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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the South Texas Veterans Health Care System in San Antonio

Mental Health Inspection	25-03943-269	September 14, 2026

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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. The OIG conducted this inspection from January 12 through 29, 2026, to assess the mental health care delivered in the acute inpatient mental health unit (inpatient unit) at the Audie L. Murphy Memorial Veterans' Hospital (facility). The OIG completed the on-site portion from January 27 through 29, 2026. The facility is part of the South Texas Veterans Health Care System in San Antonio. At the conclusion of the January 2026 on-site visit, the OIG team provided the Facility Director with preliminary findings and observations from the inspection. In May 2026, facility staff provided an estimated December 2027 resolution date for environmental safety deficiencies.

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 quality of care provided on the inpatient unit. Thirteen recommendations were issued to facility leaders.

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 information on the OIG's data collection methods, see appendix A.[1]

Domain	OIG Summary
Leadership and Organizational Culture	The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care. During the on-site inspection, mental health leaders reported submitting a new bed letter to the Veterans Integrated Service Network. Veterans Health Administration's (VHA's) Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, requires 'current, complete, and accurate" reporting of bed availability.[2] The OIG made no recommendations for this domain.

[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 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, November 28, 2017.

Domain	OIG Summary
Recovery-Oriented Principles 	To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, treatment planning, therapeutic and interdisciplinary programming, and the care environment. Facility leaders did not follow VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, which requires program-specific processes for inpatient unit treatment planning.[3] Inpatient unit staff did not consistently offer veterans at least four hours of daily programming on weekends as required by VHA Directive 1160.06(1), *Inpatient Mental Health Services*.[4] The inpatient unit did not consistently meet the standards for a safe, hopeful, and healing environment outlined in VA's *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.[5] Although cameras were used on the unit to monitor veterans' safety, the facility did not have a standard operating procedure for camera use as mandated by VHA's "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units under VHA Directive 1160.06."[6] Additionally, the unit did not post signage regarding video monitoring, prohibit recording in treatment areas, or restrict video access to VA healthcare staff, as required by VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*.[7]
Clinical Care Coordination 	To assess the quality of clinical care coordination, the OIG reviewed access to services, facility procedures for involuntary treatment, medication management, and discharge planning. The facility policy outlined processes for involuntary hospitalization but did not establish written guidelines to ensure compliance with state laws for involuntary hospitalization as required by VHA Directive 1160.06(1).[8] Only 36 percent of reviewed electronic health records included documentation of prescribers discussing medication risks and benefits with veterans prior to medication administration, as mandated by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[9] Additionally, 13 percent of follow-up appointment locations and services listed in discharge instructions were described in easy-to-understand language.[10]

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023; Acting Deputy Under Secretary for Health for Operations and Management (10N), "Mental Health Treatment Planning and Software Tools," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23) et al., May 3, 2019.

[4] VHA Directive 1160.06(1), *Inpatient Mental Health Services*, December 27, 2024.

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

[6] VHA Office of Mental Health Standard Operating Procedure 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units under VHA Directive 1160.06," October 11, 2024.

[7] VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

[8] VHA Directive 1160.06(1).

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

[10] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," May 24, 2023.

Domain	OIG Summary
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 made no recommendations for this domain.
Safety 	The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. Not all required Interdisciplinary Safety Inspection Team members attended safety inspections, and attendance records were not provided to the Comprehensive Environment of Care Committee as mandated by VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.[11] Appeals for two unresolved safety element deficiencies were not resubmitted within the required time frames. In May 2026, staff reported requesting approval for a contract to resolve the safety deficiencies, with a projected completion date of December 2027. Inpatient unit staff and Interdisciplinary Safety Inspection Team members did not consistently complete Mental Health Environment of Care Checklist training.[12]

[11] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* May 12, 2017, was rescinded and replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients,* November 4, 2024. Unless otherwise specified, the two directives contain the same or similar language related to the inpatient mental health environment and inspections. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

[12] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024; VHA Office of Mental Health SOP 1167.1, "Standard Operating Procedure for Submission of MHEOCC Inspections and Appeals Under VHA Directive 1167," November 5, 2024.

VA Comments and OIG Response

Health Service Area and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). Based on information provided, the OIG considers recommendations 6 and 9 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

The Facility Director committed to formalizing written processes for inpatient mental health treatment planning, procedures for involuntary commitment legal compliance, and the use of video monitoring on the unit. The Facility Director described plans for therapeutic programming, improved discharge instructions and recovery environment of care, adherence to interdisciplinary safety inspection team requirements, and staff completion of required safety training. Facility leaders also reported updating note templates for documentation of informed consent discussions for medications.

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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 over nine million enrolled veterans.[13] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. On January 12, 2026, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the Audie L. Murphy Memorial Veterans' Hospital (facility), part of the South Texas Veterans Health Care System in San Antonio.[14] The OIG conducted inspection activities from January 12 through 29, 2026, and completed the on-site portion from January 27 through 29, 2026. At the conclusion of the on-site visit, the OIG team provided the Facility Director with preliminary findings and observations from the inspection. On May 11, 2026, facility staff provided an estimated December 2027 resolution date for inpatient mental health unit safety deficiencies.

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).[15] 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.[16] All healthcare systems must provide diagnosis, evaluation, and treatment for the full spectrum of mental health conditions. Required services include psychological and neuropsychological evaluation, evidence-based individual and group psychotherapy, pharmacotherapy, peer support, and vocational rehabilitation counseling.[17]

[13] "Mission, Vision, and Values," VA OIG, accessed December 15, 2025, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed December 15, 2025, https://www.va.gov/health/aboutvha.asp. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[14] 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.

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

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

[17] VHA Directive 1160.01. If a healthcare system does not provide required services, those services must be offered through another VA facility or program.

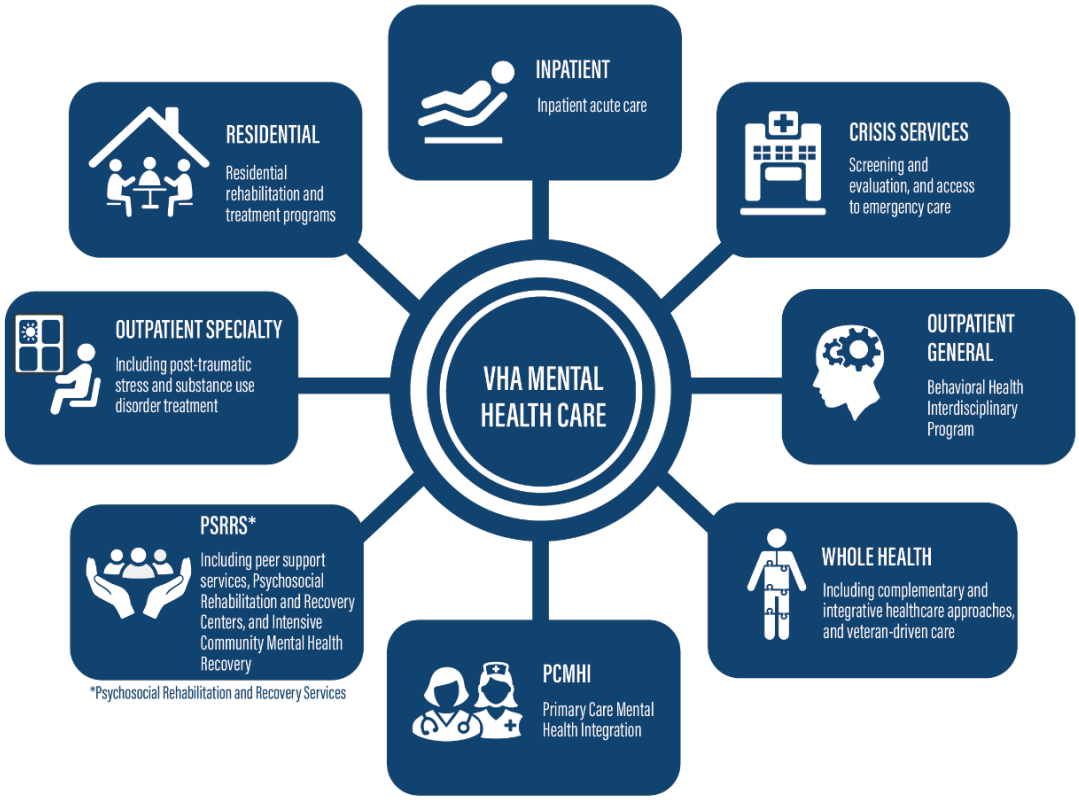

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, August 14, 2025.

In fiscal year 2025, VHA healthcare systems delivered inpatient mental health care for 63,240 veteran stays.

VHA Directive 1160.06(1), *Inpatient Mental Health Services*, 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.[18]

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.

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

About South Texas Veterans Health Care System

South Texas Veterans Health Care System is part of Veterans Integrated Service Network (VISN) 4.[19] At the time of the inspection, the health care system was part of former VISN 17; all VISN references in this report reflect the previous organizational structure. South Texas Veterans Health Care System provides acute inpatient mental health care at the facility in San Antonio. The South Texas Veterans Health Care System operates an additional facility in Kerrville and 15 community-based outpatient clinics in San Antonio, New Braunfels, Randolph Air Force Base, and Victoria, Texas.

From October 1, 2024, through September 30, 2025, the South Texas Veterans Health Care System provided outpatient health care to 123,806 veterans. Of those, 43,645 received outpatient mental health care. Inpatient mental health unit (inpatient unit) staff cared for 637 veterans and maintained an average daily census of 13.[20] According to facility data, staff submitted 22 consults for inpatient mental health care in the community during this period. Facility data indicated that the inpatient unit had 33 operating mental health beds during the inspection time frame (discussed further in Access to Care).

[19] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[20] "VHA Support Service Center Capital Assets (VSSC)," VA, accessed July 18, 2025, https://www.data.va.gov/dataset/VHA-Support-Service-Center-Capital-Assets-VSSC-/2fr5-sktm/about_data.

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."[21] 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.[22]

The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care.

Leadership Structure

At the time of the OIG's inspection, facility staff reported the healthcare system executive leadership team included the Executive Director, Chief of Staff, and Associate Director of Patient Care Services.[23] The Associate Chief of Staff, Mental Health Services (Associate Chief of Staff, Mental Health) served as the mental health lead and was responsible for all mental health programs, including the inpatient unit. The mental health lead position is required by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.[24]

Mental health and inpatient unit leaders described the organizational structure as collaborative between leaders and staff, and reported using tiered huddles (brief discipline-specific meetings on patient care) to communicate unit needs.[25] The VISN Chief Mental Health Officer reported providing support by conducting annual site visits and community of practice meetings to share knowledge between individuals across disciplines and programs.[26]

According to VHA Directive 1160.01, healthcare systems are required to establish a mental health executive council to ensure quality mental health care is delivered and includes treatment that is responsive to veteran preferences.[27] The facility Mental Health Executive Council was chaired by the Associate Chief of Staff, Mental Health and included membership representation

[21] Edgar H. Schein, *Organizational Culture and Leadership,* 4th ed, (San Francisco, CA: Jossey-Bass, 2010), https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

[22] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024.

[23] The executive leaders listed have supervisory responsibility over the inpatient unit and do not represent the healthcare system's full executive leadership team.

[24] VHA Directive 1160.01.

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

[26] VHA Acting Chief Learning Officer, "Veterans Health Administration Communities of Practice Guidebook," memorandum to VHA senior leaders and VISN Network Directors," July 26, 2021.

[27] VHA Directive 1160.01.

from inpatient unit staff, the local recovery coordinator, and the suicide prevention coordinator. The council also met the requirement to have a veteran representative.[28]

Inpatient Unit Operations

VHA Directive 1160.06(1) requires facilities to have an inpatient mental health program manager to coordinate and promote consistent, sustained, high-quality therapeutic programming on the inpatient unit.[29] The inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services.[30]

The facility identified the inpatient mental health program director in the role described above.[31] The inpatient mental health program director reported having direct patient care duties, administrative responsibilities, and oversight of inpatient unit operations and clinical services, but did not formally supervise unit staff.

Facility leaders reported using recruitment and retention tools such as an education debt reduction program, psychiatry residency programs, and competitive salaries for various clinical positions. However, facility and mental health leaders identified administrative changes such as position cuts, a hiring freeze, voluntary early retirement, and return-to-office as recruitment and retention barriers.

During the on-site inspection, the OIG observed that the unit consisted of three wings; two were gender-specific and, according to mental health leaders, one had been closed for approximately five years due to construction. Although facility data indicated 33 operating inpatient mental health beds, the OIG learned the unit had 25 operating beds with 2 beds out of service due to water leakage in their respective bathrooms.[32] The absence of timely systemic resolutions to barriers within the physical environment, discussed more in the Mental Health Environment of Care section, may have resulted in continued construction delays and stalled resolution of identified safety issues on the inpatient unit.

Mental health leaders attributed the discrepancy in bed numbers to not submitting an updated bed letter in a timely manner. VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, states that the VISN Director is responsible for ensuring that reporting of bed availability is "current, complete, and accurate."[33] During the on-site inspection, mental health leaders reported submitting a new bed letter to the

[28] VHA Directive 1160.01.

[29] VHA Directive 1160.06(1).

[30] VHA Directive 1160.06(1).

[31] VHA Directive 1160.06(1).

[32] "VHA Support Service Center Capital Assets (VSSC)," VA.

[33] VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, November 28, 2017.

VISN for approval and provided the OIG with the updated letter following the inspection. Leadership oversight and accurate bed reporting ensures operational efficiencies to minimize community care referrals and is particularly important considering this facility's ongoing construction status.

Mental health leaders reported collecting inpatient unit providers' input regarding process improvement, as required by VHA Directive 1160.01, through a mental health provider survey and inpatient mental health recovery meetings. VHA Directive 1160.01 requires facilities to have mechanisms for collecting feedback from veterans who obtain mental health services. Inpatient mental health leaders reported using a patient experience survey and leadership rounding to meet this requirement.

The OIG made no recommendations for this domain.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent value."[34] 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.[35]

The OIG examined aspects of leadership, programming, and the physical environment to evaluate the facility's integration of recovery-oriented principles on the inpatient unit.

Leadership

Local recovery coordinators play an important role in VA healthcare systems. They are considered collaborative mental health leaders who ensure recovery-oriented principles are integrated into care delivery. Their role is primarily nonclinical in nature, which allows them to dedicate most of their time to activities such as training, consultation, and education.[36]

To support veterans' recovery, VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services,* requires healthcare systems to have a full-time local recovery coordinator and a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[37] Additionally, VHA Directive 1160.06(1) requires the local recovery coordinator, in collaboration with the program manager, to establish a standard operating procedure (SOP) that includes processes for "the education, staff training, and implementation of recovery-oriented care" on the inpatient unit.[38]

Mental health leaders met the requirement in VHA Directive 1163 to have a full-time local recovery coordinator. The facility had a local recovery plan across mental health services but did not demonstrate executive leaders had reviewed the plan with concurrence. After the OIG presented this finding, executive leaders documented concurrence with the plan.

The OIG found that mental health leaders did not establish an SOP for staff training, education, and implementation of recovery-oriented services on the inpatient unit, as required by VHA

[34] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery, 10 Guiding Principles of Recovery*, 2012.

[35] US Department of Health and Human Services, HHS Publication No. SMA-09-4371, *Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions,* 2011.

[36] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025.

[37] VHA Directive 1163.

[38] VHA Directive 1160.06(1).

Directive 1160.06(1), until during the inspection.[39] The local recovery coordinator discussed ongoing collaboration with inpatient mental health leaders and staff that resulted in the incorporation of recovery-oriented elements on the unit, such as a therapeutic garden. The local recovery coordinator reported conducting recovery-oriented activities on the inpatient unit such as facilitating groups, consulting with staff, and co-leading an inpatient mental health recovery workgroup for staff.

Recovery-Oriented Treatment

VHA's "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06" requires inpatient unit staff to orient veterans to the unit and recovery-oriented care.[40] Additionally, VHA requires the interdisciplinary treatment team to develop, implement, and monitor progress on each veteran's treatment plan.[41] The local recovery coordinator and the inpatient unit nurse manager reported that staff offered veterans an orientation brochure and a recovery-oriented orientation handbook.

The facility did not have established program-specific processes for inpatient unit treatment planning requirements, as outlined in VHA Directive 1160.01.[42] The inpatient mental health program director stated that staff primarily documented treatment planning in psychiatry progress notes, but also described plans to develop an SOP and a templated note with evidence of interdisciplinary input. Additionally, the inpatient mental health program director reported that team members collaborated with veterans to discuss their individualized goals prior to the interdisciplinary treatment team meeting for treatment planning.

Inpatient unit staff offered veterans between four to six hours of recovery-oriented interdisciplinary programming on weekdays but did not ensure a minimum of four hours of daily programming on weekends, as mandated in VHA Directive 1160.06(1).[43] Mental health leaders stated that having staff on alternate work schedules would address weekend programming needs, but this posed a challenge as staff preferred working weekdays. Insufficient access to structured therapeutic programming, which is a core component of recovery-oriented care, may limit veterans' opportunities to develop skills and work toward recovery goals while hospitalized."

[39] VHA Directive 1160.06(1); South Texas Veterans Healthcare System SOP 116A-26-30, "Enhancing and Sustaining Recovery-Oriented Care within Inpatient Mental Health Units," January 13, 2026.

[40] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.3, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023.

[41] VHA Directive 1160.06(1).

[42] VHA Directive 1160.01.

[43] VHA Directive 1160.06(1).

Figure 2. *Animal-assisted therapy facilitated by recreational therapist.*
Source: Photo of the facility's inpatient unit taken by OIG staff, January 28, 2026.

Mental health leaders reported that staff offered separate programming schedules to meet the needs of female veterans. Additionally, the programming schedule included a weekly recovery action planning group; a peer support-led group for ongoing veteran education; and interdisciplinary components such as animal-assisted therapy (see figure 2).[44] During the on-site inspection, the OIG observed most group programming occurred as scheduled.

The inpatient unit demonstrated a recovery-oriented culture and veteran-centric care through staff's presence and engagement with veterans in the hallways and common areas.

Physical Environment

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care. The *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities* provides standards for healthcare systems to create hopeful and healing environments while maintaining safety. Examples of hopeful and healing elements include natural lighting, artwork, and "warm/grounding neutral earth tone paint colors with accent tones."[45]

Figure 3. *Common area (without natural lighting, warm paint colors, or artwork) and bedroom (without natural lighting or furniture beyond a bed).*
Source: Photos of the facility's inpatient unit taken by OIG staff, January 27–28, 2026.

The OIG observed the unit had aspects of a recovery-oriented environment; however, most elements did not meet VHA standards for a safe, hopeful, and healing environment.[46] Although safe, veteran bedrooms were dimly lit and painted in an off-white color, with no furniture beyond a bed. Blinds (located inside the windowpane for safety) were not adjustable, thus restricting natural light.

[44] VHA SOP 1160.06.3.

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

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

The designated male wing had a common area used for dining with a wall phone available for veteran use; however, the setup did not allow for privacy. Additionally, the common area did not have natural lighting, warm paint colors, or artwork (see figure 3, above). The Associate Chief of Staff, Mental Health reported the unit appeared "very old and institutionalized." A recovery-oriented environment that incorporates hopeful and healing elements while ensuring safety can promote veterans' engagement in their personal recovery.

The inpatient unit had access to a spacious outdoor area that included a mural and garden, which contributed to a therapeutic environment. The staff integrated designated outdoor time into daily programming to provide veterans with fresh air breaks, as recommended by VHA Directive 1160.06(1).[47]

The designated female wing had a dining area with a television but did not offer a separate space for group therapy. Instead, female veterans were escorted to a secured closed wing for groups and were allowed to access the outdoor space.

VHA's "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units under VHA Directive 1160.06" requires a facility SOP for the use of camera monitoring on the inpatient unit.[48] Additionally, VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, permits video and audio monitoring in treatment areas but prohibits the recording of images when monitoring equipment is used for patient safety purposes.[49] Only VA healthcare staff responsible for ensuring the safe delivery of care and who are authorized to take action may monitor treatment areas with video monitoring, and signs must be posted in locations where video monitoring is used.

The OIG observed cameras being used in common areas on the inpatient unit. The chief nurse, mental health reported that VA police monitored and recorded activity on the inpatient unit. The unit lacked posted signs notifying veterans that video monitoring was occurring, as required by VHA Directive 1078.[50] Additionally, the inpatient unit did not have the required facility SOP for video monitoring.[51]

[47] VHA Directive 1160.06(1).

[48] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units under VHA Directive 1160.06," October 11, 2024.

[49] VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

[50] VHA Directive 1078.

[51] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.1.

When leaders do not establish a required facility SOP and staff do not follow national policy regarding video and audio equipment use, inconsistent practices and increased privacy risks can result.

Recommendations

1. The Associate Chief of Staff, Mental Health develops and implements written processes to ensure treatment planning on the inpatient mental health unit aligns with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service* requirements.
2. The Associate Chief of Staff, Mental Health requires a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit, in alignment with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.
3. The Facility Director ensures implementation of a recovery-oriented environment on the inpatient mental health unit, consistent with Veterans Health Administration's *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.
4. The Facility Director develops and implements a written standard operating procedure for the use of video monitoring on the inpatient mental health unit, as required by Veterans Health Administration Office of Mental Health Standard Operating Procedure 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units under VHA [Veterans Health Administration] Directive 1160.06."
5. The Chief of Staff ensures that only healthcare staff have access to video monitoring in treatment areas and that video equipment is used for monitoring, not recording, in accordance with Veterans Health Administration Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*.
6. The Facility Director posts signage to notify veterans of video monitoring on the inpatient mental health unit, as required Veterans Health Administration Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*.

For detailed action plans, see appendix C.

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.[52] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[53] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a lower level of care.[54]

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 hospitalization and treatment, 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.[55] Facility leaders established a standard operating procedure (SOP) for inpatient unit admission and transfer processes, per VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[56]

During fiscal year 2025, facility staff submitted 22 consults for inpatient mental health care in the community.[57] In an interview with the OIG, mental health leaders reported that staff diverted veterans to other hospitals when there were no available beds.[58] Mental health leaders reported

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

[53] 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*, vol. 3 (August 14, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[54] VHA Directive 1160.06(1).

[55] VHA Directive 1160.01.

[56] VHA Office of Mental Health SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," December 19, 2024, was replaced by VHA Office of Mental Health SOP 1160.06.2(1), "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," on February 17, 2026. Unless otherwise specified, both versions contain the same or similar language related to inpatient unit requirements; South Texas Veterans Health Care System SOP 11-24-38, "Admission Policy," November 4, 2024.

[57] "VA Information Resource Center (VIReC), VHA Corporate Data Warehouse (CDW)," VA, accessed August 17, 2026, https://vaww.virec.research.va.gov/CDW/Overview.htm#FAQs.

[58] VHA Directive 1101.14(1), *Emergency Medicine*, March 20, 2023, amended March 7, 2025; VHA defines diversion as a "situation in which an individual who is being transferred to the ED [emergency department] from an off-campus location cannot be accepted for evaluation because the appropriate beds are not available."

once construction was completed, they anticipated seven additional operational beds. In May 2026, facility leaders estimated the project would be completed in December 2027. The delay in completion of planned construction on the inpatient unit (discussed further in Mental Health Environment of Care) could have resulted in the unavailability of operating beds, directly contributing to diversion of veteran care.

Involuntary Hospitalization and Treatment

Facility policy, "Emergency Detention" outlined written processes for involuntary hospitalization but did not include guidelines to ensure compliance with state laws, as required by VHA Directive 1160.06(1).[62] Mental health leaders described informal processes such as huddles to communicate veterans' legal (voluntary or involuntary) commitment statuses with staff. The absence of clearly defined written processes to ensure compliance with state commitment laws can contribute to the illegal hospitalization of veterans.

The facility met requirements under VA's memorandum "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts."[63] Facility leaders confirmed assigning the inpatient program coordinator as the subject matter expert point of contact to consult with facility staff and leaders who oversaw processes related to involuntary commitment.

> 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."[59]
>
> Standards and procedures for civil commitment are provided by state law and vary by state.[60] VHA requires that healthcare system leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[61]

VHA policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)" requires a registered nurse to conduct and record a review of admission documentation, including legal commitment

[59] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed September 10, 2025, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

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

[61] VHA Directive 1160.01.

[62] VHA Directive 1160.06(1); South Texas Veterans Health Care System MCP 116A-20-15, "Emergency Detention," November 24, 2020.

[63] Acting Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts," memorandum to Veterans Integrated Services Network Directors (10N1-23), July 30, 2025.

status, prior to veterans' arrival on the inpatient unit.[64] Ninety-six percent of electronic health records included evidence that nursing staff recorded veterans' legal commitment status in the appropriate note template, which exceeded the 90 percent expected compliance level.

Medication Treatment

VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, requires documentation of informed consent discussions between prescribers and veterans for newly prescribed central nervous system medications used to treat a wide range of neurologic and psychiatric conditions.[65] The OIG found only 36 percent of electronic health records reviewed included documentation of informed consent discussions between prescribers and veterans on the risks and benefits of medication use. When providers do not communicate the risks and benefits of medication, veterans may not have sufficient information needed to make informed decisions about their treatment options.[66]

Discharge Planning

In alignment with VHA Directive 1160.01, facility leaders established written guidance on care coordination processes for veterans transitioning out of the inpatient unit.[67] Additionally, mental health leaders and inpatient unit staff reported ongoing care coordination involvement with outpatient and specialty mental health providers.

All reviewed electronic health records included the required discharge instructions and had documentation that the veteran was offered a copy of the discharge instructions, as indicated in VHA's *Health Record Documentation Program Guide Version 1.2*.[68]

Most reviewed discharge instructions reflected documentation of scheduled outpatient mental health follow-up appointments prior to the veteran's discharge.[69] VHA's "Clinical Profile

[64] VHA Office of Nursing Services VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," September 20, 2022, revised September 10, 2024.

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

[66] VHA Directive 1004.01(3).

[67] VHA Directive 1160.01; South Texas Veterans Health Care System SOP 122-INPT-24-03, "Standard Operating Procedure Inpatient Mental Health Social Work – Discharge Planning," July 1, 2024.

[68] VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023, was updated and replaced with VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.3*, on February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements.

[69] VHA Office of Mental Health SOP 1160.06.2, September 29, 2023; VHA Office of Mental Health SOP 1160.06.2, December 19, 2024. These policies were rescinded and replaced with VHA Office of Mental Health SOP 1160.06.2(1) on February 17, 2026. For the purposes of this report, the policies contain the same or similar language related to discharge planning.

Management Business Rules," specify follow-up outpatient appointment locations and services should be in easy-to-understand language and free from abbreviations and acronyms.[70]

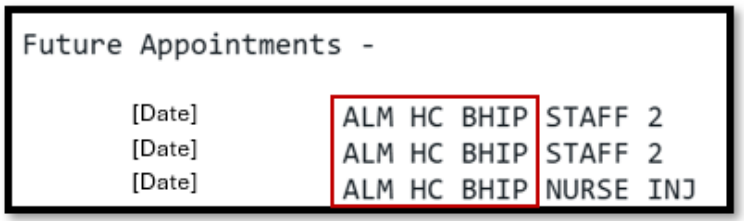

Figure 4. *Example from discharge instructions with abbreviated appointment location information outlined in red.*
Source: OIG review of veterans' electronic health records.

The OIG found most records did not have discharge instructions with easy-to-understand language for follow-up appointment locations and services (see figure 4). In an interview with the OIG, the inpatient mental health program director reported that mental health leaders approved patient-friendly clinic names for hospital discharges with anticipated implementation in March 2026. Discharge instructions with abbreviated location information can create barriers for veterans to attend follow-up appointments and receive timely mental health care.

All reviewed records included documentation that a medication list was provided at discharge and most discharge instructions included the reasons for the prescribed medications.[71] Most discharge instructions were free of medical abbreviations that could be difficult for non-medically trained individuals to understand (see figure 5).[72]

[70] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," updated May 24, 2023.

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

[72] VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.2*; VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.3.*

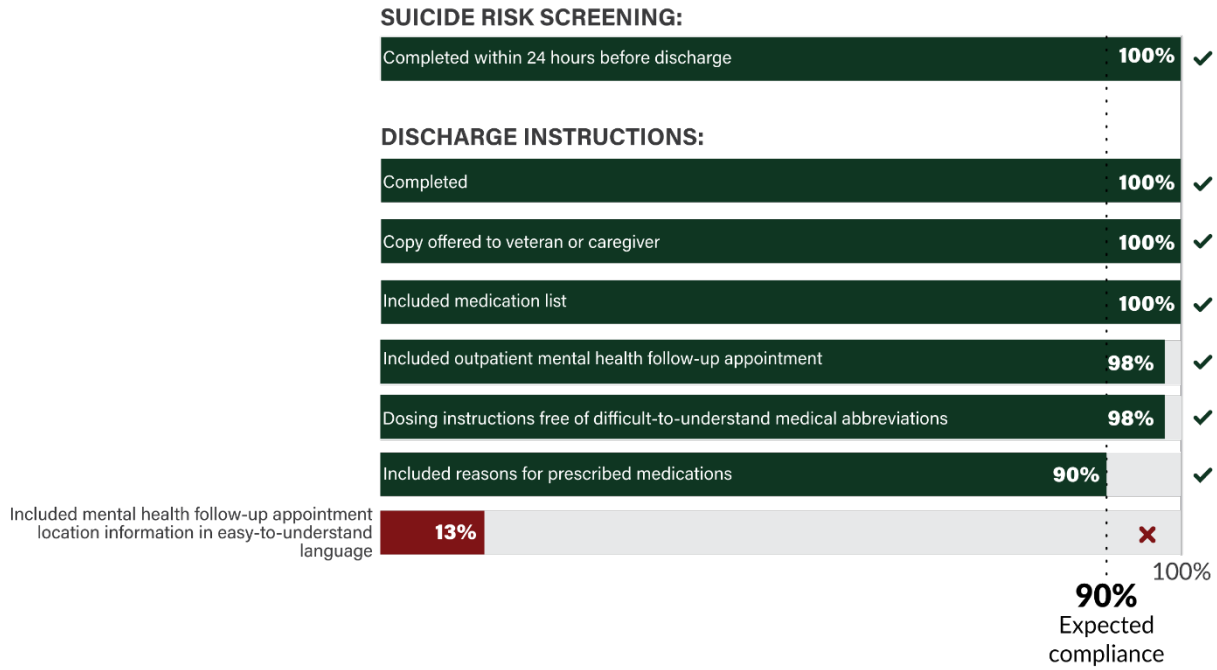

Figure 5. *Discharge-related screening and documentation.*
Source: OIG review of inpatient unit electronic health records.
Note: Based on analysis of 50 records. Suicide risk screening discussed in Suicide Prevention (below).

Recommendations

7. The Facility Director develops and implements written processes to ensure compliance with state involuntary commitment requirements in Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.
8. The Chief of Staff requires documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance, in accordance with Veterans Health Administration Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.
9. The Chief of Staff ensures discharge instructions include appointment locations in easy-to-understand language, consistent with Veterans Health Administration's "Clinic Profile Management Business Rules."

For detailed action plans, see appendix C.

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.[73]

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."[74] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[75]

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

Suicide Risk Screening and Evaluation

The "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting" 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.[76] Inpatient unit clinical staff consistently completed suicide risk screenings within the required time frame in all reviewed electronic health records (see figure 5, above).[77]

VHA memorandum "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update" requires facility directors or designees to implement SOPs for suicide risk screening and evaluation and directs executive leaders to identify a champion to ensure staff

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

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

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

[76] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting," (fact sheet), updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (RISK ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director, et al., November 23, 2022, was rescinded and replaced by "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum on January 7, 2025.

[77] VA, "VA Suicide Risk Identification Strategy, Minimum Requirements by Setting," updated May 10, 2023, February 25, 2025, and October 30, 2025; While VHA requires staff to complete Columbia-Suicide Severity Rating Scales 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 electronic health record reviews.

stay informed of national updates.[78] Facility leaders established a local standard operating procedure and identified a facility champion, per the memorandum requirements.[79]

Safety Planning

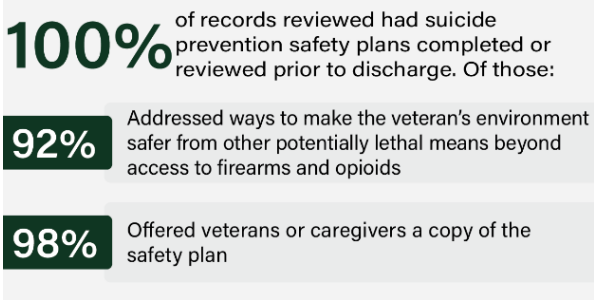

Figure 6. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' electronic health records.

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."[80]

The OIG found that inpatient staff consistently completed or reviewed safety plans prior to discharge, which is a requirement by VHA Office of Mental Health SOP 1160.06.2(1), "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06."[81]

Most reviewed safety plans had documentation that staff provided a copy of the plan to veterans or caregivers.[82]

Most reviewed safety plans had documentation that staff addressed ways to make the environment safer from other potentially lethal means beyond firearms and opioids, as outlined in the *VA Safety Planning Intervention Manual* (see figure 6).[83]

[78] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11) "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum.

[79] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; South Texas Veterans Health Care System SOP 116A-25-31, "Suicide Risk Identification and Management," July 22, 2025.

[80] Barbara Stanley and Gregory K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* 19, (2012): 256-264, https://doi.org/10.1016/j.cbpra.2011.01.001.

[81] VHA Office of Mental Health SOP 1160.06.2, September 29, 2023, updated on December 19, 2024. Previous versions of this policy were rescinded and replaced with SOP 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the three policies contain similar language regarding safety planning processes.

[82] VHA Office of Mental Health SOP 1160.06.2(1), February 17, 2026.

[83] VA, *VA Safety Planning Intervention Manual*, updated February 23, 2022.

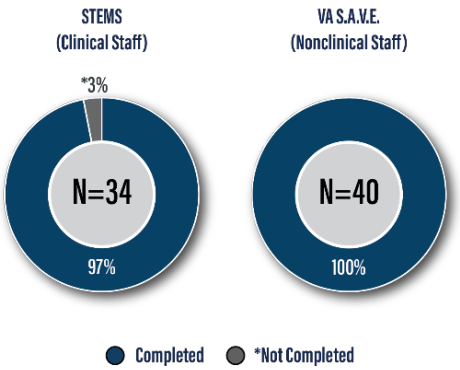

Figure 7. *Inpatient unit staff completion of mandatory suicide prevention trainings.*
Source: OIG document review of clinical and nonclinical staff training records.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings from January 12, 2025, to January 11, 2026.

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 and supporting next steps) help clinicians and nonclinical staff, respectively, identify the warning signs of suicide risk and appropriate interventions.[84]

The OIG determined that the facility met the 95 percent target for inpatient unit staff completion of STEMS and VA S.A.V.E training established in the "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ [Frequently Asked Questions]" (see figure 7).[85]

The OIG made no recommendations for this domain.

[84] 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.

[85] VHA Office of Suicide Prevention, "Suicide Prevention Mandatory Training Dashboard FAQ," accessed April 15, 2026, https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators/SitePages/Education-and-Training.aspx. (This site is not publicly accessible.)

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."[86] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[87]

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

Mental Health Environment of Care

VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, outlines expectations for environment of care inspections.[88] The Interdisciplinary Safety Inspection Team (safety inspection team), comprised of both mental health and other facility staff, is responsible for conducting environment of care inspections using the Mental Health Environment of Care Checklist.[89] The National Center for Patient Safety continually updates this checklist "based on reports from the field of hazards or adverse events encountered at the local level."[90] Inspection team members are required to use this comprehensive checklist of more than 140 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[91]

As outlined in VHA Directive 1167, the safety inspection team should include an inspection lead, inpatient mental health unit program director, inpatient unit nurse manager, suicide prevention coordinator, patient safety manager, representative from engineering or facilities

[86] VHA Directive 1160.06(1).

[87] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and 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 inpatient mental health unit interdisciplinary safety inspection team and Mental Health Environment of Care Checklist inspections and training requirements. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

[88] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[89] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[90] "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. This website provides an explanation of the Mental Health Environment of Care Checklist but does not link directly to the checklist.

[91] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, October 24, 2025, updated April 29, 2026, https://dvagov.sharepoint.com/sites/vhancps/SitePages/Mental-Health.aspx. (This site is not publicly accessible.) The October 2025 version was in place during the inspection time frame.

management, and "one additional clinical staff from any discipline or work area."[92] The safety inspection team is required to report to the facility environment of care committee, with team membership, attendance, and findings documented as part of the inspection rounds summary.[93]

The facility had an established safety inspection team and team lead and conducted inspections at the required frequency.[94] Although the safety inspection team recorded meeting minutes and provided summaries to the Comprehensive Environment of Care Committee, the biannual inspection attendance was not included, limiting senior leaders' opportunity to monitor required attendance.[95] Additionally, not all required inspection team members attended environment of care inspections.[96] When inspection team members do not attend Mental Health Environment of Care Checklist inspections, environmental hazards may go unrecognized and unabated.

The OIG observed adherence to most of the high-risk safety elements reviewed during a physical inspection of the unit. However, staff did not count flatware before and after meals, as required on the Mental Health Environment of Care Checklist, to ensure veterans do not use the flatware for self-harm or to harm others.[97] Prior to the OIG leaving the facility, mental health leaders addressed this process deficiency by specifically documenting the flatware count at meals.

Per VHA Standard Operating Procedure (SOP) 1167.1, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Inspections and Appeals Under VHA Directive 1167," when identified hazards cannot be corrected within six months, an appeal must be submitted to the Office of Mental Health.[98] Through the appeal a facility can request additional time, up to two years, to resolve the deficiency.[99] At the time of the inspection, the facility had six appeals for unresolved safety elements on the inpatient unit.[100] Specifically, appeals had been repeatedly approved and in place for six years for deficiencies related to sinks and toilets with anchor points that created safety risks for veteran hanging. Additionally, an appeal for paper towel dispensers, which also created a safety risk for veteran

[92] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[93] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024. The new directive revised the reporting requirements for the safety inspection team.

[94] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[95] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[96] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[97] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, November 18, 2025.

[98] VHA Office of Mental Health SOP 1167.1, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Inspections and Appeals Under VHA Directive 1167," November 5, 2024.

[99] VHA Office of Mental Health SOP 1167.1.

[100] VHA Office of Mental Health SOP 1167.1. "VA medical facilities must submit an appeal request with a mitigation plan for each partially met or not met Mental Health Environment of Care Checklist item when the item cannot be fully corrected to meet compliance within 6 months of submitting the MHEOCC [Mental Health Environment of Care Checklist] inspections results."

hanging, had been in place for more than four years. Although these appeals had risk mitigation plans identified, the mitigation strategies were primarily person-dependent, such as nursing staff completing 15-minute observation checks of the deficiencies. Further, there was no documentation to support that risk mitigation occurred as expected.[101] At the request of the OIG, mental health leaders created and implemented a document to record the 15-minute observations. The chief nurse of mental health reported this risk mitigation strategy placed an ongoing burden on nursing staff.

According to engineering staff, a contract was in place to address deficiencies related to toilets, sinks, and paper towel dispensers; however, the contract was terminated due to not having the materials essential for completion of the work. At the time of the inspection, there was no projected completion date for this project. On May 11, 2026, in response to the OIG's request for an update, facility staff reported requesting VISN approval for an emergency contract to remediate the deficiencies, with an estimated completion window of December 2027. The delay in resolving deficiencies in the physical environment perpetuates significant safety risks to veterans on the inpatient unit.

Per VHA SOP 1167.1, if additional time is needed to resolve the deficiency, a new appeal request must be submitted to the Mental Health Environment of Care Checklist (MHEOCC) Review Board at least three months prior to the expiration date.[102] The OIG found two of the six appeals were not resubmitted within the required time frame. Resubmitting timely appeals allows the Office of Mental Health to review risk mitigation plans and provide feedback as needed.

Training

VHA Directive 1167 requires staff to be trained on environmental hazards and oriented to the use of the Mental Health Environment of Care Checklist.[103] Additionally, VA medical facility leaders must attest that required staff have completed the training, per VHA SOP 1167.2, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Attestations Under VHA Directive 1167."[104]

[101] VHA Office of Mental Health SOP 1167.1.

[102] VHA Office of Mental Health SOP 1167.1.

[103] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[104] VHA Office of Mental Health SOP 1167.2, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Attestations Under VHA Directive 1167," November 5, 2024.

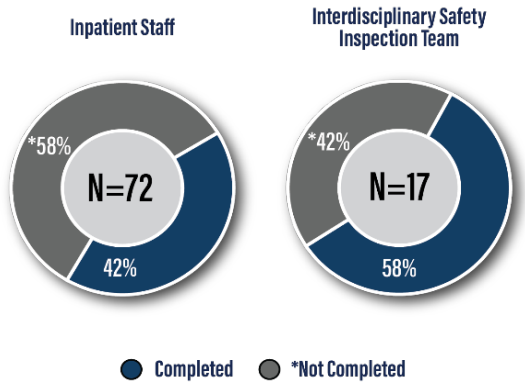

Figure 8. *Mental Health Environment of Care Checklist training completion.*
Source: OIG document review of staff training records for inpatient unit and safety inspection team staff.
Note: The OIG evaluated completion of the training from January 12, 2025, through January 11, 2026. Safety inspection team staff who were also inpatient unit staff are included in the denominator for both document reviews.

Facility leaders complied with the required attestation of training completion from May 4, 2025, through January 11, 2026. However, the OIG found that inpatient unit staff and safety inspection team members did not consistently complete required annual training (see figure 8).[105] Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.

Recommendations

10. The Facility Director requires all Interdisciplinary Safety Inspection Team members attend biannual inspections and record attendance consistent with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.
11. The Facility Director directs the Interdisciplinary Safety Inspection Team to provide biannual inspection attendance to the Comprehensive Environment of Care Committee, as required by Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.
12. The Facility Director ensures staff complete appeals within the required time frame in accordance with Veterans Health Administration Office of Mental Health Standard Operating Procedure 1167.1, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Inspections and Appeals Under VHA [Veterans Health Administration] Directive 1167."
13. The Facility Director directs staff to complete the required Mental Health Environment of Care Checklist training as required by Veterans Health Administration

[105] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.

For detailed action plans, see appendix C.

Conclusion

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

The facility demonstrated compliance with some, but not all, VHA requirements evaluated for inpatient mental health care. Facility leaders had a formalized Mental Health Executive Council that included required staff and veteran representation.

During the on-site inspection, mental health leaders reported submitting a bed change request letter to the VISN to accurately record the number of operating inpatient unit beds.

Facility policy included guidelines for involuntary hospitalization; however, facility leaders did not have formal processes to ensure compliance with state laws.

Mental health leaders met the requirement to have a plan across mental health care to direct veteran-centered, recovery-oriented care. However, the required standard operating procedure for the staff training, education, and implementation of recovery-oriented services on the inpatient unit was not established until during the inspection. Additionally, mental health leaders also did not have established processes that outlined inpatient unit treatment planning requirements.

Staff offered the required amount of interdisciplinary programming on weekdays but did not consistently meet the four-hour daily minimum programming on weekends. Only 36 percent of reviewed electronic health records included required documentation of informed consent discussions between prescribers and veterans on medication risks and benefits. When released from inpatient hospitalization, 13 percent of discharge instructions with follow-up appointment locations and services were described in easy-to-understand language. All reviewed records included evidence of timely suicide risk screening and safety planning, and 92 percent of safety plans addressed ways to make the veteran's environment safer from potentially lethal means. Most inpatient clinical staff and all inpatient nonclinical staff completed required suicide training.

Veterans who received inpatient mental health treatment at the facility experienced a physical environment that did not incorporate natural lighting, warm paint colors, or artwork. The facility lacked a policy governing the use of video monitoring on the inpatient unit. Contrary to VA policy, VA police used cameras on the unit to monitor and record veterans. Additionally, no signage was posted to inform veterans that video monitoring was in use.

Despite the limitations of the physical environment, the OIG observed veteran-centric care through staff's presence and engagement with veterans in the hallways and common areas. Additionally, veterans had access to a spacious outdoor area that included a mural and garden.

The facility had an established interdisciplinary safety inspection team, including a lead, and completed the required biannual environment of care inspections of the unit. However, the biannual inspection attendance was not included in the summaries provided to the Comprehensive Environment of Care Committee, and not all required inspection team members attended inspections. Not all appeals were resubmitted within the required time frame. Not all inpatient unit staff and inspection team members completed required annual Mental Health Environment of Care Checklist training. The OIG issued 13 recommendations to the Facility Director; Chief of Staff; and Associate Chief of Staff, Mental Health.

These recommendations may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond. For the open recommendations, the OIG will follow up on the planned actions until they are completed.

The Facility Director committed to formalizing written processes for inpatient mental health treatment, procedures for monitoring and tracking compliance with state involuntary commitment laws, and the use of video monitoring on the unit. The Facility Director described plans for recovery-oriented, interdisciplinary weekend programming, discharge instructions in easy-to-understand language, improvements to the recovery environment of care, adherence to interdisciplinary safety inspection team requirements, and staff completion of required safety training. Facility leaders also reported updating provider progress note templates to include documentation of informed consent discussions for medications.

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: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[106] The OIG randomly selected the VHA healthcare systems included in fiscal year 2026 reviews from all systems with inpatient mental health beds.[107] The OIG conducted a virtual and on-site review at the facility and did not receive complaints beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed VHA and facility policies, standard operating procedures, and guidance documents in effect at the time of the inspection. Additionally, the OIG reviewed 12 months of healthcare system Mental Health Executive Committee meeting minutes. 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 reviewed select staff's training records for annual completion of Skills Training for Evaluation and Management of Suicide (STEMS), VA S.A.V.E (Signs of suicide, Asking about suicide, Validating feelings, and Encouraging help and supporting next steps), and Mental Health Environment of Care Checklist trainings.[108] 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 and Mental Health Environment of Care Checklist training.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of the Inspectors General on Integrity and Efficiency's standards.[109] 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 took full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. Office of Healthcare Inspections teams do not use AI as the

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

[107] The OIG identified health care 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 2026, the OIG excluded facilities with inpatient mental health beds that the OIG inspected in fiscal years 2024 and 2025. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[108] VHA Directive 1071(1); VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

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

principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact 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.*"[110]

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 appendix B and appendix C.

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.[111] 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, 2024, through September 30, 2025.[112] The OIG reviewed for documentation of a risk and benefit discussion specific to veterans who were newly prescribed central nervous system medications (used for treatment of "a wide range of neurological and psychiatric conditions") during the inpatient stay.[113] 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.[114] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as

[110] 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.

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

[112] The OIG identified the electronic 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.

[113] VHA Directive 1004.01(3); 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.

[114] VHA Directive 1160.06(1).

natural lighting, artwork, and calming paint colors. The OIG also observed the unit for cleanliness and veteran access to secure outdoor space.[115] Further, the OIG's physical inspection of areas in the inpatient unit focused on selected safety elements specific to this facility.

The OIG reviewed the Mental Health Environment of Care Checklist data documented in the Patient Safety Assessment Tool, the software tool VHA uses to document these types of inspections, and assessed corrective actions taken for deficiencies that were unresolved for more than six months.[116]

[115] VHA Directive 1160.06(1); VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities;* VHA Directive 1850.01(1), *Health Care Environmental Sanitation Program,* March 29, 2023.

[116] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety; VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

Appendix B: Health Service Area Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 6, 2026

From: Acting Executive Director, Department of Veterans Affairs (VA) Health Service Area 4.3

Subj: Mental Health Inspection of the South Texas Veterans Health Care System in San Antonio

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with the Office of Inspector General's draft report entitled – South Texas Veterans Health Care System in San Antonio.
2. Furthermore, I have reviewed and concur with the Medical Center Director's action to the recommendations.
3. Should you have any questions or require further information, please contact the Health Service Area 4.3 Quality Management Officer.

(*Original signed by:*)

Jamie D. Park, Ed.D.
Interim Health Service Area 4.3 Director, Veterans Health Administration

[OIG comment: The OIG received the above memorandum from VHA on August 7, 2026.]

Appendix C: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 6, 2026

From: Director, South Texas Veterans Health Care System (671)

Subj: Mental Health Inspection of the South Texas Veterans Health Care System in San Antonio

To: Acting Executive Director, Department of Veterans Affairs (VA) Health Service Area 4.3

1. We appreciate the opportunity to review and comment on the OIG draft report. The Healthcare System concurs with the recommendations and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality and Risk Management.

(*Original signed by*:)

Julianne Flynn, MD
Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on August 7, 2026.]

Healthcare System Director Response

Recommendation 1

The Associate Chief of Staff, Mental Health develops and implements written processes to ensure treatment planning on the inpatient mental health unit aligns with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service* requirements.

__X__Concur

_____Nonconcur

Target date for completion: February 2027

Director's Comments

On July 9, 2026, a Standard Operating Procedure (SOP) entitled Inpatient Mental Health Treatment Planning was submitted and is currently being routed through Quality and Patient Safety (QPS) Light Electronic Action Framework (LEAF) system for approval and is pending Policy Coordinator approval. On April 16, 2026, the inpatient mental health team members were educated on new requirements and expectations for documentation of the Behavioral Health Recovery Plan using the respective note title in Computerized Patient Record System (CPRS). The Inpatient Mental Health Program Coordinator initiated random Recovery Plan audits in May 2026 and will continue with a goal of 90% sustained compliance for a period of 6 months. Audit results will be reported monthly to the Mental Health (MH) Community of Practice (CoP), and minutes from the MH CoP will be submitted to the MH Executive Council Meeting quarterly for oversight and provided quarterly to the Clinical Executive Board (CEB). The MH Associate Chief of Staff (ACOS) will also present an executive summary of findings to the Executive Leadership Team (ELT) monthly briefing.

Recommendation 2

The Associate Chief of Staff, Mental Health requires a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit, in alignment with Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.

__X__Concur

_____Nonconcur

Target date for completion: March 2027

Director's Comments

MH ACOS identified a current inpatient unit staff member to work weekends in support of the 4 hours mandatory programming. Efforts are underway to hire a full-time staff member with an alternate work schedule for the inpatient unit that will provide weekend programming. MH Inpatient Recovery Workgroup reviews group programming audit on a biweekly basis, including identifying and monitoring action steps to address gaps. The Workgroup representative reports weekend programming audit results to the MH CoP monthly. Minutes from the MH CoP will be submitted to the MH Executive Council Meeting quarterly and provided to the CEB. MH Leadership will monitor compliance until 90% compliance is established for 6 consecutive months.

Recommendation 3

The Facility Director ensures implementation of a recovery-oriented environment on the inpatient mental health unit, consistent with Veterans Health Administration's *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

__X__Concur

_____Nonconcur

Target date for completion: December 2027

Director's Comments

On June 23, 2026, MH Leadership received approval to close the ground-level female inpatient mental health unit for repairs with a start date of July 11, 2026, and an expected completion date of July 19, 2026. An extension was requested and approved to continue the closure of the unit until July 27, 2026. Items being addressed during the closure include enhancing the environment of care by adding new paint colors, replacing old mattresses, purchasing new ligature resistant linens, replacing the shower curtains with new aesthetic and safe doors, and plumbing repairs.

On June 16, 2026, a Statement of Work (SOW) was submitted to Engineering with the Mental Health Environment of Care Checklist (MHEOCC) standards, which has since been released for bids. The estimated date for completion of this project is December 2027. The MH Administrative Officer (AO) will continue working with Engineering for updates and monitoring of this SOW, and updates will be reported monthly at the ELT service level briefings.

Recommendation 4

The Facility Director develops and implements a written standard operating procedure for the use of video monitoring on the inpatient mental health unit, as required by Veterans Health Administration Office of Mental Health Standard Operating Procedure 1160.06.1, "Standard Operating Procedure for Maintaining Safety and Security on Inpatient Mental Health Units under VHA [Veterans Health Administration] Directive 1160.06."

__X__Concur

_____Nonconcur

Target date for completion: October 2026

Director's Comments

The Inpatient Mental Health Program Coordinator completed a draft SOP which governs policies surrounding use of video monitoring on the inpatient mental health unit and has requested review by the facility Privacy Director and will request feedback from the National Office of Mental Health (OMH). Progress toward the SOP publication will be reported monthly to the MH CoP and once approved, will be routed in LEAF for review by QPS for eventual publication. MH CoP chair will provide an Executive Summary of meeting minutes detailing this progress, which will be presented to the MH Executive Council quarterly. The MH ACOS will also present an executive summary of findings to the ELT monthly briefing.

Recommendation 5

The Chief of Staff ensures that only healthcare staff have access to video monitoring in treatment areas and that video equipment is used for monitoring, not recording, in accordance with Veterans Health Administration Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*.

__X__Concur

_____Nonconcur

Target date for completion: October 2026

Director's Comments

The current SOP draft for video monitoring is being reviewed by local Privacy Director for concurrence with Veterans Health Administration (VHA) Directive 1078, Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings. Following this review, MH Leadership will request consultation with National OMH to review procedural content to ensure consistency with VHA Directive 1160.06(1), Inpatient Mental Health Services. Feedback from both local Privacy Director and National OMH will be included in future draft revisions of the video monitoring SOP. In the interim, the facility is installing privacy screens on video monitors to ensure monitors are only visible by healthcare staff. The Interdisciplinary Safety Inspection Team (ISIT) Chair will report the status of this SOP and clinical practice to the Environment of Care Safety Committee (EOCSC) as part of monthly report until the SOP and clinical practice is consistent with Directive 1078 and Directive 1160.06.1.

Recommendation 6

The Facility Director posts signage to notify veterans of video monitoring on the inpatient mental health unit, as required Veterans Health Administration Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*.

__X__Concur

_____Nonconcur

Target date for completion: January 2026

Director's Comments

MH leadership procured signage on the unit, which has been installed since January 2026. Signage remains in place as of the date of this action plan.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 7

The Facility Director develops and implements written processes to ensure compliance with state involuntary commitment requirements in Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.

__X__Concur

_____Nonconcur

Target date for completion: February 2027

Director's Comments

SOP 116A-26-35, Involuntary Mental Health Evaluation and Treatment was submitted to Office of General Counsel (OGC) for review on January 28, 2026 and returned on February 12, 2026 without findings or need for procedural revisions. This SOP was published on June 1, 2026, detailing procedures for monitoring and tracking compliance with state involuntary commitment requirements. The tracking document specified in this SOP, Involuntary Mental Health Hold/Commitment, was published on July 13, 2026, and records health factors related to involuntary mental health treatment, and the National OMH orders for inpatient mental health legal status have been implemented as of June 30, 2026. An interdisciplinary compliance team involving psychiatry, social work, and Quality Management (QM) clinicians has been created to receive medical record notifications for involuntary admissions and will be monitoring compliance with applicable orders and medical record documentation to establish at least 90% compliance for six consecutive months, which the Inpatient Mental Health Program Coordinator will report monthly to the facility MH CoP. Minutes from the MH CoP will be provided to the

MH Executive Council quarterly for oversight and will be provided to the CEB. The MH ACOS will also present an executive summary of findings to the ELT monthly briefing.

Recommendation 8

The Chief of Staff requires documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance, in accordance with Veterans Health Administration Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.

__X__Concur

_____Nonconcur

Target date for completion: March 2027

Director's Comments

The Inpatient Mental Health Program Coordinator requested Clinical Applications Coordinator (CAC) assistance updating provider progress note templates. Specifically, selections were added for documenting informed consent discussions between prescribers and Veterans (or guardian/authorize surrogate when indicated) on the risks and benefits of newly prescribed medications prior to administration on the inpatient mental health unit. Monthly audits will be conducted until at least 90% compliance with documenting risk/benefit discussions for all newly prescribed medications is established for at least 6 consecutive months. The Inpatient Mental Health Program Coordinator will report findings on monthly basis to the facility MH CoP until compliance goals are met. Minutes from the MH CoP will be provided to the MH Executive Council quarterly for oversight and will be provided to the CEB. The MH ACOS will also present an executive summary of findings to the ELT monthly briefing.

Recommendation 9

The Chief of Staff ensures discharge instructions include appointment locations in easy-to-understand language, consistent with Veterans Health Administration's "Clinic Profile Management Business Rules."

__X__Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

On March 15, 2026, Group Practice Management completed the updates of MH clinic names to patient-friendly names that include clinic names and locations in easy-to-understand language, the type of appointment (therapy or psychiatry) and the name of the provider in clinic. The Inpatient Mental Health Program Coordinator consulted both CAC and Office of Information

Technology (OIT) to have new data objects built which populate these revised, easy-to-understand clinic names into discharge notes and instructions. These updates were applied on April 24, 2026.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 10

The Facility Director requires all Interdisciplinary Safety Inspection Team members attend biannual inspections and record attendance consistent with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.

__X__Concur

_____Nonconcur

Target date for completion: August 2027

Director's Comments

The facility ISIT charter was approved by the Clinical Executive Board (CEB) on June 10, 2026. Attendance records will be collected by the ISIT Chair, and these records will be submitted to the EOCSC for reporting on a biannual basis (January and July). Attendance will be monitored and recorded biannually during MHEOCC inspections. Attendance records presented to EOCSC will also be reported by the MH ACOS at the ELT briefing. Attendance records will be monitored until 90% compliance is achieved for at least 2 consecutive biannual periods.

Recommendation 11

The Facility Director directs the Interdisciplinary Safety Inspection Team to provide biannual inspection attendance to the Comprehensive Environment of Care Committee, as required by Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.

__X__Concur

_____Nonconcur

Target date for completion: August 2027

Director's Comments

The ISIT Chair began reporting attendance to the EOCSC in June 2026 and will provide ongoing inspection attendance reports biannually. The EOCSC reports to Healthcare Operations Executive Board, chaired by the Associate Director of Resources, which reports to Joint

Leadership Council chaired by the Facility Director. Attendance records will be monitored until 90% compliance is achieved for at least 2 consecutive biannual periods.

Recommendation 12

The Facility Director ensures staff complete appeals within the required time frame in accordance with Veterans Health Administration Office of Mental Health Standard Operating Procedure 1167.1, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Inspections and Appeals Under VHA [Veterans Health Administration] Directive 1167."

__X__Concur

_____Nonconcur

Target date for completion: March 2027

Director's Comments

Expired appeals were submitted by the ISIT Chair in January and February 2026 consecutively, and these were approved by the National Mental Health Environment of Care Checklist Review Board Members in March 2026. The ISIT charter was approved by the CEB on June 10, 2026, which establishes the ongoing responsibilities for monitoring and submission of timely appeals in accordance with VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients. The Charter was submitted to LEAF for routing and approval by the Facility Director on July 20, 2026, and is expected to be approved and signed by September 2026. Additionally, the ISIT team established and uses an internal tracker to monitor all appeals' expected renewal dates and expiration dates to ensure timely submissions and renewals. Compliance with submission of appeals will be monitored monthly through reporting to the EOCSC with a goal of 90% sustained compliance for a period of 6 months.

Recommendation 13

The Facility Director directs staff to complete the required Mental Health Environment of Care Checklist training as required by Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.

__X__Concur

_____Nonconcur

Target date for completion: March 2027

Director's Comments

The MH leadership team will ensure assigned staff have completed the mandatory MHEOCC training. The MH AO will monitor monthly reports from Education Service on the completion

rates of MHEOCC training, with a goal of establishing a minimum of 90% compliance for at least 6 consecutive months. Compliance reports will be shared in the MH CoP monthly meetings and the Mental Health Executive Council. Training rates presented to MH CoP will also be reported by the MH ACOS at the monthly ELT briefing.

OIG Contact and Staff Acknowledgments

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