US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

**VETERANS HEALTH ADMINISTRATION**

# Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha

**Healthcare Inspection** | **25-00421-37** | **January 22, 2026**


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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection, from November 19, 2024, through May 14, 2025, at the request of Congressman Don Bacon to evaluate allegations related to the environment of care on the inpatient mental health unit (unit) at the VA Nebraska-Western Iowa Health Care System (facility) in Omaha. The OIG also evaluated allegations received from another source that the facility Associate Director, Patient Care Services (ADPCS) did not ensure adequate staff for the unit. The OIG identified additional concerns related to the lack of required Prevention and Management of Disruptive Behavior (PMDB) training for facility staff working on the unit, lack of Veterans Health Administration (VHA) and facility leaders' guidance on use of a risk for violence assessment (risk assessment), inconsistent root cause analysis (RCA) monitoring and reporting of action and outcome measures, and delay and absence of Veterans Integrated Service Network (VISN) and facility leaders' reporting of unit bed changes.

## OIG Findings

### The Unit's Environment of Care

The OIG substantiated that facility leaders did not ensure adequate night lighting in the unit's patient rooms that was homelike or adjustable as VA, *Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities* recommends, which may affect patients' ability to sleep.[1]

Facility leaders acknowledged awareness of the lighting concerns and improvement attempts; however, the unit's new night lighting pilot did not provide adequate illumination for nursing staff to complete patient safety observation rounding. The associate chief nurse, mental health reported that staff have the option to use a "small, hand-held" flashlight to provide additional light to assess the patient during patient safety observation rounds. The OIG found a lack of written guidance related to the use and security of staff flashlights that could result in a patient obtaining a flashlight without staff's awareness or staff being without necessary lighting and thereby posing a safety risk to patients and staff.

VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," requires that for all units with staff who conduct patient safety observations, written guidance in a standard operating procedure must include

[1] VA, *Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021.

rounding frequency, procedures for documentation, and applicable staff training.[2] Facility leaders did not provide a facility standard operating procedure related to patient safety observation rounds that occur on the unit, as required.[3] The lack of policy can lead to inadequate and inconsistent patient safety observation practices and thereby increase the safety risk for patients.

The OIG did not substantiate that the women's restrooms did not lock, but found that at the time of the review, female patients did not have adequate access to restrooms. To address this issue, facility leaders placed unisex signs on all unit restroom doors and, with one exception, the doors remained open for patient access.

The OIG did not substantiate that facility leaders failed to provide a clean environment on the unit or provide adequate outdoor space for unit patients. During the site visit, the OIG observed a clean unit without odor or cluttered hallways and a 2,700 square foot outdoor space with enclosed fencing available for use by unit patients.[4]

The OIG found that the interdisciplinary safety inspection team identified hazards on the unit using the Mental Health Environment of Care Checklist (MHEOCC), a tool designed to assist with the identification and mitigation of environmental risks, but did not complete the mitigation plans required in VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients* for those hazards.[5] The OIG found three deficiencies that did not have associated mitigation plans, as required.[6] A facility suicide prevention coordinator told the OIG that "formal mitigation plans were not created" for hazards identified during MHEOCC inspections due to the low risk each element represented.[7] The OIG concluded that

[2] VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023; VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," October 11, 2024. The standard operating procedures (SOPs) contain similar language related to requirements for units to have an SOP for patient safety observation practices.

[3] VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06."

[4] The OIG team began observation of the unit within 10 minutes of notification to the Chief of Staff of the healthcare inspection. The outdoor space for unit patients is located on the 10th floor of the facility.

[5] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced by VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. The policies contain different language related to the interdisciplinary safety inspection team responsibilities. As of November 2024, VHA required the facility director to appoint a facility interdisciplinary safety inspection team lead to direct the facility interdisciplinary safety inspection team, track deficiencies and progress of corrective actions, and update the facility director of identified hazards and mitigation planning.

[6] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[7] The facility suicide prevention coordinator reported being in the role of interdisciplinary safety inspection team lead.

the lack of mitigation plans to address deficiencies hindered appropriate identification of strategies to enhance patient safety on the unit.

## Workplace Violence Prevention Program Staffing Requirements, PMDB Training, and RCA Processes

VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program* requires that facility directors develop a comprehensive workplace violence prevention program to address both patient and employee disruptive behaviors, to include "employee education, data collection and analysis, behavioral threat assessment and management, and communication protocols."[8] Further, facility directors must ensure the implementation of a mandatory PMDB workplace violence training program for all employees.[9]

PMDB consists of trainings that range from an overview of workplace violence prevention to therapeutic containment (PMDB part 3).[10] Facility workplace settings are assigned a risk level from minimal to high, which determines PMDB staff training needs.[11] The ADPCS is responsible to ensure "high risk workplaces have assigned at all times a minimum of four clinical personnel fully trained to immediately implement patient containment safety procedures."[12]

### *Unit Staffing*

The OIG substantiated that the ADPCS did not act in accordance with VHA Directive 1160.08(1) required staffing levels for the unit that included maintaining "a staffing level of at least four available staff members."[13] The OIG found that nursing leaders did not always staff the unit with four PMDB part 3 trained staff, likely due to a misinterpretation of the term 'workplace' as identified in the VHA requirement, and the facility's reported lack of clarity from the National Associate Director, PMDB on flexibilities to this requirement.[14] Facility nursing leaders believed

[8] VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2022. Workplace violence is defined as any act of violence directed toward a person at work on duty, and may include threats, bullying, verbal or emotional abuse, or disruptive behavior. Workplace violence can occur at or outside the facility.

[9] VHA Directive 1160.08(1). PMDB training ensures staff are provided with the knowledge, skills, and resources necessary to avoid or mitigate disruptive and violent behavior.

[10] VHA Directive 1160.08(1); "Therapeutic Containment is both a clinical care intervention/procedure and a form of restraint, only clinical professionals are trained in and use." Clinical personnel include nurses, psychologists, doctors, social workers, physician assistants, and health technicians. "Therapeutic Containment Trainer Requirements," Prevention and Management of Disruptive Behavior (PMDB).

[11] VHA Directive 1160.08(1). The Workplace Behavioral Risk Assessment provides a list of workplaces that include "emergency room," "inpatient/acute psychiatry," and "inpatient medicine."

[12] VHA Directive 1160.08(1).

[13] VHA Directive 1160.08(1).

[14] VHA Directive 1160.08(1).

that 'workplace' included other areas within the facility and therefore counted staff assigned to another area to meet the minimum requirement.

In late spring 2024, the ADPCS asked the acting administrative officer to the ADPCS—a nonclinician—to review the directives as a "third party" and to contact the "national office" about unit staffing. The OIG found that while a definition of 'workplace' is included in the annual Workplace Behavioral Risk Assessment, it is not included in the VHA requirement.[15] The lack of descriptions or definition of 'workplace' in the VHA requirement and the acting administrative officer's documentation after consulting with the National Associate Director for PMDB Workplace Violence Prevention Program may have contributed to facility leaders' misinterpretation of the term 'workplace' and inadequate staffing on the unit.

### *Prevention and Management of Disruptive Behavior Training for Staff Members Working on the Unit*

The OIG did not substantiate that several incidents resulting in injury occurred on the unit. However, a single incident occurred that resulted in multiple staff members being injured; at the time of the incident, four trained staff were not immediately available. The OIG found not all clinical staff working on the unit were trained in PMDB part 3 and some staff who received PMDB part 3 training did not complete the required hands-on component of the training. The OIG would expect that nursing leaders ensure staff assigned and providing coverage to the unit are able to implement therapeutic containment techniques acquired in PMDB part 3 training prior to working on the unit. When staff do not receive required training and leaders are not aware of staff's training status on a high-risk unit, staff and patients are placed at risk for harm.

### *Guidance on Risk Assessment*

The OIG learned that in November 2024, the associate chief nurse, mental health implemented a risk assessment to be used on the unit each shift to increase awareness of potential unit safety concerns and determine appropriate staffing levels. However, the OIG determined that the associate chief nurse, mental health did not develop and implement a process for how the risk assessment would be used.

During an interview with the OIG, the National Director, Workplace Violence Prevention Program explained that while there was no VHA written guidance, if issues arise in meeting the four-person requirement on a high-risk unit, nursing leaders have the option to assess the unit's acuity and decrease staffing if they determine the risk for patient violence is low. The absence of written guidance on use of a risk assessment from both VHA and facility leaders may have contributed to a lack of clarity regarding the purpose and application of the risk assessment at the facility. Nursing leaders' lack of clear processes regarding the risk assessment may have

[15] VHA Directive 1160.08(1). The Workplace Behavioral Risk Assessment is an annual report of all facility disruptive events completed by the facility disruptive behavior committee.

contributed to a misapplication of the risk assessment, leading to times when adequate staffing was not immediately available on the unit, and consequently placing patients' and employees' safety at risk.

### *Root Cause Analysis Monitoring and Reporting*

The OIG found that the patient safety manager did not consistently report open RCA action items through implementation to the patient safety council, as required by VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.[16] The patient safety manager could not provide an explanation regarding the reason the action items were not included in the monthly patient safety council presentations but stated that communication to facility leaders regarding outcome measure updates only occur if an issue arises. The lack of communication and reporting of action items and outcome measures may result in facility leaders not being aware of barriers to address system vulnerabilities and improve quality of care.

## Bed Reporting

The OIG found that facility leaders did not submit a bed change request to the VISN after temporarily closing beds for greater than 60 days, as required by VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures* and VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*.[17] The OIG determined that facility leaders were delayed and remiss in submitting issue briefs reflecting temporary changes in the number of unit beds. The OIG concluded that facility leaders' lack of a bed change request to temporarily or permanently modify the number of authorized unit beds after designating as unavailable for more than 60 days contributed to a misrepresentation of bed utilization data.[18] The VISN Chief Mental Health Officer's lack of awareness of the facility's bed management and VHA's bed change request procedures prevented adequate oversight of facility leaders' reporting of operational bed adjustments and any necessary changes to the national bed database.

[16] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, version 14*, March 2024. This guide was in place during the time of the events discussed. It was updated in December 2024. VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, *version 19.1*, December 2024. Unless otherwise specified, the December 2024 guide contains the same or similar language regarding root cause analysis as the March 2024 guide.

[17] VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010; VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, November 28, 2017.

[18] VHA Handbook 1000.01.

## Recommendations

The OIG made two recommendations to the Under Secretary for Health related to the evaluation of written VHA guidance for high-risk workplace staffing and consideration of written guidance regarding risk of violence assessment use in high-risk workplaces.[19] The OIG made one recommendation to the VISN Director related to inpatient mental health unit bed changes.[20] The OIG made 10 recommendations to the Facility Director related to patient room night lighting, handheld flashlight use and storage, patient safety observation rounds standard operating procedure, MHEOCC mitigation plans, high-risk workplace staffing requirements, PMDB staff training for high-risk workplaces, RCA, inpatient mental health unit authorized, use of risk for violence assessment, and operating bed change processes.

The OIG is aware of VA's transformation in VHA's management structure. As we monitor the implementation, our oversight remains focused on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

## VA Comments and OIG Response

The Acting Under Secretary for Health, the Interim VISN Director, and the Facility Director concurred with the recommendations (see appendixes A, B, and C). The Acting Under Secretary for Health reported plans to review high-risk workplace staffing guidance and the VISN Director identified a plan to ensure active beds are accurately reported and monitored. The Facility Director provided plans to ensure unit staffing is adequate, that a patient safety observation policy is implemented, and that PMDB training is completed. The Facility Director also committed to improve patient room lighting and confirm that mitigation planning occurs. Additionally, the Facility Director outlined steps to review RCA processes and ensure accurate reporting of RCA outcome measures. The Facility Director told the OIG that an institutional disclosure was completed. The OIG will follow up on the planned actions until they are completed.

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

[19] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

[20] The recommendations addressed to the VISN Director are directed to anyone in an acting status or performing the delegable duties of the position.

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# Abbreviations

| | |
|---|---|
| ADPCS | Associate Director, Patient Care Services |
| EOC | environment of care |
| MHEOCC | Mental Health Environment of Care Checklist |
| OIG | Office of Inspector General |
| PMDB | Prevention and Management of Disruptive Behavior |
| RCA | root cause analysis |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Congressman Don Bacon to evaluate allegations related to the environment of care (EOC) on the inpatient mental health unit (unit) at the VA Nebraska-Western Iowa Health Care System (facility) in Omaha. The OIG also evaluated allegations received from another source that the facility Associate Director, Patient Care Services (ADPCS) did not ensure adequate unit staffing.

## Background

VA Nebraska-Western Iowa Health Care System, part of Veterans Integrated Service Network (VISN) 23, includes the facility; the Grand Island VA Medical Center, which provides outpatient care services; and six outpatient clinics. The facility offers a range of inpatient and outpatient services including primary care, mental health, surgery, gynecology, and geriatrics. In fiscal year 2022, the facility had 5,599 women veterans enrolled for care and of the 182 unique veterans treated in the unit, 24 (13 percent) were women.[1] In fiscal year 2023, 42 (20 percent) of the 213 unique veterans admitted to a unit bed were women.[2]

The facility has an affiliation with the University of Nebraska Medical Center, Creighton University School of Medicine, and the University of Nebraska-Omaha.

## Allegations and Related Concerns

In late October 2024, the OIG received allegations from Congressman Don Bacon that leaders did not provide adequate EOC on the unit regarding lighting at night affecting patients' sleep, women's restrooms that did not lock, overall cleanliness issues, and inadequate outdoor space. During evaluation of the allegations, the OIG identified additional concerns related to deficiencies in unit patient safety observation rounding, female restroom access, and Mental Health Environment of Care Checklist (MHEOCC) mitigation planning.

In early November 2024, the OIG received allegations from a different source that the ADPCS did not adhere to staffing level requirements on the unit, which included maintaining "a staffing level of at least four available staff members."[3] Specifically, the complainant alleged the deficiencies in staffing resulted in "several incidents of injury among both veterans and staff."

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[1] A fiscal year is a 12-month cycle that spans October 1 through September 30. Northeast Program Evaluation Center (NEPEC) Hospital Program Evaluation Team, *Acute Inpatient Mental Health Services FY [fiscal year] 2022 Annual Report*, August 18, 2023.

[2] Northeast Program Evaluation Center (NEPEC) Hospital Program Evaluation Team, *Acute Inpatient Mental Health Services FY [fiscal year] 2023 Annual Report*, February 23, 2024.

[3] VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2022.

During the inspection, the OIG identified additional concerns related to lack of Veterans Health Administration (VHA) and facility leaders' guidance on use of a risk for violence assessment (risk assessment), lack of required Prevention and Management of Disruptive Behavior (PMDB) training for facility staff working on the unit, inconsistent root cause analysis (RCA) monitoring and reporting of action and outcome measures, and delay and absence of VISN and facility leaders' reporting of unit bed changes.

# Scope and Methodology

The OIG initiated the inspection and conducted an unannounced site visit of the facility's unit on November 19, 2024. The OIG completed virtual interviews from December 10, 2024, through May 14, 2025.

The OIG team interviewed VISN and facility leaders and staff familiar with relevant processes, and the National Directors of Workplace Violence Prevention Program, Inpatient Mental Health Operations, and Women's Mental Health Program.

The OIG reviewed relevant VHA directives, memoranda, a handbook, and relevant facility policies, standard operating procedures, and organizational charts. The OIG team also reviewed facility documentation related to the unit for fiscal year 2023 through mid-November 2024, including an internal review, Joint Patient Safety Reports, Disruptive Behavior Reports, and patient advocate complaints.[4]

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

[4] Fiscal year 2023 began on October 1, 2022, and ended on September 30, 2023; fiscal year 2024 began on October 1, 2023, and ended on September 30, 2024; and fiscal year 2025 began October 1, 2024, and ended on September 30, 2025.

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

# Inspection Results

## 1. The Unit's Environment of Care

VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires that facility directors develop a comprehensive EOC program to maintain a "safe, clean, and high-quality environment" for patients and families.[5] Further, the facility director is responsible for establishing and monitoring the comprehensive EOC program through a "multi-disciplinary," comprehensive EOC committee. As part of the comprehensive EOC program, EOC rounds must occur for all patient care areas twice per fiscal year and the EOC rounds team must be led by the facility director or a member of executive leadership team and include representation from various disciplines to include patient safety, privacy, and the Women's Health Program.[6] The comprehensive EOC rounds are used to "manage environmental risk" through the "pro-active identification of unsafe conditions or noncompliance" and address "corrective actions."[7]

In addition, for VHA facilities that treat patients at high acute risk for suicide on inpatient mental health units or other areas, VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients* requires that the environment must be free of hazardous items that could pose a risk to patients' safety (such as keys, scissors, plastic bags, and tools).[8] According to Facility Standard Operating Procedure, "Environment of Care Rounds Conducted on Acute Inpatient Mental Health Unit (10W)", facility nursing staff are required to complete EOC rounds each shift to assess for hazardous items and ensure all doors are secured, including the nurses' station.[9]

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

[6] VHA Directive 1608(1).

[7] VHA Directive 1608(1).

[8] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, covered the events in this report. VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients,* November 4, 2024. The policies contain similar language related to the purpose of the checklist and adds a requirement for facilities to develop standard operating procedures for conducting environment of care rounds on inpatient mental health units; Facility Policy, Mental Health and Behavioral Science Department-125, "10 West Recovery Hazardous Items Searches," June 6, 2017; Facility Standard Operating Procedure, "Environment of Care Rounds Conducted on Acute Inpatient Mental Health Unit (10W)," January 2025.

[9] Facility Standard Operating Procedure, "Environment of Care Rounds Conducted on Acute Inpatient Mental Health Unit (10W)."

## Lighting and Patient Safety Observation

The OIG substantiated that facility leaders did not ensure adequate night lighting in the unit's patient rooms, which may affect patients' ability to sleep. During review of this allegation, the OIG found that facility leaders did not provide written guidance to ensure security of handheld flashlights used by nursing staff while conducting patient safety observation rounds. The OIG found that facility leaders also did not implement a standard operating procedure for patient safety observation rounds, as required by VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06."[10]

### *Patient Room Night Lighting and Security of Handheld Flashlights*

VA, *Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities*, recommends "home-like lighting levels" on inpatient mental health units and adjustable lighting features based on the time of day.[11] Further, a specific goal related to inpatient mental health unit artificial lighting includes, when possible, to provide "MHEOCC compliant patient lighting controls."[12] In addition, the VHA standard operating procedure requires facilities to develop a policy on monitoring for items on an inpatient mental health unit that may pose a hazard to patients.[13]

The VHA standard operating procedure requires inpatient mental health staff complete patient safety observation rounds to ensure staff's awareness "at all times" of every patient's "location, activities, movement and general status."[14] The OIG determined that staff must have adequate lighting to assess patients when completing patient safety observation rounds.

In interviews with the OIG, facility leaders reported awareness of the lighting concerns and had started working on a resolution. During a walkthrough of the unit in mid-fall 2024, the chief, engineering explained and demonstrated to the OIG that the overhead light in a patient's room

[10] VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023; VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," October 11, 2024. The standard operating procedures (SOPs) contain similar language related to requirements for units to have an SOP for patient safety observation practices.

[11] VA, *Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021.

[12] VA, *Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities.*

[13] VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023; VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," October 11, 2024. The SOPs contain similar language related to requirements for units to have an SOP for checks for hazardous items.

[14] VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023; VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06," October 11, 2024. The SOPs contain similar language related to requirements for patient safety observation rounding.

has built-in night lighting and the option is to either turn the lighting on or off as there is no dimmer function. The chief, engineering further explained that when the main lighting is turned off, the built-in night lighting disperses indirect lighting down to the room, which shines directly into patients' eyes.

In early fall 2024, the chief, engineering sent an email to the VISN safety and health officer, the chief mental health officer, and a health system specialist that described potential resolutions to the night lighting concerns, including dimmable night lighting. However, nursing staff would need to use flashlights to complete patient safety observation rounds as the dimmable night lighting would not provide enough light to assess patients.[15] Based on a discussion with the VISN Chief Mental Health Officer, the VISN health system specialist provided guidance regarding "acceptable night light options" and indicated no concerns with staff using a handheld flashlight "as long as there is a process" to account for the security of the flashlights.

In early 2025, the chief, engineering reported to the OIG piloting two different night lighting options due to varying outlet availability in the patient rooms and that either would be installed in each of the 13 patient rooms.[16] Approximately one month later, the associate chief nurse, mental health reported to the OIG that three patient rooms had been updated with the new night lighting. However, in mid-spring 2025, the associate chief nurse, mental health reported that further installation of patient room night lighting had been postponed due to trialing of another night lighting option. Further, the associate chief nurse, mental health explained the additional trial of night lighting was due to nursing staff feedback that the other options did not provide enough light to observe the patients.

The associate chief nurse, mental health reported that staff have the option to use a "small, hand-held" flashlight to provide additional light to assess the patient during patient safety observation rounds. Further, the associate chief nurse, mental health reported that the flashlights were stored in a safe and the option to use a flashlight had been discussed during staff meetings. In interviews with the OIG, two nursing staff reported not being able to find the designated flashlights and needing to find alternative options to ensure visibility during patient safety observation rounds. Consistent with guidance provided by the VISN health system specialist, the OIG would expect facility leaders to ensure a process is in place regarding the use of flashlights on the unit and that staff members are aware.

The OIG determined that facility leaders have been working to remediate the night lighting concerns that may have affected patients' ability to sleep. The OIG acknowledges the importance for staff to have adequate lighting to conduct patient safety observation rounds and recognizes that leaders' ongoing trialing of different night lighting options was to accommodate both patient

[15] VISN mental health points of contact included the chief mental health officer and a health system specialist.

[16] The chief, engineering received concurrence from the VISN health system specialist to proceed with installation of the night lighting after providing completion of a risk assessment regarding the night lighting.

comfort and ensure visibility for staff. However, the OIG found that the lack of written guidance related to the use and security of staff flashlights could result in a patient obtaining a flashlight without staff's awareness or staff being without necessary lighting and thereby posing a safety risk to patients and staff.

### *Patient Safety Observation Rounding Standard Operating Procedure*

According to VHA Directive 1160.06, *Inpatient Mental Health Services,* to meet the unique needs of patients admitted to an inpatient mental health unit, inpatient mental health unit staff need to provide the "type and intensity of clinical observation" necessary to care for the patient.[17] The VHA standard operating procedure requires that for all units with staff who conduct patient safety observations, written guidance in a standard operating procedure must include rounding frequency, procedures for documentation, and applicable staff training.[18]

While the OIG received facility standard operating procedures pertaining to patient assessment and the EOC, leaders did not provide a facility standard operating procedure related to patient safety observation rounds that occur on the unit, as required.[19] The lack of policy for patient safety observation rounds can lead to inadequate and inconsistent patient observation practices and thereby increase the safety risk for patients.

## Women's Restrooms

The OIG did not substantiate that the women's restrooms did not lock. However, the OIG found that at the time of the review, facility leaders did not provide adequate access to restrooms for female patients.

VHA Directives 1330.01(7), *Health Care Services for Women Veterans* and 1160.06, *Inpatient Mental Health Services* requires that women have access to women-only or unisex restrooms and shower facilities with appropriately locking hardware and receive "equitable" care "in an environment that provides privacy, dignity, and security."[20]

[17] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1), December 27, 2024. The policies contain similar language related to inpatient mental health.

[18] VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06."

[19] VHA, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units Under VHA Directive 1160.06."

[20] VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023; VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1), December 27, 2024. The policies contain similar language related to women's access to an equitable environment.

### *Restroom Access for Women*

During a walkthrough of the unit in mid-fall 2024, the OIG team observed that the women's restrooms locked and required staff assistance for access. Facility leaders and staff informed the OIG that unit staff only allowed one patient per restroom at a time and kept women's restroom doors closed and locked, requiring patients to request assistance from staff for access, but men's restroom doors were routinely left ajar, allowing patient access. The chief, mental health reported to the OIG that the women's restrooms were locked "to ensure others did not get in and pose a risk." The OIG learned that facility leaders received four patient complaints between February and June 2024 regarding female patients requiring unit staff assistance for entry to locked restrooms.[21] The Facility Director reported awareness of the concerns regarding access to female restrooms and supported keeping the door closed and locked to ensure safety for female patients.

In late fall 2024, the facility detailed women veterans program manager told the OIG that in response to the restroom access concern, all restrooms on the unit would be transitioned to unisex so that male and female patients could access all unit restrooms. The National Director, Women's Mental Health reported that on inpatient mental health units, women need to have "ready access" to a restroom that is secure and that having all locking unisex restrooms meets this requirement. The OIG learned through interviews that to promote safety, female patients may also request to keep a unit restroom door closed and locked when not in use. By mid-spring 2025, the associate chief nurse, mental health reported to the OIG that all restrooms have unisex signs displayed, four of the five restroom doors remained open for patient access, and one restroom remained locked for isolation.

While the OIG initially found that female patients did not have adequate access to unit restrooms, facility leaders confirmed that changes implemented by mid-spring 2025 addressed the concern and, therefore, the OIG made no recommendation.

## Unit Cleanliness and Outdoor Space

The OIG did not substantiate that facility leaders failed to provide a clean environment on the unit or provide an adequate outdoor space for unit patients.

### *Unit Cleanliness*

The Joint Commission, *Standards Manual*, e-dition, "Environment of Care," requires that patient areas are maintained to include a safe and functional environment and kept clean and free of odor.[22]

[21] VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023; VA uses the patient advocacy program for the management of complaints via the Patient Advocate Tracking System (PATS).

[22] The Joint Commission, *Standards Manual,* e-dition, "Environment of Care," January 1, 2024.

During the site visit, the OIG observed a clean unit without odor or cluttered hallways.[23] In an interview with the OIG, the unit acting nurse manager reported that the environmental management services staff clean the unit at least twice a day and the unit acting nurse manager had not received patient complaints regarding the unit's cleanliness.[24]

The OIG reviewed the facility EOC committee meeting minutes from fiscal year 2024 through January 2025, and at each meeting, facility staff presented the inpatient mental health report to discuss work orders, unfinished projects, and concerns on the unit. The OIG found one report related to overall cleanliness on the unit in early summer 2024 indicating a "urine smell" had been identified and was "under control."

The OIG concluded that facility leaders ensured a clean environment on the unit through environmental management service staff cleaning and EOC rounds.

## *Outdoor Space*

VA*, Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities* recommends facility leaders provide patients access to naturally lit outdoor spaces.[25] Outdoor spaces should be large enough to accommodate "various outdoor activities" and a rooftop terrace is an option for patients to receive fresh air and access to nature or sky views.[26] Designated inpatient mental health unit outdoor areas must also include fencing that is a minimum of 10 feet high and "tall enough to prevent elopement."[27] VHA Directive 1160.06 requires that mental health inpatient unit outdoor time is incorporated into patients' daily programming, as allowed by staffing, patient interest, weather, and the patient's clinical stability.[28] Facility Standard Operating Procedure, "Fresh Air SOP [standard operating procedure] – taking 10W veterans out to the 10th floor observation deck," requires that a provider determines a patient's clinical appropriateness to use the outdoor space, and states that all outdoor activity is "at the discretion of the Rec [recreation] Therapist and/or Charge Nurse on duty."[29]

[23] The OIG team began observation of the unit within 10 minutes of notification to the Chief of Staff of the healthcare inspection.

[24] The unit nurse manager was detailed to this role from October 20, 2024, through February 2, 2025.

[25] VA, *Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities.*

[26] VA*, Design Guide for Inpatient and Mental Health & Residential Rehabilitation Treatment Program Facilities.*

[27] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 30, 2024.

[28] VHA Directive 1160.06, September 27, 2023; VHA Directive 1160.06(1), December 27, 2024. The policies contain similar language related to a patient's use of outdoor space for clinical programming.

[29] Facility Standard Operating Procedure, "Fresh Air SOP [standard operating procedure] – taking 10W veterans out to the 10th floor observation deck," April 27, 2018.

The OIG observed a 2,700 square feet outdoor space during the site visit that is located near the unit and is available for use by unit patients.[30] The outdoor space had open fencing that enclosed the area to prevent elopement, as required.[31] Further, the outdoor space included a basketball net and eight chairs secured to two tables. Facility staff described to the OIG that the unit psychiatrist determines if patients are authorized to go outdoors and then facility staff accompany the patients to the outdoor space.

***Figure 1.*** *Facility patient outdoor space.*
*Source: Photo taken by OIG staff, November 19, 2024.*

The OIG concluded that facility leaders ensured that the outdoor area for unit patients had adequate space with appropriate fencing and patients had opportunities to engage in fresh air access and recreational opportunities.

## Inpatient MHEOCC Mitigation Planning Documentation

The OIG found that the interdisciplinary safety inspection team identified hazards on the unit using the MHEOCC but did not complete the required mitigation plans for those hazards.[32]

VHA Directive 1167 requires facilities use the MHEOCC to identify and address environmental risks on inpatient mental health units.[33] For VHA facilities that treat patients at high acute risk

[30] The outdoor space for inpatient mental health unit patients is located on the 10th floor of the facility.

[31] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[32] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain different language related to the interdisciplinary safety inspection team responsibilities. As of November 2024, VHA required the facility director to appoint a facility interdisciplinary safety inspection team lead to direct the facility interdisciplinary safety inspection team, track deficiencies and progress of corrective actions, and update the facility director on identified hazards and mitigation planning.

[33] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

for suicide on inpatient mental health units or other areas, the facility director must designate an interdisciplinary safety inspection team to evaluate the EOC "at least every [six] months" using the MHEOCC.[34] The MHEOCC is a tool designed to assist the interdisciplinary safety inspection team in the identification and mitigation of environmental risks in all areas on the unit for patients being treated who are "at high acute risk for suicide."[35]

The facility interdisciplinary safety inspection team is required to assign a risk level to any identified hazard to guide any necessary mitigation planning and prescribed hazard abatement timelines.[36] The team lead, the inpatient mental health nurse manager, and the engineering and environmental services representative collaboratively develop an action plan for identified hazards.[37] Facility staff, to include the patient safety manager, facility safety officer, and engineer, track deficiencies and corrective actions, and communicate identified hazards and mitigation planning to the facility director.[38]

The OIG reviewed completed MHEOCC reports for fiscal year 2024 and January 2025. The OIG found the interdisciplinary safety inspection team identified three deficiencies but did not complete mitigation plans, as required.[39]

The National Director, Inpatient Mental Health told the OIG that mitigation plans should be developed by all interdisciplinary safety inspection team members and communicated with inpatient mental health staff. A facility suicide prevention coordinator told the OIG that "formal mitigation plans were not created" for identified hazards on MHEOCC inspections due to the low risk each element represented.[40] In early spring 2025, the suicide prevention coordinator reported that moving forward, mitigation plans will be completed for all deficiencies identified in the MHEOCC.

The OIG concluded that the lack of mitigation plans to address deficiencies hinders appropriate identification of strategies to enhance patient safety on the unit.

## 2. Workplace Violence Prevention Program Staffing Requirements,

[34] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain different language regarding the required frequency to conduct interdisciplinary safety inspection team environment of care rounds. VHA Directive 1167 with an effective date of May 12, 2017, states "at least every 6 months." VHA Directive 1167 with an effective date of November 4, 2024, states "twice annually."

[35] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to the MHEOCC.

[36] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[37] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[38] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The Patient Safety Assessment Tool is a "web-based assessment tool managed by the VHA National Center for Patient Safety (NCPS)."

[39] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[40] The facility suicide prevention coordinator reported being in the role of interdisciplinary safety inspection team lead.

## PMDB Training, and RCA Processes

The OIG substantiated that the ADPCS did not follow required staffing levels, including maintaining "a staffing level of at least four available staff members."[41] The OIG substantiated that one incident occurred on the unit that resulted in multiple staff members being injured; at the time of the incident, four PMDB part 3 trained staff were not immediately available. The OIG reviewed data from fiscal years 2023 and 2024 and did not substantiate that other incidents occurred that resulted in injury to patients and staff due to staffing. The OIG identified additional concerns related to lack of required PMDB training for facility staff working on the unit, lack of VHA and facility leaders' guidance on use of a risk assessment, and inconsistent RCA monitoring and reporting of action and outcome measures.

### Background

According to VHA Directive 1160.06, inpatient mental health units must have adequate staffing to ensure the environment is "safe and secure."[42] The facility Chief of Staff and ADPCS must ensure (1) inpatient mental health units maintain sufficient staffing to "establish interdisciplinary teams," (2) patients have "access to inpatient mental health treatment," and (3) program requirements are implemented.[43]

#### *Workplace Violence Prevention Program*

VHA Directive 1160.08(1) requires that facility directors develop a comprehensive workplace violence prevention program to address both patient and employee disruptive behaviors, including "employee education, data collection and analysis, behavioral threat assessment and management, and communication protocols."[44] Further, facility directors must ensure the implementation of a mandatory PMDB workplace violence training program for all employees.[45] PMDB training ensures staff are provided with the knowledge, skills, and resources necessary to avoid or mitigate disruptive and violent behavior.[46] PMDB training consists of different trainings

[41] VHA Directive 1160.08(1).

[42] VHA Directive 1160.06, September 27, 2023; VHA Directive 1160.06(1), December 27, 2024. The policies contain similar language related to adequate staffing.

[43] VHA Directive 1160.06; VHA Directive 1160.06(1).

[44] VHA Directive 1160.08(1). Workplace violence is defined as any act of violence directed toward a person at work on duty, and may include threats, bullying, verbal or emotional abuse, or disruptive behavior. Workplace violence can occur at or outside the facility.

[45] VHA Directive 1160.08(1).

[46] VHA Directive 1160.08(1).

that range from an overview of workplace violence prevention to therapeutic containment (PMDB part 3).[47]

The Workplace Behavioral Risk Assessment is an annual report of all facility disruptive events completed by the facility disruptive behavior committee chair.[48] Based on the results of the Workplace Behavioral Risk Assessment, facility workplace settings are assigned a risk level of minimal, low, moderate, or high, which determines PMDB staff training needs.[49] The facility PMDB coordinator told the OIG that the unit is always assigned as a high-risk unit even in instances when the Workplace Behavioral Risk Assessment report determines a lower risk level to ensure staff receive the highest level of training.

A high-risk workplace setting potentially places employees at "risk for exposure to physical disruptive behavior severe enough to require physical containment of a patient" to "continue medical care safely."[50] The ADPCS is responsible to ensure "high risk workplaces have assigned at all times a minimum of four clinical personnel fully trained to immediately implement patient containment safety procedures."[51]

## Unit Staffing

The OIG found that nursing leaders did not always staff the unit with four PMDB part 3 trained staff, likely due to a misinterpretation of the term 'workplace' as identified in the VHA requirement, and the facility's reported lack of clarity from the National Associate Director, PMDB on flexibilities to this requirement (discussed below).[52] Specifically, nursing leaders believed the workplace included other areas within the facility rather than only the unit and, therefore, used staff from other areas to meet the minimum four PMDB part 3 trained staff scheduling requirements. Nursing leaders explained to the OIG that when they were unable to schedule four staff on the unit, individuals assigned to other areas could be factored as one of the four PMDB part 3 trained personnel. The associate chief nurse, mental health further explained

[47] VHA Directive 1160.08(1). "Therapeutic Containment is both a clinical care intervention/procedure and a form of restraint, only clinical professionals are trained in and use." Clinical personnel include nurses, psychologists, doctors, social workers, physician assistants, and health technicians. "Therapeutic Containment Trainer Requirements," Prevention and Management of Disruptive Behavior (PMDB); PMDB training consists of four trainings: "Part 1" includes an overview of workplace violence prevention; "Part 2 Low" provides instruction on verbal intervention techniques; "Part 2 Moderate/High" provides training to avoid physical assault; and "Part 3" provides training on therapeutic containment techniques. VHA Prevention and Management of Disruptive Behavior, "PMDB Fact Sheet."

[48] VHA Directive 1160.08(1).

[49] VHA Directive 1160.08(1). The Workplace Behavioral Risk Assessment provides a list of workplaces that include "emergency room," "inpatient/acute psychiatry," and "inpatient medicine."

[50] VHA Directive 1160.08(1).

[51] VHA Directive 1160.08(1).

[52] VHA Directive 1160.08(1).

that "we attempt to staff to four" but in situations when "we do not have four" on the unit, additional facility staff are available from a different area located "across the hall."[53]

The Facility Director told the OIG that nursing leaders' interpretation of the workplace "could include the entire floor" and that unit staff were interpreting the workplace as the specific unit. The Facility Director also reported that the ADPCS contacted "an expert in central office" to discuss "this definition" and believed the ADPCS received confirmation that the workplace "could be broader than just the unit."

The ADPCS told the OIG about a conflicting understanding between leaders and staff regarding staffing requirements on the unit. Specifically, the ADPCS reported staff believed that four personnel who are PMDB part 3 trained should be scheduled on the unit whereas the ADPCS reported that "it's four staff within the workplace." The ADPCS also reported that the requirement is confusing as the term 'workplace' is not defined.

In late spring 2024, the ADPCS asked the acting administrative officer to the ADPCS (acting administrative officer), a nonclinician, to review the directives as a "third party" to determine if there is "something that we're missing," and to contact "national office" about staffing on the unit. The acting administrative officer explained to the OIG about generating the questions discussed with the National Associate Director for PMDB Workplace Violence Prevention Program based on an interpretation of an email the ADPCS sent.

In an interview with the OIG, the acting administrative officer reported meeting with the National Associate Director for PMDB Workplace Violence Prevention Program by a Microsoft Teams call and taking notes during that call.[54] The acting administrative officer documented an understanding of the conversation that the National Associate Director for PMDB Workplace Violence Prevention Program recommended that "ideally" four individuals should be scheduled on the unit. The acting administrative officer's documentation also included the recommendation that some facilities with a lack of staffing may need to "supplement that with a code team," and that staff can provide coverage from other units when the unit has "a low-risk census" (as discussed below).[55] The acting administrative officer emailed the notes to the ADPCS after the call.

The OIG found that while a definition of 'workplace' is included in the annual Workplace Behavioral Risk Assessment, it is not included in the VHA requirement.[56] In an interview with the OIG, the National Director, Workplace Violence Prevention Program explained that the

[53] The 10th floor of the facility includes the unit and the Residential Rehabilitation Treatment Program.

[54] Microsoft Teams is a cloud-based collaboration platform that can be used to conduct a chat, call, or meeting.

[55] VHA Directive 1160.08(1). The directive provides the option for facility leaders to develop a behavioral code team "to respond to behavioral emergencies." The facility did not have a behavioral code team.

[56] VHA Directive 1160.08(1). The Workplace Behavioral Risk Assessment Sublocations Guide defines the respective facility workplaces. The Inpatient/Acute Psychiatry Unit is a distinct workplace per this document.

definitions of "workplaces" are developed at the "national level" for purposes of the workplace violence risk assessment conducted annually at VA facilities. The National Director, Workplace Violence Prevention Program also reported that high-risk workplaces "have to have, at a minimum" four staff who are PMDB part 3 trained "in the high risk area at all times" and can respond immediately to situations that require patient containment; they cannot rely on staff from another unit. However, the National Director, Workplace Violence Prevention Program noted that there have been situations in which flexibility around that requirement occurred specifically when a unit was determined not to be high risk based on an assessment of the current patients' risk for violence (as discussed below). The lack of descriptions or definition of 'workplace' in the VHA requirement may have contributed to facility leaders' misinterpretation of the term.

The OIG determined the information the acting administrative officer documented as being provided by the National Associate Director for PMDB Workplace Violence Prevention Program contributed to facility and nursing leaders' misinterpretation of the term workplace. Further, the guidance led to nursing leaders continuing to use staff from other areas of the facility who were not immediately available on the unit, to meet the requirement of having a minimum of four PMDB part 3 trained personnel available at all times in the workplace.[57] Moreover, the OIG determined that the lack of a nursing leader's participation in the call with the National Associate Director for PMDB Workplace Violence Prevention Program may have furthered the misinterpretation of the VHA requirement regarding minimum staffing in a high-risk workplace. The misinterpretation likely resulted in times when adequate staffing was not immediately available on the unit and placed facility staff and patients at risk if a disruptive behavior event occurred.

### *Prevention and Management of Disruptive Behavior Training for Staff Members Working on the Unit*

The OIG substantiated that one incident occurred on the unit that resulted in multiple staff members being injured; at the time of the incident, four trained staff were not immediately available. The OIG reviewed data from fiscal years 2023 and 2024 and did not substantiate that other incidents occurred resulting in injury to patients and staff due to staffing.

VHA Directive 1160.08(1) specifies that clinical staff working in areas designated as high risk are required to complete PMDB part 3 training, which includes a hands-on component, to demonstrate the skills necessary for implementing therapeutic containment.[58]

The OIG reviewed disruptive behavior events that occurred in fiscal years 2023 and 2024. In fiscal year 2023, the OIG found that of the nine reported incidents that involved staff or patient injury, a minimum of four staff members were scheduled to be working on the unit. Of the six

[57] VHA Directive 1160.08(1).
[58] VHA Directive 1160.08(1).

incidents involving staff or patient injury in fiscal year 2024, the OIG found adequate unit staffing for five incidents. The incident with inadequate staffing on the unit resulted in staff members' injury. However, the OIG found that not all clinical staff working on the unit were trained in PMDB part 3 and that not all staff who received PMDB part 3 training completed the required hands-on component of the training.

In a mid-winter 2025 interview with the OIG, the associate chief nurse, mental health reported being unaware that some staff assigned to work on the unit were listed as having completed PMDB part 3 training without demonstrating the hands-on component, thereby making them unable to participate in the therapeutic containment of a patient, if needed. The associate chief nurse, mental health recalled informing staff that the demonstration of the hands-on component was necessary to be able to participate in therapeutic containment. The National Director, Workplace Violence Prevention Program explained to the OIG that if a clinical staff member is not able to complete PMDB part 3, the supervisor needs to be notified to ensure those employees working on a high-risk unit are provided with appropriate PMDB exemptions and safety plans. The OIG would expect processes to be in place to notify nursing leaders and other applicable leaders when a staff member did not complete the required hands-on training for PMDB part 3 and therefore could not perform therapeutic containment techniques when needed. Further, the OIG would expect nursing leaders to ensure staff assigned and providing coverage to the unit are able to implement therapeutic containment techniques by completing PMDB part 3 training prior to working on the unit.

The OIG determined that for fiscal years 2023 and 2024, one incident of disruptive behavior occurred that resulted in staff injury and the required four personnel trained in PMDB part 3 were not immediately available on the unit. The OIG found that nursing leaders did not ensure staff working on the unit received PMDB part 3 and nursing leaders were unaware when a staff member did not complete the hands-on training for PMDB part 3. In a high-risk unit, without assurance that staff receive PMDB part 3 training and leaders are aware of staff's training status, both staff and patients are placed at risk for harm.

### *Guidance on the Risk Assessment*

The OIG learned that in November 2024, the associate chief nurse, mental health implemented the use of a risk assessment on the unit to assess patients' risk of violence that occurs each shift, to increase awareness of potential unit safety concerns, and determine appropriate staffing levels. However, the OIG determined that the associate chief nurse, mental health did not develop and implement a process for how the risk assessment would be used. Further, the OIG found that VHA also did not provide written guidance related to the process for facility leaders to use a risk assessment to evaluate a unit's acuity level.

The associate chief nurse, mental health reported that unit nursing staff complete the risk assessment at the beginning of each shift and document the scores on daily patient census forms. The ADPCS stated that unit staff use the risk assessment to evaluate the risk of patient violence

and aggression and overall safety on the unit. The ADPCS also explained the risk assessment can be used to determine staffing needs by nursing leaders and provided the example if a staff member takes unexpected leave from work, the unit may operate with three staff based on the assessment of patients' risk of violence on the unit.

The associate chief nurse, mental health described receiving guidance from the National Director, Workplace Violence Prevention Program that when determining if four staff members are needed on the unit, nurse leaders "need to look at your resources" and the risk for violence on the unit, and that is why the risk assessment was implemented.

The associate chief nurse, mental health, informed the OIG that a unit staff member expressed concerns about the implementation of the risk assessment given there were no accompanying written procedures. The associate chief nurse, mental health reported that there was no written guidance for the risk assessment because it was newly implemented.

During an interview with the OIG, the National Director, Workplace Violence Prevention Program explained that, while there was no VHA written guidance, if issues arise in meeting the four personnel requirement on a high-risk unit, nursing leaders have the option to assess the unit's acuity and, if the risk for patient violence is determined to be low, can decrease staffing. The National Director, Workplace Violence Prevention Program also described that once a unit's risk level increases to high, nursing leaders need to ensure four personnel are immediately available on the unit. The National Director, Workplace Violence Prevention Program explained that the decision to decrease staffing, based on acuity levels, is the responsibility of nursing leaders and the information should be communicated to staff on the unit regarding decreased staffing based on an acuity level.

The OIG acknowledges the use of the risk assessment on the unit could be beneficial to understand the clinical environment and ensure adequate staffing. However, the OIG suggests that VHA and facility written guidance outlining the process would assist facility leaders and staff in having a consistent understanding regarding the implementation of a risk assessment. The absence of written guidance on use of a risk assessment from both VHA and facility leaders may have contributed to a lack of clarity regarding the purpose and application of the risk assessment at the facility. Nursing leaders' lack of clear processes regarding the risk assessment may contribute to a misapplication of the risk assessment, leading to times that adequate staffing was not immediately available on the unit, and consequently placing patients' and employees' safety at risk.

### *Root Cause Analysis Monitoring and Reporting*

The OIG found that the patient safety manager did not consistently report the open RCA action items through implementation to the patient safety council, as required.

The RCA process is a formal, comprehensive, and multidisciplinary team approach to studying system issues that contribute to healthcare-related adverse events or close calls, to include the

identification of corrective actions to prevent future incidents.[59] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis* requires an organization to develop an action plan to "prevent recurrence or reduce the severity of harm if the event should recur."[60] RCA action statements must include outcome measures to "determine" the process, effectiveness, time frames, and compliance with the recommended actions.[61] The action implementation should be "quantifiable ***(if appropriate)***" and "realistic thresholds" and dates for action implementation "should not extend beyond 6 months."[62] The RCA team presents the final RCA findings, action statements, and outcome measures to the facility director and leadership team, facilitating action plan concurrence.[63]

Following RCA completion, actions and outcomes identified during an RCA must be monitored for completion and sustainment, ideally through a reporting system, such as a patient safety committee meeting.[64] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis* states that a system should be in place to monitor and track RCA actions and outcomes versus assignment of one individual to complete this function. Further, VHA advises, that the "status of RCA actions and outcomes are standing agenda items at patient safety committee or workgroup meetings" so that the committee is notified of the progress with the actions and outcomes and committee members could assist in "moving items forward."[65]

The Facility Director chartered an RCA following an incident on the unit and in early summer concurred with the RCA team's six identified action items and associated outcome measures.

The patient safety manager reported providing a patient safety presentation, that included root cause action items, during the monthly patient safety council meeting.[66] Further, the patient safety manager reported that once an action item is implemented, the action item is removed from the patient safety presentation although the action item continues to be followed by the assigned person, such as a service line leader, until the outcome measure is met. The patient

[59] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024; *VHA National Center for Patient Safety,* "Root Cause Analysis," accessed December 23, 2024, https://www.patientsafety.va.gov/professionals/onthejob/rca.asp#:~:text=The%20goal%20of%20the%20RCA,not%20on%20the%20%22who%22.

[60] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, version 14,* March 2024. This guide was in place during the time of the events discussed. It was updated in December 2024. VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, *version 19.1*, December 2024. Unless otherwise specified, the December 2024 guide contains the same or similar language regarding RCA as the March 2024 guide.

[61] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[62] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[63] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[64] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[65] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[66] The Facility Director is a member of the patient safety council.

safety manager explained that communication to facility leaders regarding outcome measures only occurs if an issue arises, such as not receiving a status update from the assigned person.

During the mid-September 2024 patient safety council meeting, the patient safety manager reported that four of the six action items remained open; however, the OIG found that the two action items that were not included in the patient safety manager's report were not implemented until the end of September.[67] Further the OIG found that, despite one of the six action items being open until mid-January 2025, the patient safety manager did not report on that action item in patient safety council meetings from October 2024–February 2025. In mid-spring 2025, the patient safety manager explained to the OIG that the action items should have been included in the applicable patient safety council presentations until implemented and confirmed that the action items were not included as expected. The patient safety manager could not provide an explanation regarding the reason the action items were not included in the monthly patient safety council presentations.

Given the Facility Director's concurrence with the RCA review and the patient safety manager's routine reporting at the patient safety council, the OIG would expect the patient safety manager to provide updates regarding open action items until implementation and outcome measures until completion so that council members, including the Facility Director, are made aware of the status. The lack of communication and reporting of action items and outcome measures may result in facility leaders not being aware of barriers to address system vulnerabilities and improve quality of care.

## 3. Bed Reporting

The OIG found that facility leaders did not submit a bed change request to the VISN after temporarily closing beds for greater than 60 days, as required.[68] Further, the OIG determined that facility leaders were delayed and remiss in submitting issue briefs reflecting temporary changes in the number of unit beds, as expected.

VHA utilizes a national bed control database to track and ensure accurate reporting of facility authorized and operating inpatient beds and modifications to bed numbers.[69] VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures* requires that facility directors submit a request in the national bed control database for any changes to bed numbers related to construction, workload, recruitment, or resources that extend beyond 60 days.[70] The VISN

[67] The patient safety manager reported the prior month's data at the patient safety council meeting.

[68] VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010; VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, November 28, 2017.

[69] VHA Handbook 1000.01. Authorized beds "are the potential bed capacity of a medical center, which is the sum of operating beds and beds that are temporarily unavailable."

[70] VHA Handbook 1000.01.

approving staff are electronically notified of the bed change request submission and the VISN Director must review and approve bed change request submissions in the national bed control system.[71]

Per VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities,* VA inpatient services, including facility inpatient mental health units, must also use the bed management system, a web-based tool providing timely bed movement data, to track bed utilization and indicate an accurate number and status of inpatient beds.[72] VA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs," outlines that temporary changes to the bed availability related to certain events, such as staffing, are required to be reported through an issue brief.[73] Issue briefs should be submitted for "staff vacancies" that affect regular operational bed numbers "no later than 2 business days after becoming aware of an incident," depending on the seriousness of the incident.[74]

In spring 2025, the National Director, Inpatient Mental Health Services informed the OIG that the facility was listed as having both 18 authorized and operational beds and that any changes to these numbers would occur through a bed change request for those greater than 60 days, or an issue brief for those fewer than 60 days. The OIG learned that facility leaders did not report changes in unit operating beds, as required, during fiscal year 2025 (see table 1.)

**Table 1. VHA Bed Reporting Requirements and Facility Actions**

| Bed Reporting Requirements | Unit Bed Operations | OIG Findings |
|---|---|---|
| Facility leaders submit a bed change request to VISN leaders for bed availability changes lasting longer than 60 days.[75] | January 23, 2025, through March 25, 2025, (62 days), the unit had 8 of 18 beds operational. | Facility leaders did not submit the required bed change request. |
| | January 23, 2025, through March 25, 2025, the unit had 8 of 18 beds operational. | Facility leaders submitted an issue brief 38 days after the required submission date following a bed reduction. |

[71] VHA Handbook 1000.01.

[72] VHA Directive 1002.

[73] VA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs," June 22, 2024. "Issue briefs (IBs) are internally generated reports created within VHA that are used to document situations, events, and/or issues that impact VHA's ability to provide high quality care and services to Veterans."

[74] VA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs."; Department of Veterans Affairs, "Issue Brief (IB) Tracker Guidance – Curtailment Reporting Requirements: Incidents that require Submission of an Issue Brief," August 15, 2022.

[75] VHA Handbook 1000.01; VHA Directive 1002.

| Bed Reporting Requirements | Unit Bed Operations | OIG Findings |
|---|---|---|
| Facility leaders submit an issue brief to VISN leaders, within two business days.[76] | January 6, 2025, through January 22, 2025, the unit had 12 of 18 beds operational. | Facility leaders did not submit an issue brief. |

*Source: OIG analysis of VHA policy and information provided by VA central office and facility leaders.*

In a mid-spring 2025 interview with the OIG, the associate chief nurse, mental health acknowledged a unit reduction in beds to eight, due to lack of staffing. The associate chief nurse, mental health, indicated awareness of the need to inform VISN regarding bed changes, but was unaware of to whom and reported relying on the chief, mental health.

The chief, mental health told the OIG that a discussion occurs with the Facility Director, Chief of Staff, and ADPCS to determine appropriateness of adjusting the number of available and unavailable beds on the unit but could not recall any conversations or adjustments to operating beds in early 2025. The chief, mental health reported it is possible meetings may occur among the Chief of Staff and ADPCS to discuss an adjustment of bed numbers but would expect to receive a notification from the nurse manager once the bed change is effective.

During an interview with the OIG, the VISN Chief Mental Health Officer reported monitoring the bed availability collected from the bed management system on a national dashboard report. However, the VISN Chief Mental Health Officer reported that the facility generally had 12 operating beds, but at the time of the interview, the internal VA site listed 6 operating beds and 6 unavailable beds and could not explain why 18 unit beds were listed in a separate column on the internal site. The VISN Chief Mental Health Officer indicated not contacting the chief, mental health for clarification on the bed data discrepancy and reported lack of awareness when facility leaders must submit a bed change request to the VISN to permanently change the number of authorized beds on an inpatient mental health unit. The VISN Chief Mental Health Officer further reported an expectation that facility leaders submit an issue brief to alert VISN leaders of any temporary increase or reduction to available and unavailable inpatient mental health beds.

The OIG concluded that facility leaders' lack of a bed change request to temporarily or permanently modify the number of authorized unit beds after designating as unavailable for more than 60 days, as required, contributed to a misrepresentation of bed utilization data.[77] Further, the OIG determined that facility leaders did not submit issue briefs, as expected, when changes in bed numbers were identified. The VISN Chief Mental Health Officer's lack of awareness of the facility's bed management and VHA's bed change request procedures prevented adequate oversight of facility leaders' reporting operational bed adjustments and making any necessary

[76] VA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs."; Department of Veterans Affairs, "Issue Brief (IB) Tracker Guidance – Curtailment Reporting Requirements: Incidents that require Submission of an Issue Brief."

[77] VHA Handbook 1000.01.

changes to the national bed database. Additionally, the OIG would have expected the chief, mental health to have awareness of unit operational bed adjustments and the lack of awareness likely limited the ability to direct appropriate unit staffing resources to additional mental health programs.

# Conclusion

The OIG substantiated that facility leaders did not ensure adequate night lighting in the unit's patient rooms. The OIG found that facility leaders did not implement a standard operating procedure for patient safety observation rounds, as required. Facility leaders also did not provide written guidance to ensure the security of handheld flashlights utilized by nursing staff while conducting patient safety observation rounds. To remediate the night lighting concerns that may have affected patients' ability to sleep, facility leaders trialed different night lighting options to accommodate patient comfort and ensure visibility for staff; however, did not provide written guidance related to the use and security of staff flashlights. The lack of written guidance could result in a patient obtaining a flashlight without staff's awareness or staff being without necessary lighting and thereby posing a safety risk to patients and staff. Furthermore, facility leaders did not implement a standard operating procedure for patient safety rounds. The lack of policy for patient safety observation rounds can lead to inadequate and inconsistent patient observation practices and thereby increase the safety risk for patients.

The OIG did not substantiate that the women's restrooms did not lock. However, the OIG found that at the time of the review, facility leaders did not provide adequate access to restrooms for female patients. While the OIG initially found that female patients did not have adequate access to unit restrooms, facility leaders confirmed that changes implemented by mid-spring 2025 addressed the concern and, therefore, the OIG made no recommendation.

The OIG did not substantiate that facility leaders did not provide a clean environment on the unit or provide adequate outdoor space for unit patients. Facility leaders ensured a clean environment on the unit and unit patients had adequate space with appropriate fencing and patients had opportunities to engage in fresh air access and recreational opportunities.

The OIG found that the interdisciplinary safety inspection team identified hazards on the unit using the MHEOCC but did not complete the required mitigation plans for those hazards. The OIG concluded that the lack of mitigation plans to address deficiencies hinders appropriate identification of strategies to enhance patient safety on the unit.

The OIG substantiated that the ADPCS did not act in accordance with required staffing levels for the unit, likely due to a misinterpretation of the term 'workplace' as identified in the VHA requirement, and the facility's reported lack of clarity from the National Associate Director, PMDB on flexibilities to this requirement. The lack of descriptions or definition of 'workplace' in the VHA requirement may have contributed to facility leaders' misinterpretation of the term

'workplace.' The misinterpretation likely resulted in times when adequate staffing was not immediately available on the unit and placed facility staff and patients at risk if a disruptive behavior event occurred.

The OIG substantiated that one incident occurred in the unit that resulted in multiple staff members being injured; at the time of the incident four trained staff were not immediately available. The OIG reviewed data from fiscal years 2023 and 2024 and did not substantiate that other incidents occurred resulting in injury to patients and staff due to staffing. Further, the OIG found that not all clinical staff working on the unit were trained in PMDB part 3 and that not all staff who received PMDB part 3 training completed the required hands-on component of the training. Nursing leaders did not ensure staff working on the unit received PMDB part 3 training and that nursing leaders were unaware when a staff member did not complete the hands-on training for PMDB part 3. In a high-risk unit, without insurance that staff receive PMDB part 3 training and leaders are aware of staffs' training status places staff and patients at risk for harm.

The OIG determined that the associate chief nurse, mental health did not develop and implement a process for how the risk assessment would be utilized. The absence of written guidance on risk assessment from both VHA and facility leaders may have contributed to a lack of clarity regarding the purpose and application of the risk assessment. Nursing leaders' lack of clear processes regarding the risk assessment may contribute to a misapplication of the risk assessment, leading to times when adequate staffing was not immediately available on the unit, and consequently placing patients' and employees' safety at risk.

The OIG found that the patient safety manager did not consistently report open RCA action items through implementation to the patient safety council, as required. The lack of communication and reporting of action items and outcome measures may result in facility leaders not being aware of barriers to address system vulnerabilities and improve quality of care.

The OIG found that facility leaders did not submit a bed change request to the VISN after temporarily closing beds for greater than 60 days, as required. The OIG determined that facility leaders were delayed and remiss in submitting issue briefs reflecting temporary changes in the number of unit beds, as expected. The OIG concluded that facility leaders lack of a bed change request to temporarily or permanently modify the number of authorized beds after designating unavailable beds greater than 60 days contributed to a misrepresentation of the number of authorized unit beds.

The OIG determined facility leaders did not submit issue briefs, as expected, when changes in bed numbers were identified. The VISN Chief Mental Health Officer's lack of awareness of the facility's bed management and VHA bed change request procedures prevented adequate oversight of facility leaders' reporting of operational bed adjustments and any necessary changes to the national bed database. Additionally, the OIG would have expected the chief, mental health to have awareness of unit operational bed adjustments and the lack of awareness likely limited the ability to direct appropriate unit staffing resources to additional mental health programs.

The OIG issued 2 recommendations to the Under Secretary for Health, 1 recommendation to the VISN Director, and 10 recommendations to the Facility Director (see appendixes A, B, and C.) The Acting Under Secretary for Health reported plans to review high-risk workplace staffing guidance and the VISN Director identified a plan to ensure active beds are accurately reported and monitored. The Facility Director provided plans to ensure unit staffing is adequate, that a patient safety observation policy is implemented, and that PMDB training is completed. The Facility Director also committed to improve patient room lighting and confirm that mitigation planning occurs. Additionally, the Facility Director outlined steps to review RCA processes and ensure accurate reporting of RCA outcome measures. The Facility Director told the OIG that an institutional disclosure was completed. The OIG will follow up on the planned actions until they are completed.

The OIG is aware of VA's transformation in VHA's management structure. As we monitor the implementation, our oversight remains focused on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

# Recommendations 1–13

1. The VA Nebraska—Western Iowa Health Care System Director ensures the installation of night lighting changes to accommodate patient comfort and facility staff's ability to safely conduct rounding in applicable inpatient mental health unit patient rooms.

2. The VA Nebraska—Western Iowa Health Care System Director ensures establishment and implementation of guidance related to the facility inpatient mental health unit staff's use and security of handheld flashlights to ensure appropriate education and training of handheld flashlights usage and storage.

3. The VA Nebraska—Western Iowa Health Care System Director establishes and ensures implementation of a patient safety observation rounds standard operating procedure consistent with Veterans Health Administration requirements.

4. The VA Nebraska—Western Iowa Health Care System Director reviews facility Mental Health Environment of Care Checklist processes related to development of mitigation plans as required by the Veterans Health Administration, and monitors compliance.

5. The VA Nebraska—Western Iowa Health Care System Director ensures compliance with Veterans Health Administration staffing requirements for areas identified as high-risk, such as the inpatient mental health unit, and monitors compliance.

6. The Under Secretary for Health evaluates the Veterans Health Administration written guidance for high-risk workplace staffing and determines if clarification is needed.[78]

7. The VA Nebraska—Western Iowa Health Care System Director ensures staff that may provide coverage on the inpatient mental health unit receive applicable Prevention and Management of Disruptive Behavior training for high-risk units.

8. The VA Nebraska—Western Iowa Health Care System Director strengthens processes to ensure that supervisors are made aware of staff members that have not completed the applicable Prevention and Management of Disruptive Behavior training for high-risk units, to include the hands-on component, and monitors compliance.

9. The Under Secretary for Health considers written guidance regarding risk for violence assessment use in units identified as a high-risk workplace that can be used to temporarily change a unit's acuity level and staffing needs.

10. The VA Nebraska—Western Iowa Health Care System Director reviews and ensures consistent application of facility nursing leaders' use of risk for violence assessment on the inpatient mental health unit, and monitors for compliance.

11. The VA Nebraska—Western Iowa Health Care System Director evaluates the root cause analysis processes regarding reporting of action items and outcome measures in accordance with Veterans Health Administration requirements, takes action as needed, and monitors compliance.

12. The VA Nebraska—Western Iowa Health Care System Director evaluates processes requesting and reporting changes to authorized and operating beds on the inpatient mental health unit, takes action as needed, and monitors compliance.

13. The VA Midwest Health Care Network Director strengthens processes to ensure adequate oversight and adherence to Veterans Health Administration requirements pertaining to changes to authorized and operating inpatient mental health unit beds.[79]

[78] The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.
[79] The recommendations addressed to the VISN Director are directed to anyone in an acting status or performing the delegable duties of the position.

# Appendix A: Office of the Under Secretary for Health Memorandum

## Department of Veterans Affairs Memorandum

Date: November 6, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha (VIEWS 13879213)

To: Director, Office of Healthcare Inspections (54HL06)

1. Thank you for the opportunity to review and comment on OIG's report, Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha.
2. The Veterans Health Administration (VHA) greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

*(Original signed by:)*

Steven L. Lieberman, M.D. MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on November 7, 2025.]

# Office of the Under Secretary for Health Response

## Recommendation 6

The Under Secretary for Health evaluates the Veterans Health Administration written guidance for high-risk workplace staffing and determines if clarification is needed.

_X _Concur

____Nonconcur

Target date for completion: December 2025

### Under Secretary for Health Comments

VHA's Workplace Violence Prevention Program (WVPP) will evaluate if additional guidance via an Assistant Under Secretary for Health (AUSH) Memorandum is necessary to clarify high-risk workplace staffing for all VA facilities. Guidance will include definitions of workplace, high-risk workplace, and clarify the distinction of discrete units as individual workplaces.

## Recommendation 9

The Under Secretary for Health considers written guidance regarding risk for violence assessment use in units identified as a high-risk workplace that can be used to temporarily change a unit's acuity level and staffing needs.

_X _Concur

____Nonconcur

Target date for completion: December 2025

### Under Secretary for Health Comments

VHA will evaluate if additional written guidance is necessary for use of violence risk assessments to temporarily change the unit's acuity level for staffing needs. If necessary, VHA's WVPP will develop guidance to clarify the process and expectations for temporary changes to unit acuity level and staffing needs for all VHA facilities.

# Appendix B: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: October 23, 2025

From: Interim Executive Director, Veterans Affairs (VA) Midwest Health Care Network (10N23)

Subj: VA OIG Report, Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha (VIEWS 13879213)

To: Director, Office of Healthcare Inspections (54HL06)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the report findings and recommendations of OIG report, Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha.
2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Judith L. Johnson-Mekota, FACHE

[OIG comment: The OIG received the above memorandum from VHA on November 7, 2025.]

# VISN Director Response

## Recommendation 13

The VA Midwest Health Care Network Director strengthens processes to ensure adequate oversight and adherence to Veterans Health Administration requirements pertaining to changes to authorized and operating inpatient mental health unit beds.

_X _Concur

____Nonconcur

Target date for completion: June 2026

### Director Comments

In June of 2025, the VA Midwest Health Care Network Director, Chief Nursing Officer, BMS Coordinator and Planner asked each Health Care System, including NWIHCS [Nebraska-Western Iowa Health Care System], to submit an attestation of Bed Data accuracy. The attestation included the statement "The facility has done a physical walk-around inspection of all beds to ensure accurate bed reconciliation including BMS, VistA and Bed Control System". Received attestation signed by NWIHCS Medical Center Director on June 9, 2025. The Bed Letter was submitted on July 23, 2025, and approved by the VHA Chief Operating Officer on August 11, 2025, to temporarily reduce inpatient Mental Health beds from 18 beds to 12 beds.

The Veterans Integrated Service Network (VISN) 23 Planner will develop and deliver compliance focused training to staff related to bed change letters and issue brief requirements. Training will be completed for 100% of identified staff by June 30, 2026.

The VISN 23 Planner will conduct a quarterly review to ensure health care systems submit all bed changes resulting in temporary or permanent closure of beds for longer than 60 days, into the web-based VA National Bed Control System prior to implementation. By June 2026, a bed letter will be submitted 100% of the time when beds are out of service over 60 days, and an Issue Brief will be submitted within 48 hours 100% of the time.

# Appendix C: Facility Director Memorandum

## Department of Veterans Affairs Memorandum

Date: October 15, 2025

From: Director, Omaha VA Medical Center—VA Nebraska-Western Iowa Health Care System (636)

Subj: VA OIG Report, Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha (VIEWS 13879213)

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

1. We appreciate the opportunity to review and comment on the OIG report, Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha. VA Nebraska-Western Iowa Health Care System concurs with the recommendations and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Elieen Kingston

[OIG comment: The OIG received the above memorandum from VHA on November 7, 2025.]

# Facility Director Response

## Recommendation 1

The VA Nebraska—Western Iowa Health Care System Director ensures the installation of night lighting changes to accommodate patient comfort and facility staff's ability to safely conduct rounding in applicable inpatient mental health unit patient rooms.

_X _Concur

____Nonconcur

Target date for completion: August 2025

### Director Comments

Red overhead night lighting was installed to limit the effect on patient sleep and ensure adequate lighting to conduct patient safety observation rounds. We respectfully request closure of this recommendation.

### OIG Comments

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

## Recommendation 2

The VA Nebraska—Western Iowa Health Care System Director ensures establishment and implementation of guidance related to the facility inpatient mental health unit staff's use and security of handheld flashlights to ensure appropriate education and training of handheld flashlights usage and storage.

_X _Concur

____Nonconcur

Target date for completion: August 2025

### Director Comments

Due to installation of the night lights in August 2025, the use of flashlights was deemed unnecessary. All flashlights have been removed from the unit mitigating the security risk. We respectfully request closure of this recommendation.

### OIG Comments

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

## Recommendation 3

The VA Nebraska—Western Iowa Health Care System Director establishes and ensures implementation of a patient safety observation rounds standard operating procedure consistent with Veterans Health Administration requirements.

_X _Concur

____Nonconcur

Target date for completion: January 2025

### Director Comments

Inpatient Mental Health Unit Safety Rounds have always been part of the standard practice to include every 15-minute rounds on each Veteran and every eight-hour rounds assessing the safety of the unit.

The Nebraska-Western Iowa Health Care System (NWIHCS) developed and published Standard Operating Procedure (SOP) Mental Health Environment of Care 10W 100, Environment of Care Rounds Conducted on Acute Inpatient Mental Health Unit (10W), effective January 2025, in accordance with the SOP for Maintaining Safety and Security on Inpatient Mental Health Units to Veterans Health Administration (VHA) Directive 1160.06(1) Inpatient Mental Health Services. The new SOP outlines the procedures for daily environment of care rounds. These rounds are conducted by nursing staff every shift to identify environmental risks or hazards and to develop mitigation plans accordingly. We respectfully request closure of this recommendation.

### OIG Comments

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

## Recommendation 4

The VA Nebraska—Western Iowa Health Care System Director reviews facility Mental Health Environment of Care Checklist processes related to development of mitigation plans as required by the Veterans Health Administration, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: August 2026

### Director Comments

The Director reviewed the current process and as a result the NWIHCS will continue to conduct bi-annual Mental Health Environment of Care Checklist inspections followed by debriefs to develop collaborative action plans for identified hazards. Low-risk deficiencies will also be required to have mitigation plans.

Monitoring and compliance tracking of identified hazards will be conducted monthly at NWIHCS Environment of Care Committee meetings, with a goal of 100% of all findings having mitigation plans in place and tracked to completion for six consecutive months.

## Recommendation 5

The VA Nebraska—Western Iowa Health Care System Director ensures compliance with Veterans Health Administration staffing requirements for areas identified as high-risk, such as the inpatient mental health unit, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: April 2026

### Director Comments

The NWIHCS Associate Director Patient Care Services (ADPCS) conducted a review of the Inpatient Mental Health Staffing methodology. The initial review indicated that the Inpatient Mental Health Unit was appropriately staffed according to the VHA Staffing Methodology. An additional review is being conducted to determine the appropriate number of required hours per patient day; there will be a comparison to internal VA and external VA benchmarks for Inpatient Mental Health Units. Adjustments will be made accordingly following Leadership review.

The Mental Health Associate Chief Nurse and ADPCS implemented the Dynamic Appraisal of Situational Aggression (DASA) tool, which is used to assess the risk of aggression on the unit. This risk assessment is completed every shift and discussed during shift-to-shift hand-off. Unit level interventions will be implemented according to the shift aggression risk. When the aggression risk is ranked as high the following interventions will be put in place: alert all unit staff, alert nursing leadership, alert VA Police and ensure the unit is staffed according to VHA Directive 1106.08(1) VHA Workplace Violence Prevention Program.

Compliance will be monitored monthly through the Nurse Executive Council to the Executive Leadership Board. The monitoring will include the number of shifts that scored at “high risk” according to the DASA tool and number of PMDB Level 3 staff assigned to the unit with a goal

of 100% appropriately staffed according to VHA Directive 1106.08(1) VHA Workplace Violence Prevention Program.

## Recommendation 7

The VA Nebraska—Western Iowa Health Care System Director ensures staff that may provide coverage on the inpatient mental health unit receive applicable Prevention and Management of Disruptive Behavior training for high-risk units.

_X _Concur

____Nonconcur

Target date for completion: April 2026

### Director Comments

The Prevention and Management of disruptive Behavior (PMDB) Coordinator will develop and distribute a monthly report to ensure that supervisors are made aware of staff members that provide coverage to 10W are PMDB training compliant.

The Workplace Violence Committee will provide a monthly compliance report to the Executive Leadership Board and will be reflected in the minutes. Compliance with PMDB training requirements for all coverage staff will be tracked monthly through the VA Talent Management System reports by the Associate Chief Nurse of Mental Health, with the goal of achieving and sustaining 100% compliance for six consecutive months.

## Recommendation 8

The VA Nebraska—Western Iowa Health Care System Director strengthens processes to ensure that supervisors are made aware of staff members that have not completed the applicable Prevention and Management of Disruptive Behavior training for high-risk units, to include the hands-on component, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: April 2026

### Director Comments

The Prevention and Management of Disruptive Behavior training Coordinator will develop and distribute a monthly report to ensure that supervisors are made aware of staff members that have not completed the PMDB training to include the hands-on component and monitory compliance.

The PMDB Coordinator will report compliance to the Workplace Violence Committee. The Workplace Violence Committee will provide a monthly compliance report of all PMDB components to include hands-on; this will be monitored with a goal of 100% compliance for six consecutive months.

## Recommendation 10

The VA Nebraska—Western Iowa Health Care System Director reviews and ensures consistent application of facility nursing leaders' use of risk for violence assessment on the inpatient mental health unit, and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: April 2026

### Director Comments

The Associate Chief Nurse for Mental Health implemented the Dynamic Appraisal of Situational Aggression (DASA) tool to identify safety risks on the unit. To ensure consistent application, a SOP will define clear expectations and development of an electronic documentation note.

Monthly audits will be completed for compliance with the DASA tool completion and documentation; the goal is to reach 100% compliance for six consecutive months with oversight of the Quality Patient Safety Council.

## Recommendation 11

The VA Nebraska—Western Iowa Health Care System Director evaluates the root cause analysis processes regarding reporting of action items and outcome measures in accordance with Veterans Health Administration requirements, takes action as needed, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: August 2025

### Director Comments

The Director has reviewed the Root Cause Analysis (RCA) process and tracking of open action items and outcome measures with Patient Safety. As a result, the Patient Safety Manager added RCA outcome measures to data presented monthly to the Patient Safety Committee, co-chaired by the Facility Director, beginning May 2025. Open RCA action items and implementation updates are tracked and reported through completion. Compliance of reporting action items and

outcome measures from May 2025 to October 2025 was 100%. We respectfully request closure of this recommendation.

### OIG Comments

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

## Recommendation 12

The VA Nebraska—Western Iowa Health Care System Director evaluates processes requesting and reporting changes to authorized and operating beds on the inpatient mental health unit, takes action as needed, and monitors compliance.

_X _Concur

____Nonconcur

Target date for completion: April 2026

### Director Comments

The process was reviewed with the Facility Director and as a result the Clinical Review Department Manager is now responsible for requesting and reporting timely authorized and operational bed changes through the National Bed Control System as required. Processes are in place to ensure that bed numbers are accurately reflected in the National Bed Control System, and that leadership is alerted when beds are anticipated to remain closed for more than 60 days so that appropriate action can be taken, including submission of new bed letters if required. Leadership is notified once bed letters are approved or if additional follow-up is necessary.

The Inpatient Mental Health letter was submitted on July 23, 2025, and approved on August 11, 2025, to temporarily reduce six beds, adjusting the operating bed number from 18 to 12.

To ensure ongoing compliance, the Clinical Review Department Manager will monitor the accuracy of bed status and report the bed numbers that are reflected in BMS. This will be reported monthly to the Utilization Management Committee with a target of 90% compliance for six consecutive months.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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