent reincarceration.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to the availability of hygiene products, access to secure medications, and inspection dates for equipment. Facility leaders have started to implement corrective actions (see OIG Recommendations and VA Responses). Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

[72] "Veterans Treatment Court is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially-supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

OIG Recommendations and VA Responses

Recommendation 1

The Associate Director ensures staff make feminine hygiene products available in public women's and unisex restrooms.

_X_ Concur

____ Nonconcur

Target date for completion: December 2025

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Director Comments

The Associate Director was responsible for implementing and sustaining the corrective actions to address the identified recommendation. A team inspected all public female and unisex restrooms and ordered the necessary feminine hygiene dispensers and products. The Chief of Engineering's team installed these dispensers per directive in all but two public unisex restrooms, due to receiving four incorrectly supplied dispenser models. The facility is currently in the process of exchanging these models and will install them in the remaining two restrooms by December 2025. The Chief of Environmental Management Services (EMS) team ensures that the dispensers are appropriately stocked with feminine hygiene products. The Chief of Engineering will continue to report monthly to the Environment of Care committee until the installation is 100% complete.

Recommendation 2

The Medical Center Director ensures staff implement processes to secure medications from unauthorized access.

_X_ Concur

____ Nonconcur

Target date for completion: August 2026

Director Comments

During the inspection, the Associate Director of Patient Care Services/Nurse Executive immediately sent an email to all clinical staff about their accountability and role in always

safeguarding and securing medications. Below outlines the specific plans for three identified observations.

Observation 1:

Unsecured Pneumatic Tubes

Target Date of Completion: August 2026.

Healthcare System Response: The Medical Center Director, Associate Director of Patient Care Services/Nurse Executive, and Chief of Engineering have reviewed the recommendation. Nursing Services is collaborating with Engineering to install plexiglass doors equipped with keypad access for all pneumatic tube systems on inpatient units to secure medications. This project is scheduled for completion by August 2026. Implementing this process will secure all transported medications, eliminating the potential for unauthorized access. The Associate Director of Patient Care Services will oversee the progress of this practice change. The Special Projects Officer or project lead will provide monthly updates to the environment of care committee until 100% of the plexiglass doors are installed and operational.

Observation 2:

Vaccines in Unlocked Coolers

Target Date of Completion: Completed November 2024.

Healthcare System Response: Following the recommendation, the Specialty Clinic Director presented a detailed plan for the safety and security of vaccines in the specialty clinic on November 7, 2024. Specialty Clinic leadership decided to discontinue the use of insulated coolers. Vaccines are now permanently stored in a refrigerator within a locked medication room. This process change was completed on November 8, 2024. Only authorized nursing staff have access to the medication rooms. The facility requests closure of this observation.

Observation 3:

Unsecured Medication Room Doors

Target Date of Completion: Completed March 2025.

Healthcare System Response: During the inspection, when leaders were notified of the unsecured medication room doors, the Associate Director of Patient Care Services/Nurse Executive immediately emailed all clinical staff, outlining the importance of safeguarding medications and ensuring that all medication room doors were secured. Additionally, keys for the medication room doors were obtained and distributed to ICU department nurses. After the inspection, the Medical Center Director, Associate Director of Patient Care Services/Nurse Executive, Chief of Engineering, and Chief Nurse of Daily Nursing Operations & Professional Practice enhanced security by installing badge readers on inpatient medication room doors to ensure compliance

and restrict access to unauthorized staff. This project was completed on March 15, 2025. The facility requests closure of this observation.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 3

Biomedical staff indicate inspection dates on all equipment.

_X_ Concur

____ Nonconcur

Target date for completion: October 2024

Director Comments

At the time of the inspection, all required scheduled maintenance for the physiological monitoring system was documented and completed per the manufacturer's requirements, but some equipment lacked Preventative Maintenance (PM) stickers. The Chief Biomedical (Biomed) Engineer reviewed the process for placement of PM and/or exempt stickers with Biomed technical staff. Immediately following the OIG visit, Biomed corrected the PM sticker concern with the Physiological Monitoring and Telemetry Systems. The facility has shown compliance of 90% or greater for a 6-month period since October 2024. Additionally, in the spring of 2025 clinical staff were provided with Joint Commission readiness guides that included the Preventative Maintenance process with photos of the PM/exempt stickers. The facility requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, relevant prior OIG, and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG inspected the facility from October 29 through 31, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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 issues.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023.

[2] Although the OIG sent questionnaires to VSO representatives identified by facility staff, none of them responded.

[3] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[4] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[5] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.

Category	Metric	Metric Definition
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: Additional Facility Photographs

C.1. *Patient Library.*
Source: Photo taken by OIG inspector.

Figure C.2. *Unsecured tube station area.*
Source: Photo taken by OIG inspector.

Figure C.3. *Fall stretcher.*
Source: Photo taken by OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 12, 2025

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

Subj: Healthcare Facility Inspection of the Minneapolis VA Health Care System in Minnesota

To: Director, Office of Healthcare Inspections (54HF01)

Director, GAO/OIG Accountability Liaison (VHA 10OIC GOAL Action)

Thank you for the opportunity to review and comment on the Office of Inspector General Healthcare Facility Inspection of the Minneapolis VA Health Care System. I concur with the facility and the report as presented.

(Original signed by:)

Judith L. Johnson-Mekota, FACHE
Interim Executive Director
VA Midwest Healthcare Network (VISN 23) Minneapolis, MN

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 15, 2025

From: Director, Minneapolis VA Health Care System (618)

Subj: Healthcare Facility Inspection of the Minneapolis VA Health Care System in Minnesota

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

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Minneapolis VA Medical Center in Minneapolis, Minnesota. I wish to extend my gratitude to the OIG and Healthcare Facility Inspection team for the collaboration during the inspection and for the professional review of the organization.
2. Based on a thorough review of the report, I concur with the findings and recommendations. I have submitted action plans for our Minneapolis Healthcare System.
3. I would like to respectfully request closure of recommendation #3 as we have successfully completed the necessary corrective actions.

(Original signed by:)

Patrick J. Kelly, FACHE
Medical Center Director

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