US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the Lexington VA Healthcare System in Kentucky

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

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Executive Summary

The mission of the VA Office of Inspector General (OIG) Mental Health Inspection Program is to evaluate VA's continuum of mental healthcare services. On April 14, 2025, the OIG announced an inspection to address the mental health care delivered in the acute mental health inpatient unit (inpatient unit) at the Lexington VA Healthcare System (facility) in Kentucky. The OIG conducted inspection activities from April 14 through May 21, 2025, and completed the on-site portion from April 29 through May 1, 2025. At the conclusion of the on-site visit, the OIG team provided the Facility Director with preliminary findings and observations from the inspection.

The OIG evaluated acute inpatient mental health care across five domains. The OIG assessed processes in each of the domains and identified successes and challenges that affected the provision of the quality of care provided on the inpatient unit. Eleven recommendations were issued to Veterans Integrated Service Network (VISN) and facility leaders.

The OIG is aware of VA's transformation in the Veterans Health Administration's (VHA's) management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

For background information on each domain, see appendix A.[1] For information on the OIG's data collection methods, see appendix B.

Domain	OIG Summary
Leadership and Organizational Culture	The OIG looked at reporting channels, committee structures, oversight and monitoring provided by leaders, and staffing practices. The Chief of Mental Health chaired the Mental Health Executive Council, which included inpatient staff but lacked the veteran representation required by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.[2] The program manager also served as the local recovery coordinator. Facility leaders were aware the position was not full-time as required by VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services*, but believed the existing arrangement met recovery-oriented care objectives and considered requesting an exemption.[3]

[1] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[2] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

[3] VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services*, March 7, 2025. This directive was rescinded and replaced with VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, on August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services.

Domain	OIG Summary
	Despite multiple leadership roles designated to oversee mental health and nursing, the OIG found insufficient supervisory oversight. OIG recommendation: • The Facility Director ensures the Mental Health Executive Council operates in accordance with Veterans Health Administration requirements.
Recovery-Oriented Principles 	To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, treatment planning, interdisciplinary programming, and the care environment. As noted above, the facility did not meet the VHA requirement for a full-time local recovery coordinator. Although leaders had a recovery transformation plan, the standard operating procedure for education and implementation of recovery-oriented care required by VHA Directive 1160.06, *Inpatient Mental Health Services*, was only finalized after the inspection began.[4] Recovery-oriented, interdisciplinary programming did not occur as scheduled, and veterans had limited opportunity for other structured activities when group facilitators were unavailable. A newly constructed unit had natural light, warm colors, and updated furnishings. However, the OIG observed limited staff-veteran interaction and noted the absence of a dedicated, secure outdoor space for inpatient use as specified in VA's inpatient unit design guide.[5] OIG recommendations: • The Chief of Mental Health ensures compliance with Veterans Health Administration requirements for a full-time local recovery coordinator. • The Chief of Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends on the inpatient mental health unit. • The Facility Director considers consulting with the Office of Mental Health to clarify guidelines for design elements such as artwork on the inpatient unit. • The Facility Director considers alternatives to outdoor access for the inpatient unit, such as those identified in VA's *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.*

[4] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1), December 27, 2024. Unless otherwise specified, the amended directive contains similar language related to inpatient mental health unit requirements.

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

Domain	OIG Summary
Clinical Care Coordination 	To assess the quality of clinical care coordination, the OIG reviewed access to services, local procedures for involuntary treatment, interdisciplinary treatment planning, medication management, and discharge planning. Facility leaders did not follow VHA Directive 1160.06's requirement for formal processes to monitor compliance with state laws on involuntary commitment. While treatment planning procedures met VHA Directive 1160.01 requirements, staff did not consistently document discussions of medication risks and benefits as required by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[6] The facility had written guidance for post-discharge care, but some discharge instructions included unclear abbreviations and many omitted the reasons for prescribed medications, potentially limiting veterans' and caregivers' understanding of follow-up care. OIG recommendations: • The Facility Director develops and implements written processes to monitor and track compliance with state laws for involuntary hospitalization and consults with the Office of General Counsel to ensure processes are consistent with applicable laws. • The Chief of Staff ensures documentation of informed consent discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications. • The Chief of Staff ensures veterans' discharge instructions are written in easy-to-understand language and include the follow-up mental health appointment location, the purpose of each medication, and how the medication is supposed to be taken.
Suicide Prevention 	To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. The OIG found that staff completed suicide risk screenings and training as indicated in VA's suicide risk identification strategy.[7] However, reviewed safety plans often did not include strategies for reducing access to lethal means in the veteran's environment beyond access to firearms and opioids. In a recent publication, the OIG made two recommendations to the VA Under Secretary for Health regarding safety plan completion. Therefore, this report does not contain any recommendations on this topic.

[6] VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended May 1, 2024.

[7] VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting*, updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements.

Domain	OIG Summary
Safety 	The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. While leaders and staff completed Mental Health Environment of Care Checklist inspections as required by VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, the Interdisciplinary Safety Inspection Team did not consistently document meeting attendance or membership.[8] Additionally, Interdisciplinary Safety Inspection Team staff did not follow guidance for timely risk assessment documentation of identified hazards. The facility also received VISN and National Center for Patient Safety guidance on hazard correction that conflicted with VHA Mental Health Environment of Care Checklist policy. Inpatient unit staff and Interdisciplinary Safety Inspection Team staff generally followed VHA requirements for Mental Health Environment of Care Checklist annual training. OIG recommendations: • The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration requirements, including recording membership and attendance for Mental Health Environment of Care Checklist inspections. • The Veterans Integrated Service Network Director implements processes to ensure the Veterans Integrated Service Network Mental Health Environment of Care Checklist Oversight Team provides facility guidance consistent with Veterans Health Administration requirements. • The Facility Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards within the Patient Safety Assessment Tool.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes D and E). The OIG will follow up on the planned actions until they are completed. The VISN Director described the prior establishment of a Mental Health Environment of Care Checklist oversight team to ensure compliance with VHA requirements. The Facility Director described plans to ensure veteran representation on the Mental Health Executive Council, appoint a full-time recovery coordinator, expand recovery-oriented programming, and consult with the Office of Mental Health on design elements and artwork.

[8] 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. Unless otherwise specified, the policies contain the same or similar language related to the design of the inpatient unit and staff training requirements.

Additional initiatives focus on improving discharge instructions, documenting informed consent, establishing written processes for involuntary hospitalization, as well as enhancing safety inspections and hazard reporting. The OIG will follow up to ensure these actions are effective and sustained.

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Abbreviations

OIG	Office of Inspector General
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct independent oversight of VA. The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,380 healthcare facilities to more than 9.1 million enrolled veterans.[1] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. On April 14, 2025, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the Lexington VA Healthcare System (facility) in Kentucky. The OIG conducted inspection activities from April 14 through May 21, 2025, and completed the on-site portion from April 29 through May 21, 2025.[2] At the conclusion of the on-site visit, the OIG team provided the Facility Director with preliminary findings from the inspection.

VHA's "mental health services are organized across a continuum of care" and "in a team-based, interprofessional, patient-centered, recovery-oriented structure" (see figure 1).[3] Under VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA healthcare system leaders are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[4]

All VHA healthcare systems must provide assessment, diagnosis, and treatment for the full range of mental health conditions. Required services include psychological and neuropsychological evaluation, evidence-based individual and group psychotherapy, pharmacotherapy, peer support, and vocational rehabilitation counseling.[5]

[1] "Mission, Vision, Values," OIG, accessed June 10, 2024, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed January 8, 2025, www.va.gov/health/aboutvha.asp. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[2] For the purposes of this report, the OIG defines the term "healthcare system" as a parent facility and its associated medical centers, outpatient clinics, and other related VA services or programs.

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

[4] VHA Directive 1160.01; In this report, the OIG refers to veterans instead of patients to support recovery-oriented language.

[5] VHA Directive 1160.01. If a healthcare system does not offer required services, those services must be available through another VA resource.

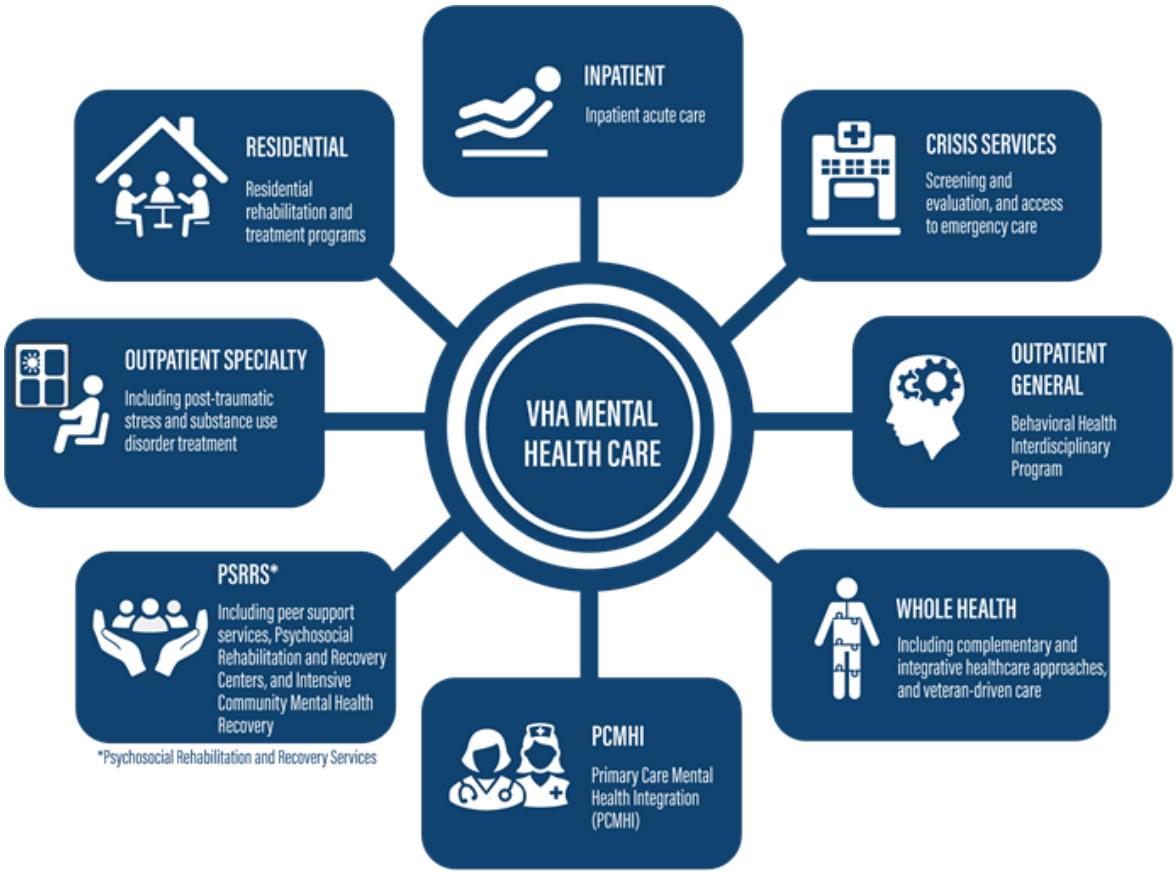

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163(1), Psychosocial Rehabilitation and Recovery Services, March 7, 2025. This directive was rescinded and replaced with VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, on August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services.

According to VHA Directive 1160.06, *Inpatient Mental Health Services*, inpatient mental health services are considered the most intensive level of mental health care used to treat veterans safely and effectively during periods of acute mental distress.[6]

[6] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1), December 27, 2024. Unless otherwise specified, the amended directive contains similar language related to inpatient mental health unit requirements.

In fiscal year 2024, VHA healthcare systems delivered inpatient mental health care for 64,298 veteran stays.[7]

To evaluate the quality of inpatient mental health care at the facility, the OIG assessed specific processes across five domains: leadership and organizational culture, recovery-oriented principles, clinical care coordination, suicide prevention, and safety. For background information and related requirements, refer to appendix A.[8]

About the Lexington VA Healthcare System

The facility, part of Veterans Integrated Service Network (VISN) 9, includes two campuses and four community-based outpatient clinics in Kentucky and offers acute inpatient, residential, and outpatient mental health care.[9] In fiscal year 2024, the facility provided health care to 34,834 veterans, with 10,973 receiving outpatient mental health care. During the same fiscal year, staff cared for 279 veterans on the acute inpatient mental health unit (inpatient unit) and did not submit consults for inpatient mental health care in the community. The inpatient unit maintained an average daily census of four. (Discussed further in the Access to Care section.) The new inpatient unit, opened in March 2025, had 10 operating beds at the time of the inspection.[10]

[7] A fiscal year is a "12-month operating cycle" that runs from October 1 to September 30 of the following year. VA, "VA Finance Terms and Definitions," enclosure 14 in *VA/VHA Employee Health Promotion Disease Prevention Guidebook* (July 2011), accessed May 3, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf. VHA identifies a "patient stay" as a distinct instance of a veteran staying on a specific unit for a defined time frame. "ADT Using NUMA," VHA Support Service Center, accessed April 30, 2024, http://vharamp.vssc.med.va.gov/VSSCSearch/Pages/results.aspx?k=ADT%20using%20NUMA. (This site is not publicly accessible.)

[8] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[9] VA administers healthcare services through a nationwide network of 18 regional systems referred to as VISNs. "Veterans Integrated Services Network (VISN)," VHA, accessed April 15, 2024, https://www.va.gov/HEALTH/visns.asp; The two medical centers are the Troy Bowling VA Campus and Franklin R. Sousley VA Campus in Lexington. The four community-based outpatient clinics are in the cities of Hazard, Berea, Somerset, and Morehead.

[10] "Corporate Data Warehouse (CDW)," VA Health Systems Research, accessed February 25, 2025, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm.

Leadership and Organizational Culture

"Leaders usually impose structure, systems, and processes [on an organization], which, if successful, become shared parts of the culture. And once processes have become taken for granted, they become the elements of the culture that may be the hardest to change."[11] Healthcare system leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement.[12]

The OIG reviewed the facility's leadership structure and inpatient unit staffing practices. The OIG evaluated how these elements support inpatient unit operations, compliance with requirements, and delivery of quality care.

Leadership Structure

At the time of the OIG inspection, the facility's executive leadership team consisted of the Facility Director, Chief of Staff, acting Associate Director, acting Assistant Director, Deputy Chief of Staff, and Associate Director of Patient Care Services. The Chief of Mental Health served as the facility's mental health lead and oversaw all mental health programs, including the inpatient unit, as required under VHA Directive 1160.01.[13]

According to the Chief of Mental Health, the service line leadership structure was effective in promoting a culture of collaboration. The Chief of Mental Health believed this was supported through daily huddles with the inpatient mental health program manager (program manager) in which pertinent information was shared. Inpatient unit leaders described facility leaders as available and responsive. Facility leaders reported staff communicated needs and concerns during regular meetings and periodic leadership rounds on the unit. However, as discussed below, the OIG found multiple gaps in leadership oversight.

VHA Directive 1160.01 requires healthcare systems to establish a mental health executive council to ensure quality mental health care is delivered and responsive to veteran preferences.[14]

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[11] Edgar H. Schein, *Organizational Culture and Leadership,* 4th Edition, (San Francisco: Jossey-Bass, 2010), accessed June 25, 2024, https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

[12] VA, "*Leader's Guide to Foundational High Reliability Organization (HRO) Practices*," July 2024, accessed July 22, 2025, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/HRO%20Assessment%20and%20Planning%20Resources.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Leaders%20Guide%20to%20Foundational%20HRO%20Practices%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This website is not publicly accessible.)

[13] VHA Directive 1160.01.

[14] VHA Directive 1160.01.

The facility Mental Health Executive Council was chaired by the Chief of Mental Health and included inpatient unit staff, but did not meet the requirement for a veteran representative.[15] The Chief of Mental Health explained that a veteran had been recently selected as a council member and would attend the next quarterly meeting.[16] Without veteran representation, the council missed opportunities to obtain and incorporate critical stakeholder input for operational and quality of care improvements.

Inpatient Unit Staffing

At the time of the inspection, the program manager also served as the local recovery coordinator, as required under VHA Directive 1160.06.[17] The program manager oversaw inpatient unit operations and supervised psychiatrists, a nurse practitioner, and a social worker. (For information on current staffing levels, see appendix C.)

Facility and inpatient unit leaders reported sufficient direct care staffing. However, the Chief of Mental Health noted that due to budget constraints, it was unlikely the facility would backfill a vacant peer support position on the inpatient unit or proceed with a previously planned hire for a full-time local recovery coordinator. The Chief of Mental Health stated that due to the program manager's existing role and familiarity with unit staff, the ancillary local recovery coordinator's responsibilities were beneficial in promoting implementation of recovery-oriented care on the inpatient unit. The Chief of Mental Health said executive and VISN leaders were aware the facility did not have a full-time local recovery coordinator. However, the Chief of Mental Health reported considering submitting an exemption request not to fill the position because facility leaders believed recovery-oriented care objectives were already being met. (Discussed further in the Recovery-Oriented Principles section.)

Facility leaders stated that available inpatient unit beds were reduced from 14 to 10 in February 2024 following an analysis of census and other data, and direct care staffing levels were adjusted based on the average daily census. The Chief of Mental Health was uncertain whether the bed reduction was permanent and described a plan to communicate with VHA leaders about this decision.

Although the facility had multiple leadership positions designated to oversee mental health and nursing staff, the OIG found the facility did not meet several recovery-oriented care and clinical care coordination requirements as a result of gaps in supervisory oversight. (Discussed in more detail below.) For example, the OIG identified inconsistent group programming on the unit and the absence of written guidance or standardized processes in several areas. These included

[15] VHA Directive 1160.01.

[16] The Chief of Mental Health reported being unable to remember the reason a veteran representative was not selected sooner for the vacancy.

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

tracking veterans who received VA-purchased inpatient mental health care in the community and monitoring alignment with state law on involuntary hospitalization. When facility leaders are not detailed or thorough in their operational oversight, clinical processes may be ambiguous and contain errors that negatively affect veteran care.

Recommendation

1. The Facility Director ensures the Mental Health Executive Council operates in accordance with Veterans Health Administration requirements.

For detailed action plans, see appendix E.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values."[18] When a veteran understands the risks and benefits of treatment options and the provider understands the veteran's preferences and values, the veteran is empowered to make decisions and meet treatment goals.[19]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the healthcare system's integration of recovery-oriented principles, as required, on the inpatient unit (see appendix B for methodology).[20]

Leadership

VHA Directive 1160.06 sets expectations for the program manager to "coordinate and promote consistent, sustained, high quality therapeutic programming" on the inpatient unit.[21] The program manager described responsibilities, including coordinating group programming, training staff, attending treatment team meetings, and providing clinical coverage. However, the OIG found the program manager conducted limited oversight of group programming and the schedule provided to veterans did not show evening program offerings. (See Recovery-Oriented Programming section.)

At the time of the inspection, the facility did not have a full-time dedicated local recovery coordinator, as required by VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services*; responsibilities were assigned as ancillary duties to the program manager in 2023.[22] The program manager stated that performing both roles supported efficient implementation of recovery-oriented services such as group programming and staff education. The absence of a

[18] "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, accessed September 19, 2022, https://www.samhsa.gov/find-help/recovery.

[19] "Shared Decision-Making in Mental Health Care," Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, accessed May 12, 2022, https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4371.pdf.

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

[21] VHA Directive 1160.06; VHA Directive 1160.06(1). According to VHA Directive 1160.06, the inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services. The amended directive contains similar language related to program manager responsibilities. VHA Directive 1160.06 defines the role of the inpatient mental health program manager as a leadership position that can be filled by the "full range of core mental health disciplines." The amended directive does not include this specification but notes the position title may vary based on "the discipline selected."

[22] VHA Directive 1163(1). "Local Recovery Coordinators – Home," VA Central Office, accessed November 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/LRC. (This site is not publicly accessible.)

full-time local recovery coordinator could prevent recovery-oriented principles and activities from being implemented on the inpatient unit and throughout the facility.

VHA Directive 1160.06 requires mental health leaders and local recovery coordinators to develop a standard operating procedure (SOP) for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[23] However, facility leaders did not publish the required SOP until two days after the OIG announced the inspection.[24]

The facility met the VHA Directive 1163(1) requirement for a strategic plan to direct veteran-centered, recovery-oriented care.[25] The OIG found facility leaders had a process to solicit input from veterans who used inpatient mental health services including an anonymous survey, morning town halls, and group programming on the inpatient unit.[26]

Recovery-Oriented Programming

The program manager reported that veterans were oriented to recovery principles on the unit during group programming. This is required by VHA's "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06."[27] Additionally, mental health leaders shared unit staff met with veterans to set individualized treatment goals and coordinate with outpatient services to support continuity of care after discharge.

Inpatient unit staff scheduled a minimum of four hours of interdisciplinary, recovery-oriented programming on weekdays and weekends, as required by VHA Directive 1160.06.[28] However, the OIG found that scheduled programming was inconsistent and lasted for a shorter duration than expected. The OIG also observed limited interaction between staff and veterans on the unit, and noted veterans had minimal opportunity for other structured activities, despite the low daily census and sufficient staff. The program manager attributed the inconsistencies to loss of a peer

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

[24] VHA Directive 1160.06; VHA Directive 1160.06(1); Lexington SOP 116A-25-044, "Inpatient Mental Health Unit Recovery Oriented Care," April 16, 2025.

[25] VHA Directive 1163(1); VHA Directive 1163, August 14, 2025; Lexington VA Healthcare System, "Strategic Plan, Recovery Transformation Sustainment (RTSS) Plan," April 23, 2024.

[26] VHA Directive 1160.01.

[27] VHA requires inpatient unit staff to provide veterans with an orientation to the unit on recovery-oriented care to include an "overview of the general unit services such as therapeutic programming, activities, and structure of the day." VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023.

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

support staff member.[29] Mental health leaders acknowledged the need for existing staff to provide additional opportunities and reported plans to increase the number of therapeutic offerings by involving facilitators from multiple disciplines.

The OIG noted limited direct interactions between veterans and staff. An inpatient unit leader reported that duties such as documentation prevented staff from interacting with veterans. Minimal staff engagement with veterans and limited programming may hinder opportunities for veterans to work on recovery goals while receiving inpatient care.

Physical Environment

The OIG found the newly constructed inpatient unit had several aspects of a safe, hopeful, and healing environment. The inpatient unit had natural light in the dayroom and bedrooms, warm paint colors, and new furniture. Staff placed cushioned seats in front of the television in the dayroom, creating a home-like environment as outlined in VA's inpatient mental health design guide.[30]

The OIG observed artwork in the dayroom and veterans' rooms; however, minimal artwork was displayed in hallways and common areas (see figure 2).[31] Additionally, the OIG identified that recovery-oriented materials such as mental health resources were not readily accessible without staff assistance. The facility also did not have a dedicated safe and secure outdoor space, or identified alternatives to outdoor space, for inpatient unit veterans. Mental health leaders reported being unable to secure an outdoor space separate from publicly accessible areas due to the proximity to a local university's campus.

VHA's inpatient unit design guidance recommends the use of artwork and incorporation of natural elements to help create a healing, engaging, and recovery-oriented environment for veterans.[32] VHA recommends design alternatives when it is not feasible to provide outdoor access, such as displaying "large artwork or murals on the unit walls to create" the appearance of outdoor space. The absence of outdoor access or alternatives could diminish the effectiveness of a therapeutic environment.[33] The program manager shared that The Joint Commission

[29] Peer support services are specifically designed to offer hope for veteran recovery, and peers serve as role models for that recovery, health, and wellness. "Peer Specialists help Veteran patients develop skills to manage their recovery from illness, improve their quality of life, support their individualized goals, facilitate support from others, and achieve independence from institutional setting." VHA Directive 1163, August 13, 2019; VHA Directive 1163(1); VHA Directive 1163, August 14, 2025.

[30] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021. Per VHA guidance, "Controlled natural lighting should be provided wherever possible to reduce glare and to promote a healing and energy-efficient environment." Further, facility leaders should "avoid excessive illumination in spaces such as corridors or exterior courtyards that reinforce an institutional image."

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

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

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

recommended removing installed artwork on the inpatient unit for reasons such as infection control concerns.

Figure 2. *Dining room/dayroom (natural light, warm paint colors, clean furniture) and hallway (limited artwork).*
Source: Photos of the facility's inpatient unit taken by OIG staff, April 30, 2025.

Recommendations

2. The Chief of Mental Health ensures compliance with Veterans Health Administration requirements for a full-time local recovery coordinator.
3. The Chief of Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends on the inpatient mental health unit.
4. The Facility Director considers consulting with the Office of Mental Health to clarify guidelines for design elements such as artwork on the inpatient unit.
5. The Facility Director considers alternatives to outdoor access for the inpatient unit, such as those identified in VA's *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.*

For detailed action plans, see appendix E.

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective" treatment.[34] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[35] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a less-intensive level of care.[36]

The OIG evaluated the quality of clinical care coordination for veterans receiving inpatient mental health treatment and assessed access to services, local procedures for involuntary treatment, interdisciplinary team treatment planning, medication management, and discharge planning.

Access to Care

Successful coordination of mental health care requires well-defined screening and admissions processes that ensure veterans are evaluated and receive clinically appropriate treatment.[37] Facility leaders established required SOPs for inpatient unit admission and interfacility transfers, per VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[38]

The VHA Office of Integrated Veteran Care's "Emergency Treatment Notification Process Standard Operating Procedures" requires facility staff to coordinate post-discharge care for

[34] "Care Coordination," Agency for Healthcare Research and Quality, accessed on April 30, 2024, https://www.ahrq.gov/ncepcr/care/coordination.html.

[35] Denise M. Hynes et al., "Understanding Care Coordination for Veterans with Complex Care Needs: Protocol of a Multiple-Methods Study to Build Evidence for an Effectiveness and Implementation Study," *Frontiers in Health Services* 3, (August 14, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

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

[37] VHA Directive 1160.01; VHA Directive 1160.06; VHA Directive 1160.06(1).

[38] VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023, replaced by VHA Office of Mental Health, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," December 19, 2024. Unless otherwise specified, both standard operating procedures contain similar language related to inpatient mental health unit requirements. The SOPs clarified the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient mental health units. Lexington Standard Operating Procedures 116A-24-042, "Admissions and Inpatient Processes for the Inpatient Mental Health Unit," September 11, 2024; Lexington Standard Operating Procedures 116A-20-029, "Involuntary Admissions to Inpatient Mental Health Unit," February 10, 2022; Lexington Medical Center Policy 11-03, "Inter-Facility Transfer Policy," August 9, 2021.

veterans who receive inpatient mental health care in the community.[39] A mental health leader provided fiscal year 2024 data demonstrating facility staff did not place any consults for inpatient mental health care in the community. However, mental health leaders and staff were unsure how many veterans sought treatment in the community on their own. The Chief of Mental Health reported assigning a coordinator to manage veterans' care in the community. However, neither the coordinator nor mental health leaders were able to articulate the process to the OIG. Additionally, leaders did not have a process to transfer and coordinate post-discharge care for veterans from the community who requested follow-up care within VHA. Without a clear process or oversight, opportunities for staff to coordinate post-discharge follow-up for veterans who received care in the community may be limited.

Involuntary Hospitalization and Treatment

The facility's policy outlined written processes for involuntary hospitalization but not for tracking compliance with state law, as required in VHA Directive 1160.06.[40] The absence of written processes to monitor compliance with state law could contribute to illegal hospitalization of veterans. Additionally, mental health leaders reported they did not consult with the Office of General Counsel regarding state laws on involuntary hospitalization, as required, and instead relied on staff's informal consultation with colleagues.[41] Ongoing consultation with the Office of General Counsel, through the Office of Chief Counsel in the Districts, is critical to ensure staff comply with state laws regarding involuntary hospitalizations.

> An involuntary hospitalization is the "legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital."[42]
>
> Standards and procedures for civil commitment are provided by state law and vary by state.[43] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[44]

VHA Office of Nursing Services' policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," requires registered nurses to conduct and record a review of admission documents, including

[39] VHA Office of Integrated Veteran Care, "Emergency Treatment Notification Process Standard Operating Procedures," January 6, 2023.

[40] VHA Directive 1160.06; VHA Directive 1160.06(1); Lexington SOP 116A-20-029.

[41] VHA Directive 1160.01.

[42] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," Substance Abuse and Mental Health Services Administration, accessed July 27, 2023, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

[43] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," Substance Abuse and Mental Health Services Administration.

[44] VHA Directive 1160.01.

veterans' legal commitment status, after arrival to the inpatient unit.[45] The OIG found electronic health records consistently included the required documentation of legal (voluntary or involuntary) commitment status.

Treatment Planning

Facility leaders established written guidance on inpatient unit treatment planning processes, including recovery-oriented elements such as veterans' involvement in setting individualized goals, in alignment with VHA Directive 1160.01.[46] Mental health leaders described overseeing the quality of treatment planning documentation through monthly chart reviews. Mental health leaders also reported conducting daily interdisciplinary treatment team rounds to discuss and collaborate on treatment plan goals with each veteran on the inpatient unit.

Medication Treatment

VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures* requires an informed consent discussion between prescribers and veterans on the risks and benefits of medication treatment.[47] The OIG found that 18 percent of health records reviewed included documentation of informed consent discussions between prescribers and veterans on the risks and benefits of medication treatment. The Chief of Mental Health stated these discussions were occurring but acknowledged they were not consistently documented by prescribers. When providers and veterans do not consistently discuss the risks and benefits of medication use, veterans may be deprived of the ability to make informed decisions.

[45] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP), revised April 5, 2023, November 2, 2023, and September 10, 2024. All three versions were in effect during the health record review period. Unless otherwise noted, all versions contain similar language related to documentation of voluntary or involuntary legal status.

[46] VHA Directive 1160.01.

[47] VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021; VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended January 12, 2024, and February 22, 2024; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024. All versions were in effect during the health record review period. Unless otherwise noted, all versions contain similar language related to medication risks and benefits discussion. The OIG reviewed for documentation of a risk and benefit discussion specific to veterans who were newly prescribed central nervous system medication during the inpatient stay; Central nervous system medications are used for the treatment of "a wide range of neurologic and psychiatric conditions." John A. Gray, "Introduction to the Pharmacology of CNS [Central Nervous System] Drugs," chap. 21 in *Katzung's Basic & Clinical Pharmacology*, 16th ed., Todd W. Vanderah, (McGraw Hill (2024)), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

Discharge Planning

Facility leaders established written guidance for coordination of care when veterans transition out of the inpatient unit, per VHA Directive 1160.01.[48] The guidance outlines processes for outpatient follow-up appointments and discharge coordination involving the veteran.[49]

In alignment with VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," most reviewed discharge instructions included the outpatient mental health follow-up appointment.[50] However, discharge instructions also contained abbreviations and acronyms that could be difficult for veterans and caregivers to understand, in contrast to VHA's *Health Record Documentation Program Guide* (see figures 3 and 4).[51] According to mental health leaders, staff hand wrote discharge instructions with follow-up appointment locations; leaders acknowledged this information was not documented in patients' health records and handwriting might be difficult to read. Discharge instructions that are not legible or complete may create barriers for veterans to attend follow-up appointments and receive timely mental health care.

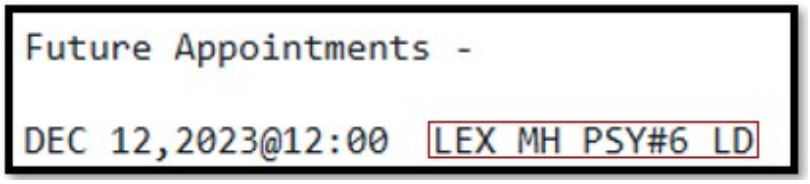

Figure 3. *Example from discharge instructions with difficult-to-understand appointment information outlined in red.*
Source: OIG review of veterans' electronic health records.
Note: Per mental health leaders, LEX refers to Lexington, MH refers to mental health, PSY#6 refers to the psychologist assigned to the clinic, and LD refers to Leestown Division.

[48] VHA Directive 1160.01; Lexington SOP 116A-25-048, "Post-Discharge Engagement (PDE): Inpatient Mental Health Unit," April 16, 2025; Lexington SOP 116A-25-047, "Post-Discharge Engagement (PDE): Suicide Prevention," April 16, 2025.

[49] Lexington SOP 116A-25-048; Lexington SOP 116A-25-047.

[50] VHA SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023, rescinded and replaced by VHA SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," December 19, 2024.

[51] VHA, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023; VHA, *Health Record Documentation Program Guide Version 1.3*, February 13, 2025.

Most reviewed records included documentation that the veteran was offered a copy of discharge instructions.[52] Additionally, all reviewed records included a discharge summary (see figure 4).

Reviewed health records did not consistently include a medication list or the reason for prescribing the medications in discharge instructions, as required by VHA Directive 1345, *Medication Reconciliation*.[53] Consistent with recovery-oriented principles, providing the reason a medication is prescribed supports veterans' participation in their care. Additionally, some reviewed records had discharge instructions with medical abbreviations that could be difficult for non-medically trained individuals to understand (see figure 4).[54]

Accurate and easy-to-understand discharge instructions could prevent medication errors following hospitalization.

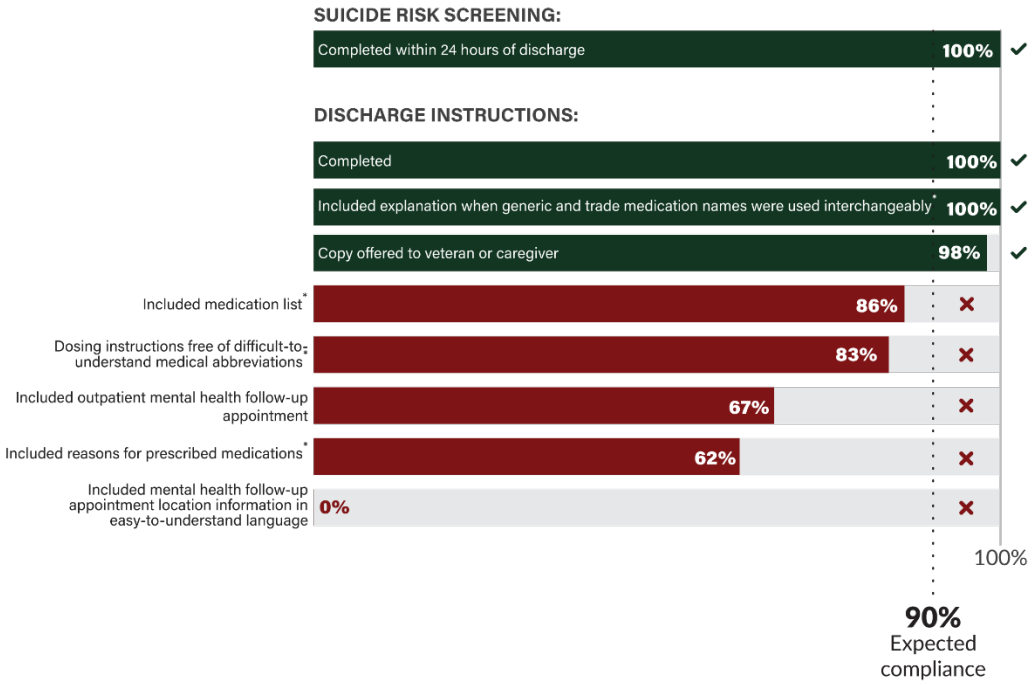

Figure 4. *Facility staff's compliance with VHA suicide risk screening and discharge instruction elements.*
Source: OIG review of veterans' electronic health records.
**Corresponds to a subset of records with a completed medication list (n = 42).*

[52] VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*. VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Office of Mental Health, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[53] VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

[54] VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*.

Recommendations

6. The Facility Director develops and implements written processes to monitor and track compliance with state laws for involuntary hospitalization and consults with the Office of General Counsel to ensure processes are consistent with applicable laws.
7. The Chief of Staff ensures documentation of informed consent discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications.
8. The Chief of Staff ensures veterans' discharge instructions are written in easy-to-understand language and include the follow-up mental health appointment location, the purpose of each medication, and how the medication is supposed to be taken.

For detailed action plans, see appendix E.

Suicide Prevention

The underlying causes of death by suicide can be complex and multifactorial. Preventing suicide may require coordinated systems, services, and resources to effectively support at-risk veterans.[55]

VA is dedicated to preventing suicide and defines prevention as "participating in activities that are implemented prior to the onset of suicidal events and are designed to reduce the potential for suicidal events."[56] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[57]

To evaluate suicide prevention activity on the inpatient unit, the OIG assessed compliance with required suicide risk screening and evaluation, safety planning, and training.

Suicide Risk Screening and Evaluation

VHA's suicide risk identification strategy requires staff to complete the Columbia-Suicide Severity Rating Scale (suicide risk screening) for all veterans within 24 hours prior to discharge from inpatient mental health units.[58] The OIG found that all the reviewed electronic health records included evidence of a suicide risk screening, and all were completed within the required time frame (see figure 4).[59]

[55] VA, *National Strategy for Preventing Veteran Suicide 2018–2028.*

[56] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[57] VA, *National Strategy for Preventing Veteran Suicide 2018–2028*.

[58] VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting*, updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements.

[59] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated May 10, 2023; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Service Network Director (10N1-23) et al., January 7, 2025; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum. While VHA requires staff to complete Columbia-Suicide Severity Rating Scale within 24 hours before discharge, the OIG also considered risk screenings compliant if completed on the day of discharge. The OIG used 90 percent as the expected level of compliance for health record reviews.

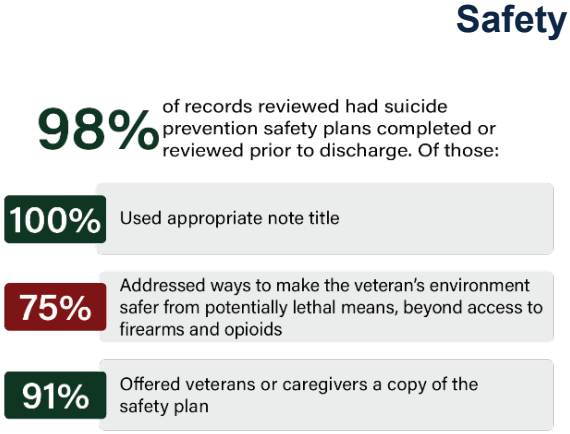

Figure 5. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' electronic health records.

Many reviewed safety plans did not address ways to make the environment safer from potentially lethal means beyond access to firearms and opioids (see figures 5 and 6), as specified in the *VA Safety Planning Intervention Manual*.[60]

The Chief of Mental Health reported believing the question addressing potential lethal means beyond firearms and opioids was optional.

The OIG has found inaccurate use of the national Suicide Prevention Safety Plan to be a consistent finding in multiple inspections.[61]

In a recent publication, the OIG made the following recommendation related to suicide safety plan completion:

> *The Under Secretary for Health identifies barriers to, and ensures documentation of, discussions specific to making the environment safer from identified lethal means in veterans' safety plans.*[62]

Therefore, this report does not contain any recommendations on this topic.

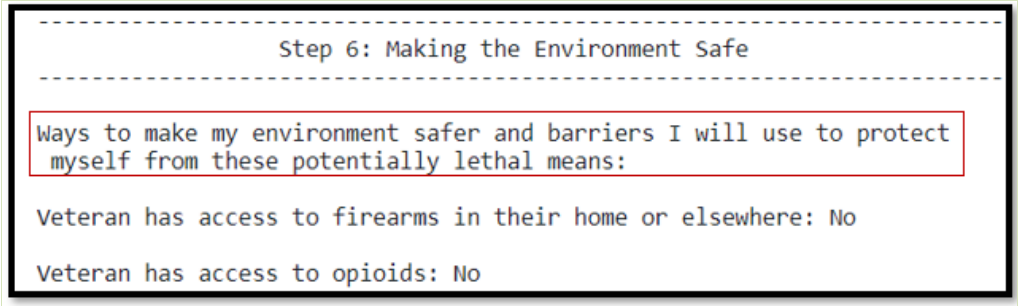

Figure 6. *Example from safety plan that did not address ways to make the environment safer from potentially lethal means, beyond firearms and opioids (outlined in red).*
Source: OIG review of veterans' electronic health records.

[60] VA, *VA Safety Planning Intervention Manual*.

[61] VA OIG, *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00675-259, September 26, 2024; VA OIG, *Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 24-01859-62, March 5, 2025; VA OIG, *Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*, Report No. 24-01862-151, June 26, 2025; VA OIG, *Mental Health Inspection of the VA Salem Healthcare System in Virginia*, Report No. 24-01861-144, June 26, 2025.

[62] VA OIG, *Mental Health Inspection of the VA NY Harbor Healthcare System in New York*, Report No. 25-00729-23, December 18, 2025.

Training

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment) assist clinicians and nonclinical staff, respectively, in identifying the warning signs of suicide risk and appropriate interventions.[63]

Facility staff were compliant with VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training* required STEMS and VA S.A.V.E trainings (see figure 7).[64]

The OIG made no recommendations for this domain.

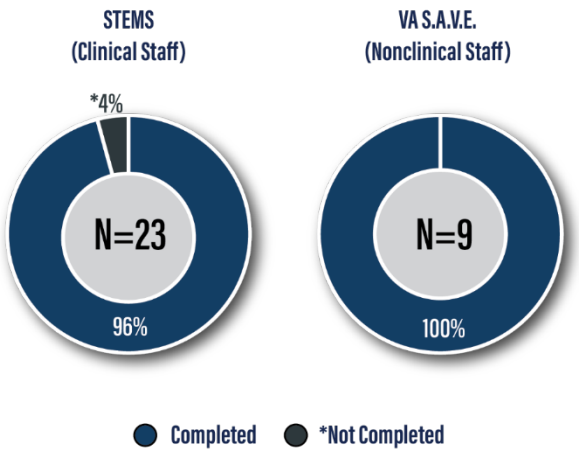

Figure 7. *Inpatient unit staff completion of mandatory suicide prevention trainings.*
Source: OIG document review of clinical and nonclinical staff training certificates.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings from April 14, 2024, through April 14, 2025. VHA established a target threshold for compliance of 95 percent for mandatory suicide prevention training completion.

[63] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), June 2025.

[64] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., June 9, 2022.

Safety

The primary goal of inpatient mental health care is to stabilize veterans experiencing acute distress through the provision of a safe and secure therapeutic environment.[65] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[66]

To assess the inpatient mental health environment, the OIG evaluated aspects of compliance with ongoing assessment of suicide hazards and completion of mandatory staff training.

Mental Health Environment of Care

The interdisciplinary safety inspection team, comprised of both mental health and other facility staff, is responsible for conducting environment of care inspections as stated in VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.[67] The National Center for Patient Safety continually updates the Mental Health Environment of Care Checklist "based on reports from the field of hazards or adverse events encountered at the local level."[68] Interdisciplinary safety inspection team members are required to use this comprehensive checklist of over 150 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[69]

The facility had an Interdisciplinary Safety Inspection Team. Although inspection team staff reported findings to the required committee, they did not report membership and inspection attendance consistently.[70] The inspection team lead and patient safety manager were unaware of the requirement to include team membership and attendance in meeting minutes.

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

[66] VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients,* May 12, 2017, replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients,* November 4, 2024. Unless otherwise specified, the policies contain similar language related to the interdisciplinary safety inspection team, environment of care inspections, and training requirements.

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

[68] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, accessed June 5, 2025, https://www.patientsafety.va.gov/features/Mental_Health_Environment_of_Care_Checklist.asp.

[69] VHA Directive 1167, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," March 19, 2025.

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

In a physical inspection of the unit, the OIG found compliance with randomized safety elements.[71] Interdisciplinary Safety Inspection Team staff conducted twice annual mental health environmental inspections at the required frequency with a supplemental inspection on March 17, 2025, prior to opening the new unit.[72] The March 2025 inspection was entered into the Patient Safety Assessment Tool, but the risk assessments for identified hazards were not documented.[73] The program manager relied on external notifications and the assistant chief of quality reported being unaware of national guidance for completion of the Patient Safety Assessment Tool outside of biannual inspections. The assistant chief of quality identified plans to seek national guidance for clarification on process timelines. When facility leaders do not complete a risk analysis, correction of environmental hazards may be delayed, potentially resulting in veteran and staff harm.

Mental health leaders reported receiving guidance from the VISN and VHA National Center for Patient Safety that did not align with written VHA mental health environment of care policy. For example, the seclusion room did not meet size requirements, but on the March 2025 Patient Safety Assessment Tool, the facility documented the room met the required width.[74] The assistant chief of quality reported previously receiving guidance from the National Center for Patient Safety to document on the Patient Safety Assessment Tool that the seclusion room met all requirements. However, the OIG was unable to confirm the reported guidance.

Leaders detailed plans to enter an appeal to the Mental Health Environment of Care Checklist Review Board for safety hazards identified in the sally port, as required.[75] However, during the OIG review, the VISN Mental Health Environment of Care Checklist Oversight Team advised all facilities within the VISN to create an SOP for mitigation rather than entering an appeal for sally port safety hazards. At the request of the OIG, the facility agreed to consult with the VISN and the National Center for Patient Safety to clarify conflicting guidance.[76]

[71] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist." The OIG reviewed the inpatient unit for randomized safety elements such as anchor free sinks, chemicals secured when not in use, and ligature free bathroom doors.

[72] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The 2024 directive states that mental health environment of care inspections should be conducted "twice annually" rather than "every 6 months" as found in the 2017 directive.

[73] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety. The Patient Safety Assessment Tool is the software tool VHA uses to document mental health environment of care inspections, including hazards identified.

[74] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety.

[75] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist." "The Sally Port is the space between two locked doors that must be traversed to enter the unit."

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

When staff identify environmental risks during inspections and receive conflicting guidance to resolve the risks, veterans and staff are potentially at risk for harm.

Training

VHA Directive 1167 requires staff to be trained on environmental hazards and oriented to the "content and proper use" of the Mental Health Environment of Care Checklist.[77]

Inpatient unit staff and inspection team staff generally completed the required annual training (see figure 8).[78]

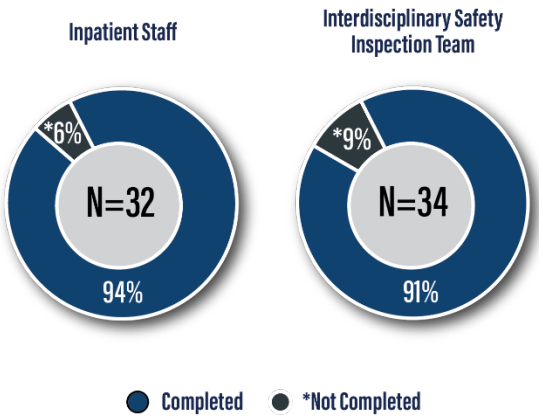

Figure 8. *Mental Health Environment of Care Checklist training completion, April 14, 2024, through April 14, 2025. Source: OIG document review of staff training certificates. Note: Interdisciplinary Safety Inspection Team staff who were also inpatient unit staff are included in the denominator for both document reviews. The OIG used 90 percent as the expected level of compliance.*

Recommendations

9. The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration requirements, including recording membership and attendance for Mental Health Environment of Care Checklist inspections.
10. The Veterans Integrated Service Network Director implements processes to ensure the Veterans Integrated Service Network Mental Health Environment of Care Checklist Oversight Team provides facility guidance consistent with Veterans Health Administration requirements.
11. The Facility Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards within the Patient Safety Assessment Tool.

For detailed action plans, see appendix E.

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

[78] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, updated December 2022.

Conclusion

To assist facility leaders in impactful quality of care improvements, the OIG conducted a review to evaluate acute inpatient mental health care provided at the facility.

Facility leaders described an effective leadership structure that promoted staff collaboration through daily huddles. However, despite sufficient leadership staffing and a low patient census, the OIG identified gaps in oversight from facility leaders, as evidenced by noncompliance with several VHA requirements and missed opportunities to strengthen recovery-oriented services.

The Mental Health Executive Council did not have the required veteran representation, limiting stakeholder input. However, leaders reported engaging veterans for feedback using a survey, town halls, and group programming. Although a recovery transformation plan was in place, an SOP for recovery-oriented care training and implementation was finalized only after the announcement of the inspection. Recovery programming was scheduled but often not delivered, leaving veterans without consistent therapeutic engagement.

Mental health leaders and an assigned coordinator were unsure how many veterans sought care in the community, and leaders did not have a process to transfer and coordinate post-discharge care for veterans in the community who requested care within VHA. Leaders also did not implement formal processes for monitoring compliance with state laws on involuntary treatment. Staff did not consistently document medication risk discussions, and discharge instructions were often unclear or incomplete. While suicide risk screenings and trainings met completion requirements, safety plans frequently lacked strategies to reduce access to lethal means.

The Interdisciplinary Safety Inspection Team incorrectly documented environmental safety hazards during the most recent inspection. Additionally, facility leaders did not resolve conflicting environmental hazard guidance from the VISN and the National Center for Patient Safety.

Comprehensive oversight is essential to ensuring sustained improvement, compliance with VHA requirements, and the delivery of consistent, veteran-centered mental health care. The OIG issued 11 recommendations to the VISN Network Director, Facility Director, Chief of Staff, and Chief of Mental Health. The VISN Director concurred with recommendation 10 and described the prior establishment of a Mental Health Environment of Care Checklist oversight team to ensure compliance with VHA requirements. The Facility Director concurred with recommendations 1–9 and 11 and described plans to ensure veteran representation on the Mental Health Executive Council, appoint a full-time recovery coordinator, expand recovery-oriented programming, and consult with the Office of Mental Health on design elements and artwork. Additional initiatives focus on improving discharge instructions, documenting informed consent, establishing written processes for involuntary hospitalization, as well as enhancing safety inspections and hazard reporting. The OIG will follow up to ensure these actions are effective and sustained.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Appendix A: Background

Inpatient Mental Health Services

VHA offers acute inpatient mental health services as a "high-intensity" treatment option for veterans experiencing "acute and severe emotional or behavioral symptoms" that pose a safety risk or result in compromised mental function. When a healthcare provider determines that inpatient mental health care is appropriate, the veteran should be immediately admitted to ensure safety and stabilization.[79]

VHA Directive 1160.06 requires inpatient unit staff use a veteran-centered, "evidence-based, recovery-oriented approach" that incorporates evaluation and monitoring, interdisciplinary treatment, discharge planning, sufficient staffing, privacy, and dignity.[80] To evaluate the quality of recovery-oriented care provided at the healthcare system, the OIG assessed compliance with VHA requirements in the five domains described below.

Leadership and Organizational Culture

Organizational structure plays a critical role in the quality of healthcare delivery. Elements such as formal reporting channels, committee structures, and staffing practices should support inpatient unit operations and align with care delivery needs.[81]

According to VHA Directive 1160.06 requirements, the healthcare system director is responsible for overseeing inpatient mental health services. The chief of staff, in collaboration with the associate director of patient care services, should ensure that inpatient units have adequate staffing to establish interdisciplinary teams, provide services, and fully implement program requirements.[82]

Each VHA healthcare system must have a dedicated chief mental health lead with overall responsibility for mental health service operations, including mental health services that may be aligned under a different department. The mental health lead may also be referred to as the mental health service line director, Chief of Mental Health, or other comparable title. According to VHA Directive 1160.01, the mental health lead or designee serves as the chair of the healthcare system's mental health executive council, which ensures staff provide high-quality care and are responsive to veterans' preferences.[83] Each mental health executive council must include veteran representation, preferably one currently receiving mental health treatment and

[79] VHA Directive 1160.06; VHA Directive 1160.06(1).
[80] VHA Directive 1160.06; VHA Directive 1160.06(1).
[81] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*.
[82] VHA Directive 1160.06; VHA Directive 1160.06(1).
[83] VHA Directive 1160.01.

not employed at the local healthcare system.[84] The council must meet quarterly and "record minutes that are accessible to all mental health clinical staff."[85] The healthcare system mental health lead must assign an inpatient mental health program manager "to coordinate and promote consistent, sustained, high quality therapeutic programming" into the inpatient unit setting.[86]

The VISN Director is responsible for ensuring that inpatient mental health services "are accessible without delay to all eligible Veterans in the VISN" and that the programs offered on the inpatient unit are compliant "with relevant state laws governing inpatient mental health care, hospital accreditation regulations, and VISN and facility level procedures."[87] VHA requires the appointment of a full-time VISN chief mental health officer to "ensure transparency of decision making and to promote communication between the field and central office."[88]

Under VHA Directive 1163(1), VHA employs peer support staff, veterans who are actively engaged in their own personal recovery, to serve as role models for other veterans receiving healthcare services.[89] Peer support staff assist veteran patients to "develop skills to manage their recovery from illness, improve their quality of life, support their individualized goals, facilitate support from others, and achieve independence from institutional setting."[90]

Recovery-Oriented Principles

The President's *New Freedom Commission on Mental Health* report, published in 2003, outlined a vision for the delivery of recovery-oriented mental health care.[91] The Substance Abuse and Mental Health Services Administration "defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[92]

Local recovery coordinators are considered collaborative mental health leaders who ensure recovery-oriented principles are integrated into care delivery. The role is primarily nonclinical in nature, which allows them to dedicate most of their time to activities such as training,

[84] VHA Directive 1160.01.

[85] VHA Directive 1160.01.

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

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

[88] "Mental Health Required Staff Listing," VA Office of Mental Health, accessed February 8, 2023, https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. (This site is not publicly accessible.)

[89] VHA Directive 1163(1); VHA Directive 1163, August 14, 2025. Peer support staff may also be referred to as peer specialists.

[90] VHA Directive 1163(1); VHA Directive 1163, August 14, 2025.

[91] "Achieving the Promise: Transforming Mental Health Care in America," President's New Freedom Commission on Mental Health, accessed June 11, 2024, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/InsideCover.htm.

[92] "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration.

consultation, and education.[93] To support veterans' recovery, VHA Directive 1163(1) requires the local recovery coordinator, in collaboration with local mental health leaders, to have a continuous recovery improvement plan.[94] Additionally, VHA Directive 1160.06 requires the local recovery coordinator, in collaboration with the inpatient mental health program manager, to establish an SOP that includes processes for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[95]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit. The healthcare system mental health lead must assign an inpatient mental health program manager "to coordinate and promote consistent, sustained, high quality therapeutic programming" in the inpatient unit setting.[96] Inpatient unit staff must offer veterans "a minimum of 4 hours of interdisciplinary, therapeutic and recovery-oriented programming daily including weekends and holidays, with 5–6 hours of programming recommended."[97]

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care, and therefore, provides design guidelines for healthcare systems to create a hopeful and healing environment while maintaining safety.[98] For VA medical facilities with a Mental Health Environment of Care Checklist-compliant secure outdoor space, daily programming should include dedicated time for veterans to be outdoors.[99]

Clinical Care Coordination

Care coordination poses a major challenge to healthcare safety, especially for chronically ill individuals who receive services from multiple providers in a variety of settings.[100] VHA Directive 1160.06 requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for a veteran's care. An interdisciplinary approach is critical to ensure comprehensive, coordinated, and holistic care.[101]

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[93] VHA Directive 1163(1).

[94] VHA Directive 1163(1).

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

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

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

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

[99] VHA Directive 1160.06; VHA Directive 1160.06(1). For VA medical facilities with a Mental Health Environment of Care Checklist-compliant outdoor space, "designated time for Veterans to be outdoors should be incorporated into the daily programming as permitted by staffing, individual Veteran interest, safety observation level of the Veteran, weather and as determined by the patient's [Interdisciplinary Treatment Team], clinical condition, and any other relevant contingency factors."

[100] The Joint Commission, *Standards Manual e-dition,* PC.02.02.01, August 2024. "The hospital coordinates the patient's care, treatment, and services based on the patient's needs."

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

VHA SOP 1160.06.2 recommends healthcare systems have SOPs outlining admission processes, and VHA Directive 1160.06(1) requires systems to provide access to mental health treatment for veterans who are either voluntarily or involuntarily held on an inpatient unit.[102] When treatment is not available within the healthcare system, staff may transfer the veteran to another VHA or non-VHA system for inpatient mental health care.[103]

The federal government lacks civil commitment laws; therefore, VHA healthcare system leaders are required to have clear guidelines that align with state and local laws for civil commitment.[104] Staff must be aware of the veteran's legal status (voluntary or involuntary admission) to safeguard against potential civil rights violations, including illegal detainment in a locked inpatient unit.[105]

The interdisciplinary treatment team must ensure the recovery-oriented treatment plan includes the veteran's personally identified goals and is completed in collaboration with the veteran. The interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including a follow-up appointment information.[106]

VHA requires that veterans receive a copy of the written discharge plan and a copy of the safety plan, as applicable, at discharge.[107] The written discharge plan must include the provider's name if available, as well as scheduling information for the follow-up appointments.[108]

Suicide Prevention

According to the *2024 National Veteran Suicide Prevention Annual Report*, "suicide was the 12th-leading cause of death for Veterans in 2022" and, for veterans under age 45, was the

[102] VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024; VHA Directive 1160.06; VHA Directive 1160.06(1).

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

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

[105] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised September 10, 2024.

[106] VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Office of Mental Health, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[107] VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Office of Mental Health, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[108] VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Office of Mental Health, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOPs use the term *written discharge plans* when inpatient unit staff must provide the veteran with information.

second-leading cause of death.[109] Suicide risk is elevated after a suicide attempt, including the period following discharge from an inpatient psychiatric setting.[110] Therefore, there is a critical need for suicide risk assessment prior to discharge from inpatient mental health care, as well as linkage to follow-up mental health care.[111]

Inpatient unit clinical staff are to complete the Columbia-Suicide Severity Rating Scale (suicide risk screening), a risk assessment tool, for veterans within 24 hours prior to discharge, as required by VA's suicide risk identification strategy.[112] According to VHA's memorandum "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," a positive suicide risk screening then requires the "timely completion of the Comprehensive Suicide Risk Evaluation."[113] Staff may complete the risk evaluation in lieu of the suicide risk screening prior to discharge.[114]

When veterans are determined to be at risk for suicide, providers are expected to engage them in safety planning.[115] Safety planning is an intervention in which "patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time" and "involves eliminating or limiting access to any potential lethal means in the environment."[116]

In 2018, VA published its 10-year strategic plan for preventing veteran suicide, which outlines the objective of reducing access to lethal means. The document discusses provider education for veterans on safe storage and access to firearms, as well as "storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons."[117] The *VA Safety Planning Intervention Manual*, a guide to help VHA providers develop safety plans with veterans, further emphasizes identification of access to potentially lethal means such as firearms, opioids, medications, ropes, and household toxins.[118]

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[109] VA Office of Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report*, December 2024.

[110] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[111] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[112] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting."

[113] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

[114] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

[115] VA, VA Safety Planning Intervention Manual.

[116] Barbara Stanley and Gregory Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* 19, no. 2 (May 2012): 256-264, https://doi.org/10.1016/j.cbpra.2011.01.001.

[117] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[118] VA, *VA Safety Planning Intervention Manual*.

According to VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," all patients in a VHA inpatient mental health setting "must be offered the opportunity to create or update a Safety Plan as part of the discharge plan. This should be documented in the patient's medical record."[119]

VHA Directive 1071(1) requires healthcare providers complete Skills Training for Evaluation and Management of Suicide and nonclinical staff complete VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment) training annually.[120] In June 2022, VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[121]

Safety

In VHA healthcare systems, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment.[122] Interdisciplinary safety inspection team members and all inpatient unit staff are responsible for ensuring a safe environment.[123] Additionally, an inspection team is required to assess the inpatient unit twice annually for suicide hazards using the Mental Health Environment of Care Checklist and the patient safety manager or other designated mental health staff track corrective actions taken for identified environmental risks.[124]

An interdisciplinary safety inspection team is a mandatory subcommittee of the healthcare system environment of care committee, with team membership documented as part of the inspection rounds summary. According to VHA Directive 1167, the inspection team should include an inpatient mental health unit program director and inpatient unit nurse manager, the suicide prevention coordinator, a patient safety manager, a representative from

[119] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[120] VHA Directive 1071(1).

[121] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification."

[122] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to integrating recovery-oriented principles into the environment.

[123] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to all staff members' responsibility to ensure safety on the inpatient unit.

[124] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to the interdisciplinary safety inspection team and use of the Mental Health Environment of Care Checklist. The 2017 directive states that the assessment of the inpatient unit is required every six months. VHA Directive 1160.06. The checklist is "designed to help identify and abate suicide hazards on mental health units and other areas treating Veterans at high acute risk for suicide. It consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion/physical restraint rooms, and staff workstations."

engineering/facilities management, and an "additional clinical staff from any discipline or work area."[125]

[125] VHA Directive 1167, November 4, 2024.

Appendix B: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[126] The OIG randomly selected the VHA healthcare systems included in fiscal year 2025 reviews from all systems with inpatient mental health beds.[127]

The OIG conducted a virtual and on-site review at the facility April 14 through May 1, 2025. The OIG did not receive any complaints beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient unit, documents, and electronic health records. Additionally, the OIG conducted a physical inspection of the inpatient unit and interviewed key staff and leaders. The OIG did not analyze compliance with individual healthcare system policies.

The OIG reviewed select staff's certificates for annual completion of STEMS, VA S.A.V.E, and Mental Health Environment of Care Checklist trainings.[128] Staff were excluded from analysis of STEMS and VA S.A.V.E trainings if identified as being employed in their position less than 90 days. Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance for record review.

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[129] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and take full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. The Office of Healthcare Inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact

[126] The OIG conducts cyclic reviews of select areas of focus within VHA's continuum of mental health care.

[127] The OIG identified healthcare systems with inpatient mental health beds using the Monthly Program Cost Report (MPCR) code of 1310 (High Intensity General Psychiatric Inpatient Unit). For fiscal year 2025, the OIG excluded facilities with inpatient mental health beds that the OIG inspected in fiscal year 2024. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[128] VHA Directive 1071(1); VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

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

as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "*Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*"[130]

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. Leaders' responses to the report recommendations appear in appendixes D and E.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[131] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

Electronic Health Record Review

The OIG reviewed 50 randomly selected electronic health records of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the facility from October 1, 2023, through September 30, 2024.[132] As previously discussed, the OIG used 90 percent as the expected level of compliance for record review.

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if the facility provided a therapeutic, recovery-oriented environment and maintained veteran safety.[133] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as natural lighting, artwork, and calming paint colors. The OIG also observed the unit for general cleanliness and veteran access to secure outdoor space.[134] Further, the OIG's physical inspection

[130] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

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

[132] The OIG identified the health record sample from a list of all individuals with a Monthly Program Cost Report discharge code of 1310 (High Intensity General Psychiatric Inpatient Unit) and excluded all other records. For veterans with multiple admissions during the review period, the OIG included the veteran's first admission only. One record was excluded on the basis of an inpatient unit stay of less than 48 hours.

[133] VHA Directive 1160.06; VHA Directive 1160.06(1). A unit is an "area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care." *Merriam-Webster.com Dictionary*, "unit," accessed August 10, 2022, https://www.merriam-webster.com/dictionary/unit.

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

of areas in the inpatient unit focused on additional selected safety elements specific to this facility.

The OIG reviewed mental health environment of care data documented in the Patient Safety Assessment Tool for inspections completed in fiscal years 2024 and 2025, and assessed corrective actions taken for deficiencies that remained unresolved for more than six months.

Appendix C: Inpatient Unit Staffing

The OIG examined the facility's inpatient unit staffing, which also reflected an interdisciplinary team approach.

Table C.1. Inpatient Unit Staffing

Discipline	FTEE	Percent Dedicated Per FTEE
Advanced Nurse Practitioner	1	100
Assistant Nurse Manager	1	50
Chaplain	3	12.5
Nurse	11	100
Nurse Educator	1	50
Nursing Assistant	4	100
Pharmacist	1	100
Psychiatrist*	2	80–90
Recreation Therapist	1	100
Social Worker	3	10–100

Source: OIG review of the facility's mental health inpatient unit staffing spreadsheet and other correspondence (received from April 16 through April 23, 2025).

Note: FTEE indicates full-time equivalent employee.

**Includes one psychiatrist and one lead inpatient psychiatrist.*

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 16, 2026

From: Acting Network Director, Veterans Affairs (VA) Mid-South Healthcare Network (10N09)

Subj: Office of Inspector General (OIG) Report, Mental Health Inspection of the Lexington VA Healthcare System in Kentucky

To: Director, Office of Healthcare Inspections (54MH00)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the OIG's Office of Health Care Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. I concur with the report findings and recommendations of OIG report, Mental Health Inspection of the Lexington VA Healthcare System in Kentucky

2. I have reviewed the documentation and concur with the action plans as submitted.

3. Should you need further information, contact the Veterans Integrated Service Network (VISN) 9, Quality Management Officer.

(*Original signed by:*)

Anthony M. Stazzone, MD, MBA, FACP

[OIG comment: The OIG received the above memorandum from VHA on January 14, 2026, and an updated version on February 5, 2026.]

VISN Director Response

Recommendation 10

The Veterans Integrated Service Network Director implements processes to ensure the Veterans Integrated Service Network Mental Health Environment of Care Checklist Oversight Team provides facility guidance consistent with Veterans Health Administration requirements.

__X _Concur

_____Nonconcur

Target date for completion: Request Closure

VISN Director's Comments

Per VHA Directive 1167 Mental Health Environment of Care Checklist for Units Treating Suicidal Patients the VISN Director established a VISN MHEOCC Oversight Team (MOT) in January 2025. This team meets bi-annually following local facility completion of MHEOCC to review all partially met and unmet standards. All standards that cannot be fully met within 6 months are reviewed for appropriateness for an appeal submission. This team met in February 2025, August 2025, and will meet in February 2026. During these meetings all risk mitigation plans are reviewed to ensure they are in compliance with VHA requirements. This team also met in April 2025 to review the Inpatient Mental Health Unit out-of-cycle MHEOCC for the 1N unit in preparation for opening at Lexington VAMC. Following MOT meetings, all appeals are submitted to the national Mental Health Review Board via the LEAF portal as directed.

OIG Comments

The OIG considers this recommendation open. This will allow time for the VISN Director to submit documentation confirming the VISN MHEOCC Oversight Team was instructed to follow VHA MHEOCC guidance.

Appendix E: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 16, 2026

From: Director, Lexington Veteran Affairs (VA) Medical Center (596)

Subj: Office of Inspector General (OIG) Report, Mental Health Inspection of the Lexington VA Healthcare System in Kentucky

To: Acting Network Director, Veterans Affairs (VA) Mid-South Healthcare Network (10N9)

1. Thank you for the opportunity to review and comment on the draft report regarding the Mental Health Inspection that was conducted at the Lexington VA Health Care System.

2. I have reviewed and concurred with the recommendations and will ensure the corrective actions are completed and sustained.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care to our Veterans. We will continue to partner with the Office of Inspector General, VISN, and Lexington VA Leadership to implement corrective actions as we are committed to ensuring we serve exceptional service at our health care system.

4. Comments regarding the contents to this memorandum may be directed to the Chief of Quality.

(*Original signed by*:)

Russell W. Armstead, CGFM

[OIG comment: The OIG received the above memorandum from VHA on January 14, 2026, and an updated version on February 5, 2026.]

Facility Director Response

Recommendation 1

The Facility Director ensures the Mental Health Executive Council operates in accordance with Veterans Health Administration requirements.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

The Veterans Affairs (VA) medical facility Mental Health Executive Council (MHEC) will align with Veterans Health Administration (VHA) requirements by ensuring there is Veteran representation on the committee. Compliance will be monitored via review of the VA medical facility MHEC minutes and attendance and reported in Health Care Delivery Council.

Recommendation 2

The Chief of Mental Health ensures compliance with Veterans Health Administration requirements for a full-time local recovery coordinator.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

The Lexington VA Health Care Chief of Mental Health has temporarily assigned the duties of the Local Recovery Coordinator to Mental Health Staff as a collateral duty until a 1.0 full-time equivalent (FTE) can be appointed. This mitigation plan ensures that the expected roles and responsibilities are covered by one or more Mental Health staff members. A Mental Health Policy Waiver was approved by the Office of Mental Health on August 1, 2025, with an expiration date of February 28, 2026, following its submission in July 2025. On October 29, 2025, Chief Mental Health Officer (CMHO) and Lexington Chief of Mental Health consulted with the VHA National Office of Mental Health, which supported a plan to submit a new waiver allowing for the 1.0 FTE Local Recovery Coordinator requirement to be met by combining 0.5 FTE from two different positions. An updated waiver and timeline for the position will be submitted by Lexington. Status will be tracked and reported in MHEC.

Recommendation 3

The Chief of Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends on the inpatient mental health unit.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

The Lexington VA Health Care System Chief of Mental Health will ensure the implementation of a recovery-oriented interdisciplinary programming plan that includes a minimum of four hours on weekdays and weekends. Group offerings and attendance will be audited for 90% or greater compliance for three consecutive months and reported in MHEC.

Recommendation 4

The Facility Director considers consulting with the Office of Mental Health to clarify guidelines for design elements such as artwork on the inpatient unit.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

Adherence to the design guide and consultation from the Office of Mental Health were taken into consideration during construction of the newly renovated inpatient Mental Health unit. The unit features nine windows, each measuring 67 inches in height, allowing for ample natural light. Additionally, the space includes five scenic pictures, each measuring 48 inches by 36 inches, a floor-to-ceiling lighted meadow mural measuring 94 inches by 95 inches, and large floor-to-ceiling mural of rolling hills with fence measuring 193 inches by 101 inches. Artwork displayed in the public corridors is appropriately scaled to fit the dimensions of the space. The artwork features landscape images that evoke a sense of tranquility and restfulness. All installed artwork meets the safety standards outlined in the design guide and Mental Health Environment of Care Checklist (MHEOCC).

Lexington VA Health Care System Chief of Mental Health will seek additional consultation from the Office of Mental Health regarding the addition of artwork. Results of this consultation will be presented to the Executive Leadership Board for consideration.

Recommendation 5

The Facility Director considers alternatives to outdoor access for the inpatient unit, such as those identified in VA's *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.*

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

Considerations were taken during the development and design of the newly renovated space, including adherence to the design guide and consultation to the Office of Mental Health. In addition to the design elements discussed in response to recommendation 4, the unit encourages Veteran use of the walking path, participation in indoor recreation therapy, and regularly scheduled whole health offerings. While space constraints posed certain challenges due to the central location within a densely developed area, we optimized the available space to ensure functionality and therapeutic benefit. Nature views are strategically accessible in both public areas and patient rooms, leveraging the therapeutic benefits of biophilic design principles. The common indoor space is designed to accommodate a diverse range of activities, fostering interaction between staff and patients in an open milieu. The design features incorporate natural light, nature views, and flexible common spaces, strictly comply with the established safety standards outlined in the design guide and MHEOCC. By integrating these thoughtful features, we ensure that the renovated space meets both practical needs and therapeutic goals of our inpatient mental health services.

Lexington VA Health Care System Chief of Mental Health will seek additional consultation from the Office of Mental Health regarding alternatives to outdoor space. Results of this consultation will be presented to the Executive Leadership Board for consideration.

Recommendation 6

The Facility Director develops and implements written processes to monitor and track compliance with state laws for involuntary hospitalization and consults with the Office of General Counsel to ensure processes are consistent with applicable laws.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

The Facility Director and Mental Health Leadership have established a local Standard Operating Procedure (SOP) in compliance with state law regarding involuntary commitment. A facility subject-matter expert, who has completed national training on this topic, has been identified. The SOP is being submitted to Office of General Counsel for review to ensure processes are consistent with Kentucky state law as part of the concurrence process. Monthly audits of involuntary hospitalizations will be conducted, aiming for 90% or greater compliance with local the local SOP for three consecutive months. Results will be reported to Health Care Delivery Council.

Recommendation 7

The Chief of Staff ensures documentation of informed consent discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

Clinical documentation will be completed in accordance with the clinician Bylaws. Note templates will be revised with required field prompting informed consent discussion between prescriber and Veteran on the risks and benefits of newly prescribed medication. Random sampling of Veterans will be audited monthly to ensure that this note is completed timely and the documentation reflects informed consent, risks, and benefits of new prescribed medications. Ten audits of prescriber medication documentation of risks and benefits of newly prescribed medications will be conducted monthly, with a rate of 90% or greater compliance for three consecutive months. The compliance rates will be reported to the MHEC.

Recommendation 8

The Chief of Staff ensures veterans' discharge instructions are written in easy-to-understand language and include the follow-up mental health appointment location, the purpose of each medication, and how the medication is supposed to be taken.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

Discharge instructions will be revised to include the follow-up mental health appointment, purpose of each medication, and how the medication is supposed to be taken in an easy-to-understand language. Ten audits of discharge documentation will be conducted monthly to ensure instructions are written in easy-to-understand language and include the follow-up mental health appointment location, the purpose of each medication, and how the medication is supposed to be taken, with a rate of 90% or greater compliance for three consecutive months. Compliance rates will be reported in MHEC.

Recommendation 9

The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration requirements, including recording membership and attendance for Mental Health Environment of Care Checklist inspections.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

The participation of all required members on the Interdisciplinary Safety Inspection Team, as well as the date of the last MHEOCC training, will be documented and reported to the Environment of Care (EOC) Committee after scheduled MHEOCCs. Compliance will be monitored using meeting minutes until 90% compliance is achieved and maintained for at least one quarter.

Recommendation 11

The Facility Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards within the Patient Safety Assessment Tool.

__X _Concur

_____Nonconcur

Target date for completion: February 2026

Director's Comments

Facility Director will ensure that for each hazard identified during the MHEOCC inspections, the facility Interdisciplinary Safety Inspection Team must complete an assessment using the Risk Assessment Matrix. The risk assessment score must be entered in the Patient Safety Assessment Tool (PSAT) for each identified hazard. Quality Leadership will audit each hazard that an entry has been made into PSAT. An audit of the July 2025 and January 2026 MHEOCC will be

completed to ensure hazards are entered into the PSAT correctly. Compliance will be reported in EOC Checklist.

OIG Contact and Staff Acknowledgments

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