US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Bedford Healthcare System in Massachusetts

Healthcare Facility Inspection	25-00247-234	September 28, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Bedford Healthcare System (the facility) from July 22 through 24, 2025, and performed additional follow-up in June 2026. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to about 20,300 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations based on its findings.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The facility did not have printed maps to help patients navigate the hospital, and the website map did not include directions to all facility locations. The *VA Signage PG-18-10, Design Manual* requires facilities to provide accessible and comprehensive navigational tools to support all veterans.[3] The team also found damaged walls and concrete walkways, unsecured medication and sharps (objects that can penetrate skin, such as needles), dusty equipment, and cluttered exit corridors. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to ensure a safe and clean healthcare environment.[4] The OIG made five recommendations for corrective action.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.

[1] VHA classifies facilities based on their complexity level. Low-complexity facilities have "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2025 Through June," VHA Support Service Center, last updated March 18, 2026, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer. (This web page is not publicly accessible.)

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025.

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

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[5] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate actions throughout the facility to support patient and visitor navigation, in alignment with *VA Integrated Wayfinding & Recommended Technologies.*
2. The Director takes appropriate steps to repair exterior walkways and mitigate identified safety hazards, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.
3. The Director takes appropriate actions to improve the cleanliness, safety, and maintenance of patient care areas, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.
4. The Director implements measures to keep exit pathways free of obstructions, as required by the Joint Commission *Standards Manual*, Life Safety, 02.01.20.
5. The Director requires the Comprehensive Environment of Care Committee to monitor corrective actions for identified findings and report on the sustainability of improvements, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

[5] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments).[6] Based on information provided, the OIG considers all recommendations closed.

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[6] 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.

Abbreviations

ADPCS	Associate Director, Patient Care/Nursing Service
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[7] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[8]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[9]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[10]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[11]

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[7] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[8] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

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

[10] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

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

The VA Bedford Healthcare System (the facility) includes the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford and three community-based outpatient clinics.[12] A facility leader reported the medical care budget for fiscal year (FY) 2025 was approximately $342 million, and the facility had 21 acute psychiatry, 51 domiciliary, 42 transitional residence, and more than 200 community living center beds.[13]

Figure 1. *Facility photo.*
Source: "Edith Nourse Rogers Memorial Veterans' Hospital," VA, accessed August 7, 2025, https://www.va.gov/bedford-healthcare.

The OIG inspected the facility from July 22 through 24, 2025, and performed additional follow-up in June 2026. The executive leaders referred to throughout this report include the Acting Medical Center Director (Acting Director); Acting Associate Director; Associate Director, Patient Care/Nursing Service (ADPCS); and Chief of Staff.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[14] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and

[12] "Locations," VA, accessed August 19, 2025, https://www.va.gov/bedford/locations.

[13] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. Compensated work therapy "provides evidence based and evidence informed vocational rehabilitation services" for veterans as well as other supports and partnerships for employment. "Compensated Work Therapy," VA, accessed July 21, 2026, https://department.va.gov/cwt. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/clc.

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

assess their level of trust in VA).[15] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[16]

System Shocks

Facility leaders described three separate communication network outages that occurred because of interruptions in power during FY 2025 as system shocks. They said the unexpected outages occurred during generator testing and ranged from approximately 15 to 90 minutes. Each outage disrupted communication systems, including email and phones, and executive leaders said there was no impact on patient care. Employees traced the interruptions to a defective circuit breaker, which they replaced. The OIG team received an update from facility staff on June 4, 2026, stating that a project to correct the generator issue was developed and had an estimated completion date of December 31, 2026.

During each outage, leaders collaborated with engineering and information technology employees and activated an incident command center (a standard, organized response framework for emergency situations) to manage communications.[17] Specifically, leaders explained they used alternative communication methods such as mass text messages.

OIG questionnaire respondents also identified executive leader turnover as a system shock. The chief of quality management reported the previous director retired in January 2025, and the former associate director left the position in November 2024. Executive leaders reported the turnovers were disruptive because each new leader had their own communication process and expectations for employees. During an interview, the OIG team learned of mitigating actions: The Acting Director walked around the facility to speak directly to employees, and the Chief of Staff and ADPCS ensured they sent consistent messages to service chiefs and employees throughout the transitions. The Acting Director said the January 2025 federal hiring freeze (in effect from January 20, 2025, to October 15, 2025) required leaders to pause recruiting for the director and associate director positions, but VHA leaders were reviewing both positions so they could authorize hiring for them.[18] The facility's accreditation coordinator reported that a facility

[15] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[16] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[17] VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020.

[18] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025.

director was officially appointed on February 22, 2026. However, as of June 4, 2026, the associate director position remained filled in an acting capacity, and the hiring process for a permanent associate director was still ongoing.

Employee Experiences

Of the 202 respondents to the OIG questionnaire, approximately 75 percent indicated they felt comfortable reporting patient and safety concerns. From the facility's internal website and the chief of quality management, the OIG team learned about additional ways executive leaders recognized employees, such as recurring Daisy and Bee awards, to celebrate nurses and nursing assistants, respectively.[19] Executive leaders reported they had previously given these awards annually, but because of so many employee nominations, they now present them quarterly.

Approximately 40 percent of respondents to the OIG questionnaire replied that the facility's culture was moving in the right direction. Executive leaders said this resulted from treating each employee with respect and a concerted effort to offer professional certifications. For example, in the facility's strategic plan, the ADPCS reported that staff created and distributed a guidebook for employees earning professional certifications that facility leaders supported.[20] The ADPCS explained that leaders made information easy for employees to access to reduce certification barriers and help them improve their annual proficiency ratings. Several janitorial employees earned the Certified Health Care Environmental Services Technician certificate, and some restorative nursing assistants obtained national certification.[21]

Veteran Experiences

The facility's VSignals trust scores were between 95–97 percent during the first and second quarter of FY 2025, which exceeded the VHA average of 94 percent during that time. In response to an OIG questionnaire, the facility liaison reported sharing survey results and patient letters with employees during weekly town halls and visits to work areas. The Acting Director stated that most letters are positive, and many recognize employees and convey thankfulness.

Executive leaders said they help resolve veterans' concerns quickly by offering office hours when veterans can interact directly with them. The Chief of Staff explained that meeting veterans in person to discuss providers' clinical decisions was more effective than sending templated letters. These conversations allowed leaders to more clearly explain decisions to veterans and enabled them to resolve any issues when veterans disagreed with the decision. An example of a

[19] "Employee Information," VA, accessed February 11, 2026, https://dvagov.sharepoint.com/VHABED/employee. (This website is not publicly accessible.)

[20] VA Bedford Healthcare System, *Strategic Plan Fiscal Years 2024-2028*, revised May 2025.

[21] The Certified Health Care Environmental Services Technician certification confirms an individual has the skill set to clean, disinfect, and help prevent infection in a healthcare setting. "Certified Health Care Environmental Services Technician (CHEST)," Association for the Health Care Environment, 2026, https://www.ahe.org/certification/chest.

successful meeting was after a veteran experiencing homelessness requested to meet with the Acting Director. The Acting Director discussed the veteran's current unhoused status and worked with a health coordinator to connect the veteran with case management and to help find housing.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[22] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[23]

General Inspection

The inspection team observed several well-marked parking lots, which included spaces accessible to those with disabilities. However, the team also observed out-of-order tags on emergency call boxes in outdoor areas, with a posted phone number to call for help. Facility staff explained they deactivated the call boxes to troubleshoot intermittent connectivity issues, but the problem had been difficult to identify, and they did not have an estimated completion date as of June 4, 2026.

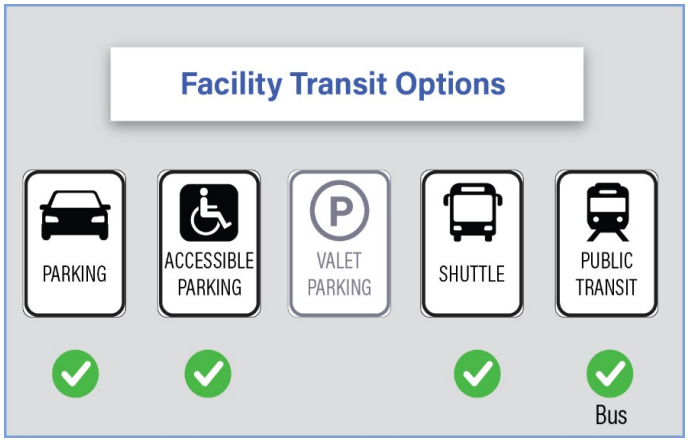

Figure 2. *Transit options for arriving at the facility. Source: OIG observations.*

The team also observed easy-to-read signs that direct veterans to the main entrance. OIG questionnaire respondents indicated the facility does not offer valet parking, but there is a shuttle

[22] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[23] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC [environment of care].02.06.01, July 1, 2025.

bus that provides rides to and from any campus location. A separate shuttle service provides transportation between the main facility and the three community-based outpatient clinics.

Inspectors also noted signs at building entrances that guide veterans to specific areas or units. However, there were no posted or printed maps of buildings available. When asked for printed maps, facility staff directed the OIG to an interactive map on the facility's website.[24] However, the map did not provide directions between all the buildings and did not list the library and chapel, which may prevent veterans from independently locating services. Facility staff became aware of this issue when they observed the OIG inspection team trying to use the interactive map. According to the *VA Integrated Wayfinding & Recommended Technologies*, facilities are required to provide accessible and comprehensive navigational tools to support all veterans.[25]

Recommendation 1

The Director takes appropriate actions throughout the facility to support patient and visitor navigation, in alignment with *VA Integrated Wayfinding & Recommended Technologies*.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The facility evaluated its existing wayfinding resources to ensure Veterans and visitors have accessible and comprehensive options for navigating the campus and independently locating services.

The facility utilizes MedMap, an online virtual wayfinding application that provides navigational assistance throughout the campus. In response to the identified finding, the facility also implemented a printed MedMap pamphlet that mirrors the online wayfinding system to provide Veterans and visitors with an accessible paper-based alternative. Printed wayfinding pamphlets are readily available at the main entrances of the campus for individuals who prefer or require a paper navigation tool.

The facility has also enhanced physical wayfinding throughout the campus. Permanent directional signage using easily recognizable symbols has been installed at the main campus entrances to assist Veterans and visitors in identifying and locating services. In addition, numeric building identifiers have been placed on the flooring throughout the tunnel system to provide additional visual cues and assist Veterans and visitors with navigating between buildings.

[24] "Bedford Healthcare System," VA, accessed July 15, 2025, https://v2.interactive.medmaps.com/bedfordva.

[25] VA, *Integrated Wayfinding & Recommended Technologies*.

The facility recognizes that campus construction, clinic relocations, and changes in service locations require ongoing evaluation and maintenance of wayfinding resources. Accordingly, the MedMap system and associated printed materials are reviewed and updated as necessary to reflect clinic relocations, construction projects, changes in building use, and other changes that may affect campus navigation. This ongoing review is intended to ensure that navigational information remains accurate, current, and useful to Veterans and visitors.

Through the combination of online interactive wayfinding, printed navigational materials, permanent directional signage, and enhanced building identification within the tunnel system, the facility has established multiple wayfinding options to support Veterans and visitors in independently locating services throughout the campus. The facility requests closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

While inspecting the outside of the facility, the OIG team found exterior walkways with cracked and crumbled concrete. There was damaged concrete at the main entrance curbside drop-off area, in a parking area, and on many sidewalks throughout the facility. Uneven, cracked, and crumbling concrete increases the risk of falls. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to ensure a safe and clean environment.[26]

Recommendation 2

The Director takes appropriate steps to repair exterior walkways and mitigate identified safety hazards, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The facility evaluates the safety of exterior walkways and other exterior infrastructure through ongoing Environment of Care monitoring, safety assessments, and infrastructure management processes. Identified conditions are evaluated for hazard potential, impact on Veterans, employees, and visitors, level of risk, and appropriate corrective action.

[26] VHA Directive 1608(1).

VA Bedford Healthcare System completed its Annual VA Risk Assessment – Infrastructure & Environmental Conditions in June 2026. The assessment identifies infrastructure and environmental risks identified by facility Safety staff and evaluates each condition based on hazard potential, potential impact to Veterans and employees, risk level, and recommended corrective action. Identified infrastructure needs are prioritized based on risk, and project designs have been initiated for identified deficiencies requiring more extensive repairs and are awaiting funding.

Since the OIG inspection, the facility has taken corrective action to address damaged exterior concrete and improve accessibility in several areas of the campus. Repairs have been completed at the main entrance curbside drop-off area in front of Building 78, in front of Building 10, in the parking area surrounding Building 4, and at various staircases throughout the campus. In addition, handicap-accessible ramps were installed at Buildings 7 and 9 to improve safe and accessible access to these buildings. These corrective actions address conditions that presented potential trip, fall, and accessibility concerns and demonstrate the facility's ongoing efforts to identify and mitigate exterior safety hazards for Veterans, employees, and visitors.

In addition, VCT Project #518-26-704 for masonry repairs is currently underway to address damaged concrete and masonry conditions at staircases throughout the campus. The estimated completion date for this project is October 31, 2026. The facility will continue to monitor the identified areas during Environment of Care rounds and through routine safety assessments while corrective work is in progress.

For conditions requiring more extensive replacement rather than minor repair, the facility has initiated planning for a FY28 project to fully replace damaged stairs, steps, and handrails throughout the campus. This longer-term project is intended to address aging infrastructure and provide a more comprehensive correction of exterior accessibility and safety concerns.

The facility will continue to evaluate exterior walkways, stairs, steps, curbs, and related infrastructure through routine Environment of Care inspections, safety assessments, and work-order/project tracking. Identified hazards will be documented, prioritized based on risk, and referred for appropriate corrective action which are reported to the executive leadership team through the Healthcare Operations Committee. Completed repairs will be monitored through subsequent inspections to verify that corrective actions were effective and that exterior walkway conditions remain safe for Veterans, employees, and visitors.

Through these processes, the facility is evaluating exterior walkway safety, implementing immediate and interim corrective actions when hazards are identified, and pursuing longer-term infrastructure improvements to address systemic or recurring conditions. The facility requests closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

As to cleanliness and infection control, the OIG team found dust on a ceiling fan and on a heating, ventilation, and air conditioning grill in the Denali and Acadia community living centers. There was also dust on wall-mounted medical tools (otoscope and ophthalmoscopy sets, to examine ears and eyes, respectively) in a primary care exam room, permanently stained textured flooring in a shower, and damaged walls in the Acadia community living center.[27] A previous OIG report from April 2024 also identified damaged walls.[28]

When staff do not maintain a clean environment, as required by VHA Directive 1608(1), it can increase the risk of infection for veteran patients as well as employees. Facility staff explained that although Environmental Management Services staff regularly clean all areas, the dusty grill, ceiling fan, and medical tools had escaped their attention. They also said the shower floor texture made it difficult to clean over time but could not explain why staff had not repaired the damaged walls.

Recommendation 3

The Director takes appropriate actions to improve the cleanliness, safety, and maintenance of patient care areas, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The facility implemented a facility-wide work order management platform to strengthen operational oversight and ensure timely identification, assignment, tracking, and resolution of environmental, maintenance, and safety concerns. In FY26 to date, the platform has facilitated the closure of 4,280 work requests. The system provides enhanced visibility of outstanding work, supports assignment to the appropriate responsible service, and enables leadership to monitor the status and timely completion of requests through resolution. The facility utilized this work order management platform to specifically address the damaged walls identified by OIG in the Acadia Community Living Center. Work orders were entered and completed for wall repair and painting in Building 62, Acadia, providing

[27] An otoscope examines "the condition of the ear canal and eardrum." MedlinePlus, "Otoscope Examination," last reviewed May 2, 2024, https://medlineplus.gov/ency/8771. "Ophthalmoscopy is an examination of the back part of the eye." MedlinePlus, "Ophthalmoscopy," last reviewed January 20, 2025, https://medlineplus.gov/article/003881.

[28] VA OIG, *Comprehensive Healthcare Inspection of the VA Bedford Healthcare System in Massachusetts*, Report No. 23-00101-137, April 11, 2024.

documented evidence of corrective action and resolution. This process also strengthens ongoing oversight by ensuring identified environmental deficiencies are formally tracked from identification through completion.

Environmental Management Services (EMS) developed standardized cleaning guides and Job Aides to establish consistent environmental cleaning practices and expectations across the EMS workforce. The guides provide specific, hour-by-hour responsibilities so staff have clear expectations regarding required cleaning and inspection activities. The guides include specific tasks such as checking vents, HVAC grills, and ceiling fans and cleaning them as needed, as well as cleaning and disinfecting common-area bathrooms and shower rooms. The Job Aides provide staff with detailed procedures for the cleaning of specific equipment (i.e. wall mount fan) per manufacturer guidelines. Standardizing these expectations promotes consistency across shifts and staff assignments and provides a clear framework for staff accountability.

To further address the shower-floor condition identified by OIG, monthly and as-needed power washing of shower floors was implemented in the Acadia Community Living Center and throughout all Community Living Centers. EMS evaluates textured shower flooring during routine cleaning and inspection activities to ensure surfaces remain cleanable and appropriately maintained. When staining, deterioration, or other environmental conditions cannot be adequately addressed through routine cleaning, the concern is referred through the facility work order process for evaluation and corrective action. This provides both a routine cleaning intervention and an established mechanism for escalation when environmental conditions require additional repair or replacement.

In Primary Care, clinical staff implemented a biweekly patient-care equipment cleaning checklist requiring staff to document completion of disinfection of patient-care equipment, including wall-mounted medical equipment such as otoscope and ophthalmoscope sets, as well as examination tables. The Primary Care Nurse Manager has reinforced the expectation that patient-care equipment and examination surfaces are cleaned and disinfected after each patient appointment. The biweekly checklist is maintained on the Primary Care SharePoint site and is accessible to all Primary Care staff. Compliance is monitored by the Nurse Manager, providing an ongoing mechanism to identify gaps, reinforce staff accountability, and validate adherence to established cleaning expectations.

Compliance with the actions to improve the cleanliness, safety, and maintenance of patient care areas was monitored until at least 90 percent compliance was achieved and sustained for three (3) consecutive months. The facility requests closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

The Joint Commission *Standards Manual*, LS [life safety] 02.01.20 also requires exits to be clear of obstructions or impediments.[29] Inspectors observed wheelchairs, soiled laundry in hampers, clean linen in carts, computers on wheeled stands, and medication carts stored in exit pathways in both community living centers. Storing equipment in hallways could delay safe and efficient evacuations during emergencies.

Recommendation 4

The Director implements measures to keep exit pathways free of obstructions, as required by the Joint Commission *Standards Manual*, Life Safety, 02.01.20.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

Upon identification of the discovery, the facility immediately addressed the identified obstructions and impediments within designated means of egress. Wheelchairs, soiled laundry hampers, clean linen carts, computers on wheeled stands, and medication carts were removed from exit access routes and relocated to appropriate designated storage or staging areas.

The facility conducted a review of the affected areas to identify appropriate locations for the storage and staging of equipment while maintaining required exit access pathways. Unit and service leadership were reinforced on the requirement to maintain designated means of egress free of obstructions and impediments at all times.

Re-education was provided to staff regarding the importance of maintaining unobstructed means of egress and the appropriate storage and staging of equipment, including wheelchairs, soiled laundry hampers, clean linen carts, computers on wheeled stands, and medication carts.

To support early identification and correction of unsafe conditions, the facility established a new Unsafe Working Conditions Reporting Site, which is readily accessible to all employees through the facility homepage. This reporting mechanism allows any staff member to report an unsafe environmental or safety condition, including obstructed exit access routes, for timely review and follow-up.

The facility also incorporated unobstructed exit access into routine Environment of Care (EOC) multidisciplinary safety rounds. The multidisciplinary rounding team identifies environmental and life safety concerns, ensures the appropriate subject matter experts and points of contact are included in the rounding process, and assigns identified findings to the appropriate responsible party for corrective action.

[29] The Joint Commission, *Standards Manual*, E-dition, LS [life safety].02.01.20, July 1, 2025.

Within the Community Living Centers (CLCs), Nurse Managers perform daily rounds using a standardized rounding document to assess environmental and safety conditions, including verification that designated exit access routes remain clear of equipment, supplies, carts, and other potential impediments. Nurse Managers are required to attest to completion of the daily rounds and sign the standardized rounding document, which is then uploaded to the Associate Chief Nurse (ACN) for review and accountability. This process provides a standardized mechanism for documenting completion, identifying deficiencies, and ensuring leadership oversight of compliance with unobstructed means of egress requirements.

In addition, the Healthcare Quality & Performance Management team conducts random environmental audits throughout the facility to assess compliance with life safety requirements, including maintaining unobstructed means of egress. Findings are addressed in real time when identified, and staff are provided immediate feedback regarding the importance of maintaining clear exit access routes and compliance with applicable Joint Commission Life Safety requirements.

Compliance measures to keep exit pathways free of obstructions was monitored until at least 90 percent compliance was achieved and sustained for three (3) consecutive months. The facility requests closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

The OIG team identified several repeat environment of care findings from previous oversight inspection reports.[30] VHA Directive 1608(1) requires leaders to watch for repeat or similar environmental issues at facilities; they must check for patterns and confirm staff resolve issues. When leaders do not oversee corrective actions, problems may persist.

Recommendation 5

The Director requires the Comprehensive Environment of Care Committee to monitor corrective actions for identified findings and report on the sustainability of improvements, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

[30] The Joint Commission, *Final Accreditation Report Edith Nourse Rogers Memorial Veterans Hospital, Behavioral Health Care and Human Services*, *Home Care*; VA OIG, *Comprehensive Healthcare Inspection of the VA Bedford Healthcare System in Massachusetts*.

Director Comments

The facility has implemented a systematic process to monitor Environment of Care (EOC) findings for repeat or similar deficiencies, track corrective actions, and provide ongoing leadership oversight to ensure corrective actions are effective and improvements are sustained.

The facility utilizes Performance Logic reporting to identify and trend similar or repeat EOC findings and to monitor reportable metrics, including corrective action completion timelines. Previously identified deficiencies for the respective areas are reviewed by the Comprehensive Environment of Care (CEOC) Coordinator prior to subsequent CEOC inspections. During subsequent inspections, the CEOC Coordinator specifically evaluates the area for repeat deficiencies, unresolved findings, and conditions that are similar in nature to previously identified deficiencies. When a repeat finding is identified, the CEOC Coordinator documents the finding as a repeat deficiency. Upon closure of repeat findings, the CEOC Coordinator verifies that the corrective actions documented in the deficiency have been completed.

The CEOC Coordinator gathers the required reportable EOC data for review monthly by the CEOC Committee per VHA Directive 1608(1). The CEOC Committee is a multidisciplinary committee that includes the Associate Director, Chief of Engineering, Safety Program Manager, Infection Prevention, Chief of Environmental Management, and other applicable disciplines. Among other requirements, the committee reviews identified trends by deficiency category. Trending deficiency categories are considered for required annual Performance Improvement Plans (PIP). Deficiencies identified by the assigned Responsible Service as being unable to be closed out within the required 14-day timeline are assigned Action Plans by the respective service. The CEOC Committee monitors the open Action Plans and reviews the information monthly as required and addresses identified concerns. Monitoring Action Plans promotes staff ownership and accountability for implementing timely solutions to identified problems. Deficiencies identified as being difficult to observe correction over long periods of time, such as cleaning or improperly stored equipment deficiencies will sometimes be selected for random review of correction after deficiency closeout by the CEOC Coordinator. Repeat deficiencies identified under those circumstances would be brought to the attention of the CEOC Committee and identified within the CEOC Committee Meeting Minutes.

The CEOC Committee also evaluates whether corrective actions are producing sustained improvement by reviewing subsequent CEOC inspection results, repeat or similar findings, deficiency trends, monthly performance measures, and corrective action completion. This allows the committee to determine whether an identified deficiency has remained resolved over time or whether additional intervention is necessary.

To provide ongoing leadership oversight, CEOC findings and identified trends are reported through the Healthcare Operations Committee (HOC), chaired by the Associate Director. Information reported to and reviewed through this process includes the current status of the CEOC rounding schedule to meet annual inspection requirements, deficiencies closed or addressed through an Action Plan within 14 days, monthly performance measures, top

deficiency trends, repeat findings, and the status of corrective actions. This information allows leadership to monitor not only whether corrective actions have been completed, but also whether improvements are sustained and whether previously identified concerns recur.

Through this process, the facility monitors for repeat and similar EOC deficiencies, tracks the timeliness and completion of corrective actions, evaluates the effectiveness and sustainability of improvements through subsequent inspections and performance data, and provides ongoing multidisciplinary and executive leadership oversight. This process supports the facility's ability to identify patterns, prevent recurrence, and sustain improvements over time.

The facility requests closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The facility had service-level workflows that outline the test result communications process, but the Geriatrics and Extended Care workflow did not include nurses' roles and responsibilities. VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* requires facilities to create workflows that outline each team members' role in the process.[31] When staff do not clearly understand expectations, it may delay care. The Chief of Staff reported being unaware that nurses were missing from the workflow and updated it during the inspection. Therefore, the OIG did not make a recommendation in this report.

Action Plans and Process Improvements

The facility had no recommendations from prior oversight reports related to test result communications.[32] Staff said the accreditation coordinator tracks oversight findings to ensure

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

[32] VA OIG, *Comprehensive Healthcare Inspection of the VA Bedford Healthcare System in Massachusetts*. The Joint Commission, *Final Accreditation Report Edith Nourse Rogers Memorial Veterans Hospital, Behavioral Health Care and Human Services, Home Care*.

staff sustain compliance with corrective actions. Further, facility staff stated that facility leaders regularly visit clinical patient care areas to observe practices, identify issues firsthand, and educate staff as needed. Facility staff discuss action plan compliance trends at monthly meetings and meet with stakeholders such as engineering and safety staff to resolve issues.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[33] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

Primary care leaders reported vacancies for four providers, two registered nurses, four licensed practical nurses, and two medical support assistants across 18 primary care teams as of the July 2025 inspection. At that time, they stated these vacancies were in various hiring stages with one provider having an expected start date and another a tentative offer. According to a June 4, 2026, update, both providers began employment in fall 2025. To increase the applicant pool, leaders expanded provider recruitment efforts to nurse practitioners, and they planned to convert a licensed practical nurse vacancy to an intermediate care technician position. They also advertised the medical support assistant positions. Cross-trained staff were supporting primary care teams as needed.

Based on the data available at the time of the inspection in July 2025, the OIG found that average wait times for new primary care patients had increased from 23.5 days in FY 2024 to 30.4 in the second quarter of FY 2025.[34] Primary care leaders attributed the increase to the staffing vacancies stated above. The leaders reported they used clinical resource hub and float staff to cover the vacancies and offered community care to eligible veterans.[35] The OIG acknowledges that facility leaders were making multiple efforts to address the problem and therefore did not make a recommendation.

[33] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

[34] VHA Support Services Center.

[35] Clinical Resource Hubs are "VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH.

Community Care Staffing and Access to Care

Facility leaders reported an increase in community care referrals based on care decisions that patients and their facility providers agree to and are in the patients' best medical interest. Facility staff reported these referrals increased from about 459 in FY 2024 to 686 in FY 2025. Community care leaders attributed the increase to the 2025 implementation of the Senator Elizabeth Dole 21st Century Veteran's Healthcare and Benefits Improvement Act, which allowed facility providers to make best medical interest referrals to community providers without additional clinical review.[36] Leaders anticipated continued additional workload for the facility's community care staff based on the increased referrals.

The OIG found that the top three types of care patients received in the community were home health, dental, and diagnostic imaging and radiology. Community care leaders within the facility told the OIG that referrals for dental care in the community had increased in the previous six months due to facility staffing challenges; community care leaders cited three dentist vacancies and said it was difficult to retain dental hygienists. Facility staff reported vacancies were in various stages of the recruitment process at the time of the inspection in July 2025.

The OIG also discussed concerns with facility leaders about appointment scheduling delays and community care staff's problems receiving electronic health record documents from community providers. The OIG reviewed facility data and found it took an average of 11 days to schedule patients for a community care appointment in the second quarter of FY 2025, which is longer than the expected 7-day time frame in VHA's *Consult Timeliness Standard Operating Procedure*.[37] The leaders shared difficulties communicating with community providers to schedule patients' appointments due to the length of time some community providers take to review and accept referrals—some up to a week to complete this process. Also, some patients chose to self-schedule directly with community providers, but staff did not always receive timely appointment information needed to document the referral as scheduled. As a result, staff had difficulty meeting scheduling goals despite their efforts.

To reduce delays and facilitate document retrieval from community providers who do not use existing VHA systems, community care staff use electronic faxing and have access to two community electronic health record systems. Additionally, community care staff use electronic health record system notifications to inform providers of results from community providers. Facility primary and community care leaders and primary care staff did not report any incidents

[36] Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Pub. L. No.118-210, 138 Stat. 2706 (2025).

[37] "Average Days to First Scheduled" VHA Support Service Center (VSSC), https://vssc.med.va.gov/home. (This website is not publicly available.) VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," June 12, 2025.

of patient harm related to scheduling or community provider documentation delays. Because of these actions to address scheduling timeliness, the OIG did not issue a recommendation.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[38]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.[39] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[40] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program

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

[39] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024.

[40] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.* Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens, a veteran can typically stay between 4 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[41]

Performance and Improvement Highlights

- The facility's program met the intake percentage (HCHV5) target in FY 2024 but fell short for quarters one and two of FY 2025. Facility program staff attributed not meeting the measure in the first half of FY 2025 to two employees being on extended leave.
- The program missed the exit to permanent housing (HCHV1) and negative exit (HCHV2) targets in FY 2025. Program staff said they face challenges finding permanent housing because affordable units and rentals are scarce. Staff also were working with contractors to limit negative discharges due to substance abuse, first-time rule violations, or medical issues.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[42] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[43]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[44]

Performance and Improvement Highlights

- The facility's program did not reach the voucher use (HMLS3) target from FY 2024 through the second quarter of FY 2025. Program staff cited barriers such as limited

[41] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

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

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

[44] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

affordable housing, facility program staffing vacancies, and veterans' poor rental histories and low credit scores.

- The program also appeared to fall short of the employment (VASH3) target for FY 2024; the program supervisor stated new staff incorrectly entered veterans' employment data in the Homeless Operations Management and Evaluation System (a VA database). After the supervisor trained staff, the program met the target in the first and second quarters of FY 2025. Staff reported they partnered with community organizations to help veterans find work.
- Staff described enhanced program services at housing facilities where many veterans live as a positive factor. The facility's program employs a nurse to manage veterans' medications and medical needs, an occupational therapist to ensure safe mobility, a physical therapist to provide movement and flexibility therapy, a nursing assistant to help with walking and daily activities, and a recreational therapist to organize group activities.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[45] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[46]

Performance and Improvement Highlights

- The facility's program met the enrollment (VJP1) target from FY 2024 through the second quarter of FY 2025. The facility's homeless program supervisor attributed this to staff correctly entering enrolled veterans into the Homeless Operations Management and Evaluation System.
- Facility program staff said they streamlined the court referral process to connect veterans to local VA services faster. Previously, all state district court referrals through a facility program coordinator could take up to a month. Now, court liaisons send referrals directly to local coordinators, often on the same day.

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

[46] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

Conclusion

To assist leaders in evaluating the quality of care at the Bedford facility, the OIG conducted an inspection across five domains. The OIG made five recommendations related to facility navigation; exterior walkway safety; cleanliness, safety, and maintenance in patient care areas; unobstructed exit pathways; and environment of care oversight. Facility leaders implemented corrective actions, which resulted in the OIG closing all recommendations. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[47] The OIG administered a voluntary questionnaire to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. Additionally, the OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from July 22 through 24, 2025, and performed additional follow-up in June 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[48] 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 AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact 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.*[49]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[50] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[47] The accreditation reports covered the time frame of January 13, 2020, through July 17, 2025—the most recent available at the time of the inspection.

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

[49] 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.

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

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[51] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 12, 2026

From: Director, VA North Atlantic Health Network (10N1)

Subj: Healthcare Facility Inspection of the VA Bedford Healthcare System in Massachusetts

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report regarding the healthcare inspection report at the VA Bedford Healthcare System. The VA North Atlantic Health Network is committed to providing exceptional healthcare to Veterans.
2. I thank the OIG team for their recommendations which identified areas for improvement.
3. The leadership teams at VA Bedford Massachusetts Healthcare System and the Veterans Integrated Network Office are committed to implementing corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans that we serve.

(Original signed by:)

Ryan S. Lilly, MPA
Veterans Integrated Service Network 1 Director
Veterans Health Administration

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 4, 2026

From: Director, VA Bedford Healthcare System (518)

Subj: Healthcare Facility Inspection of the VA Bedford Healthcare System in Massachusetts

To: Director, VA North Atlantic Health Network (10N1)

Thank you for the opportunity to review the Office of Inspector General (OIG) Healthcare Facility Inspection Draft Report for VA Bedford Healthcare System. I have completed a thorough review of the report and concur with the OIG's recommendations.

The facility has completed the necessary corrective actions to address the identified deficiencies, and I concur with the responses submitted for each recommendation. Based on the completion of these actions, I respectfully request closure of the recommendations.

Should additional information or documentation be required, please contact the Chief, Healthcare Quality.

(Original signed by:)

Barrett Franklin, MS, MBA, FACHE, CCE
Executive Director, Bedford VA Healthcare System

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.