US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Southern Nevada Healthcare System in North Las Vegas

Healthcare Facility Inspection	25-00215-32	February 3, 2026

OUR MISSION

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

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Southern Nevada Healthcare System (facility) from April 29 through May 1, 2025.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders described system shocks as shortages of medical providers in their geographic area (see Primary Care for a detailed discussion); lack of community providers' participation in VA's community care program; VA operational

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

changes, which included VHA's strategic hiring initiative, return to in-person work, and concerns about reductions in force; and infrastructure issues.[2]

Executive leaders said it was difficult to find community providers due to limited participation in the VA community provider network. One example was a urologist group who left community care because of the large amount of required paperwork. The Chief of Staff described seeking alternative treatment options for veterans, such as out-of-state VA facilities or telehealth providers.[3]

Executive leaders also discussed operational changes, such as VHA's fiscal year (FY) 2024 strategic hiring initiative, as a system shock. OIG questionnaire respondents identified the FY 2025 return to in-person work, and potential reductions in force as additional system shocks that increased worry the government would eliminate their positions. Executive leaders further explained infrastructure issues such as broken air conditioners, water leaks, and aging medical equipment also negatively affected the facility.

The Patient Advocate said staff are responsive to veterans' concerns, including long appointment wait times.[4] Executive leaders described regular communication with veterans and veterans service organizations, strengthened by monthly meetings and a Veterans and Family Advisory Committee, which uses veterans' feedback to improve care at the facility.[5]

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[2] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed October 9, 2025, https://www.va.gov/community. "Heads of all departments and agencies in the executive branch of Government shall, as soon as practicable, take all necessary steps to terminate remote work arrangements and require employees to return to work in-person at their respective duty stations on a full-time basis, provided that the department and agency heads shall make exemptions they deem necessary." Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025). VHA directed leaders to "make strategic, Veteran-centric decisions about which positions we should be hiring, filling, or managing through attrition." Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23) Medical Center Directors (00), VHACO Program Office Leadership, May 31, 2024; "In the Federal Government, layoffs are called reduction in force (RIF) actions. When an agency must abolish positions, the RIF regulations determine whether the employee keeps his or her present position, or whether the employee has a right to a different position." "Reductions in Force (RIF)," Office of Personnel Management, accessed June 10, 2025, https://www.opm.gov/policy-data/workforce-restructuring.

[3] Telehealth is "health care provided remotely to a patient in a separate location using two-way voice and visual communication (as by computer or cell phone)." *Merriam-Webster*, "Telehealth," accessed July 24, 2025, https://www.merriam-webster.com/telehealth.

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

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

Environment of Care

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

The OIG observed cleanliness issues such as dust on medical equipment and dirty microwaves used for warming veterans' food. The OIG also noted inconsistent labels to show whether reusable medical equipment was clean and ready for use, which poses a risk to veterans' safety, and issued a recommendation. In response, the Executive Director reported leaders implemented labeling procedures, educated staff, and began compliance audits to ensure staff clean and label reusable medical equipment (see OIG Recommendations and VA Responses).

Further, the OIG observed two ceiling leaks, one above the Emergency Department and Pharmacy and another above the Primary Care Clinic. Engineering staff completed temporary repairs to the latter during the inspection. Facility leaders did not repair the leak above the Emergency Department and Pharmacy because doing so would significantly disrupt operations. Instead, they chose to address it as part of a planned maintenance project. The OIG did not make a recommendation because leaders initiated and secured project funding to correct the issue.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG determined staff had processes to communicate urgent, noncritical test results to providers and patients, per VHA requirements.[6]

However, the Chief of Staff identified a challenge with laboratory staff communicating results to physicians in training because the physicians had rotating schedules. The Chief of Pathology and Laboratory Medicine said physicians in training now add their supervising providers in the electronic health record so they can also receive test results, which has helped.

Primary Care

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

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

Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected primary care delivery structure and new patient appointment wait times.[7]

The OIG found that primary care teams had vacancies for seven providers, four registered nurses, five licensed practical nurses, and one medical support assistant. Executive leaders said it was difficult to recruit and hire qualified providers. According to the Acting Executive Director, Nevada has fewer healthcare providers per resident, as compared with the rest of the nation. The Chief of Staff explained that five physicians had ultimately declined previously accepted job offers, concerned that government employment was unstable.

The OIG found an increase in veteran enrollment and staffing deficits negatively affected access to care. Staff said they used the Veterans Integrated Service Network's Clinical Resource Hub to decrease patients' appointment wait times and increase their access to care.[8] Despite efforts, the average appointment wait time for new patients was 42.7 days for the first three quarters of FY 2025 because of increased enrollment.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The Health Care for Homeless Veterans program did not meet the target for completing intake assessments on unsheltered veterans in FYs 2022 through 2024. However, it improved during FY 2024. Staff described working closely with community partners to create an outreach response team to identify and respond to the locations of unsheltered veterans.

The Housing and Urban Development–Veterans Affairs Supportive Housing program missed targets for issuing housing vouchers in FYs 2022 through 2024 despite increasing the numbers of veterans housed during these years. The program coordinator explained that staffing shortages and lack of landlords willing to accept the housing voucher contributed to not meeting the voucher targets. The program also missed targets for veteran employment in FYs 2022 through 2024. To improve performance, the coordinator said staff refer veterans to the employment specialist to help them access computers for job searches, resumes, and interviews. In addition, veterans also received referrals to the facility's compensated work therapy program.

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

[8] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed September 23, 2025, https://department.va.gov/integrated-service-networks/. Clinical Resource Hubs are VISN programs that assist local VA facilities to provide clinical services to veterans through telehealth or in-person visits when gaps in care or service capabilities exist. "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed February 10, 2025, https://www.patientcare.va.gov/primarycare/CRH.asp.

The Veterans Justice Program did not meet the target for the number of veterans entering the program in FY 2023; however, it met the target in FY 2024. The Veterans Justice Program Supervisor reported reminding staff to correctly enter the veteran's intake assessment in the national homeless database and the hiring of additional staff as contributors to the program's improvement in FY 2024.

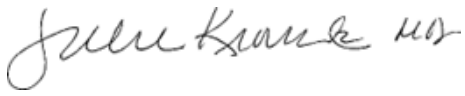
What the OIG Recommended

The OIG made one recommendation.

1. The Executive Director ensures staff consistently label reusable medical equipment to show it is clean and ready for use.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Executive Director agreed with our inspection findings and recommendation and provided an acceptable improvement plan (see OIG Recommendations and VA Responses and appendixes C and D for the full text of the directors' comments). Leaders are implementing corrective actions, and the OIG will follow up on them until they are completed.



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

Abbreviations

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

FACILITY IN CONTEXT

VA Southern Nevada Healthcare System
North Las Vegas, Nevada
Level 1b-High Complexity
Clark County
Hospital Referral Region: Las Vegas

Description of Community

POPULATION

Female **2,403,515**	Male **2,390,096**
Veteran Female **30,925**	Veteran Male **242,354**

Homeless - State **7,618**
Homeless Veteran - State **752**

MEDIAN INCOME

$58,081

EDUCATION

86% Completed High School
54% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **332**

SUBSTANCE USE

23.8% Driving Deaths Involving Alcohol
19.6% Excessive Drinking
1,272 Drug Overdose Deaths

UNEMPLOYMENT RATE

6% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	1,590,322
Carpool	217,758
Work at Home	119,450
Public Transportation	43,649
Other Means	40,150
Walk to Work	30,088

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**18 Minutes, 14 Miles**
Specialty Care	**104.5 Minutes, 104.5 Miles**
Tertiary Care	**225.5 Minutes, 239 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **29,000**

Veterans Receiving Telehealth (Facility)	46%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	17%

Health of the Veteran Population

405 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

23,199

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.67 Days

30-DAY READMISSION RATE

12%

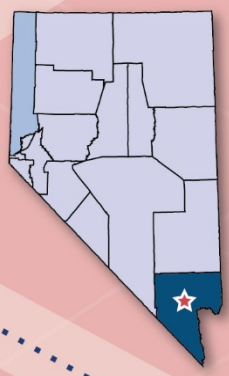
SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
27	51

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	73K
Unique Patients VA Care	69K
Unique Patients Non-VA Care	37K



COMMUNITY CARE COSTS

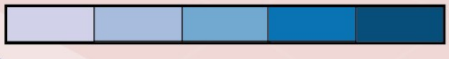
Unique Patient $13,287	Outpatient Visit $364
Line Item $510	Bed Day of Care $347

STAFF RETENTION

Onboard Employees Stay <1 Yr	12.41%
Facility Total Loss Rate	12.74%
Facility Retire Rate	2.08%
Facility Quit Rate	9.87%
Facility Termination Rate	0.73%

★ VA MEDICAL CENTER

VETERAN POPULATION



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

Contents

Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

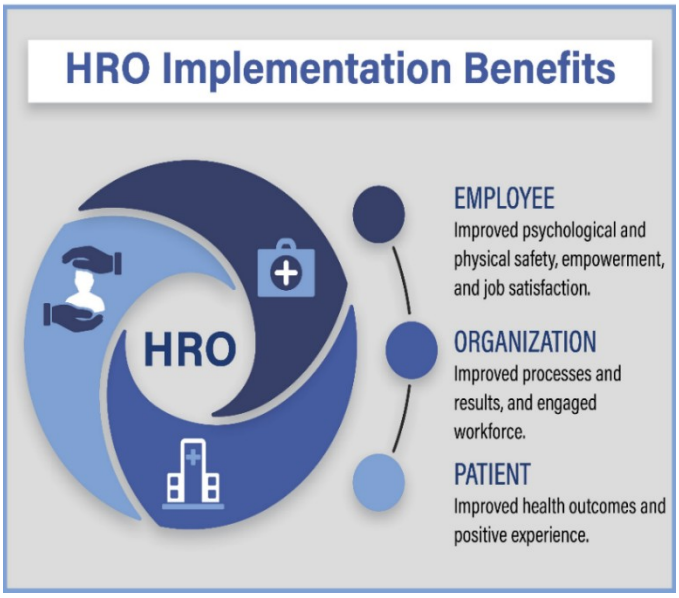


Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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

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

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

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

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

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

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

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

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

PACT Act

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

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

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

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

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

Content Domains

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

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

The VA Southern Nevada Healthcare System (facility) provides outpatient and inpatient services to veterans who reside in Clark, Lincoln, and Nye counties in southern Nevada. The facility began serving patients in 2012. It had a fiscal year (FY) 2023 medical care budget of about $1 billion and 150 operating beds, which included 110 hospital and 40 domiciliary beds.[13]

The OIG inspected the facility from April 29 through May 1, 2025. During OIG interviews, leaders identified the executive leadership team as the Acting Executive Director, Acting Deputy Director, Acting Associate Director, Chief of Staff, Deputy Chief of Staff, Associate Director for Patient Care and Nurse Executive, Deputy Nurse Executive, Assistant Director, and Communication and Customer Experience Executive. The Acting Executive Director was appointed in July 2024. The permanent Associate Director, who was selected on May 9, 2024, had been temporarily reassigned to a different facility and will resume the role once VHA fills that position.

A 2018 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[16]

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed June 3, 2024, https://www.va.gov/dchv.

[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.

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

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18]

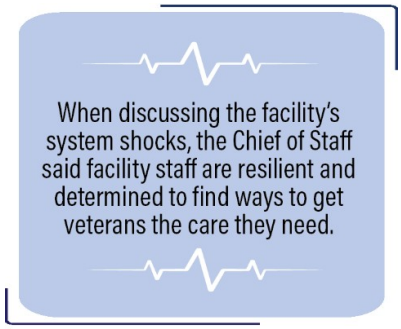


Figure 4. *Systems shocks. Source: OIG interview.*

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. Executive leaders described several system shocks that affected leaders' and staff's ability to deliver care to veterans, including shortages of healthcare providers leading to vacancies in provider positions (discussed in the Primary Care section of this report); lack of community providers' participation in VA's community care program; VHA's strategic hiring initiatives, mandated return to in-person work and anticipated reduction in force; and the facility's aging infrastructure.[19]

The Chief of Staff explained that limited participation by community specialty providers in VA's community care program negatively affected veterans' care. For example, a large group of local urologists stopped taking part in the program due to the significant amount of paperwork VA requires to approve additional care needs they identify during veterans' appointments.[20] The chief added that losing community urology providers limited veterans' access to care and increased appointment wait times.

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

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

[19] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed October 9, 2025, https://www.va.gov/Community. VHA directed leaders to "make strategic, Veteran-centric decisions about which positions we should be hiring, filling, or managing through attrition." Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23) Medical Center Directors (00), VHACO Program Office Leadership, May 31, 2024. "Heads of all departments and agencies in the executive branch of Government shall, as soon as practicable, take all necessary steps to terminate remote work arrangements and require employees to return to work in-person at their respective duty stations on a full-time basis, provided that the department and agency heads shall make exemptions they deem necessary." Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025). "In the Federal Government, layoffs are called reduction in force (RIF) actions. When an agency must abolish positions, the RIF regulations determine whether the employee keeps his or her present position, or whether the employee has a right to a different position." "Reductions in Force (RIF)," Office of Personnel Management, accessed June 10, 2025, https://www.opm.gov/policy-oversight/restructuring.

[20] A urologist is "a physician who specializes in the urinary or urogenital tract." *Merriam-Webster*, "Urologist," accessed July 24, 2025, https://www.merriam-webster.com/urology.

The chief also shared concerns with the Office of Integrated Veteran Care about the limited number of community care providers in the network and potential delayed access to essential medical care, especially urology and oncology.[21] Additionally, the chief requested and received approval from the office to increase payment rates to attract more providers, but many still declined because of the administrative requirements.[22]

To ensure veterans have timely access to these services, the chief reported meeting with the third-party administrator every other week to discuss veterans' community care needs.[23] Additionally, when community care is not available, they coordinate with the Veterans Integrated Service Network (VISN) to provide care through telehealth or at other VA facilities, sometimes out of state.[24] Executive leaders explained they regularly inform congressional representatives and veterans service organizations about issues.[25]

Leaders also discussed VHA's FY 2024 strategic hiring initiative and explained that executive leaders prioritized hiring essential positions without increasing staffing levels.[26] OIG questionnaire respondents identified the FY 2025 return to in-person work order and the anticipated reduction in force, which caused fear about job insecurity, as system shocks.[27] Additionally, 500 of the facility's approximately 3,600 staff met criteria for the voluntary early retirement program, which raised leaders' concerns about staffing losses.[28]

The Acting Executive Director also discussed the importance of transparency and communicating with staff about their concerns, but acknowledged leaders often do not have the

[21] Oncology is "a branch of medicine concerned with the prevention, diagnosis, treatment, and study of cancer." *Merriam-Webster*, "Oncology," accessed July 24, 2025, https://www.merriam-webster.com/oncology.

[22] The VA Office of Integrated Veteran Care "manages and advocates for Veterans' and beneficiaries' access to health care in both VA and community facilities" and manages the Veterans Community Care Program. "Community Care, About Us," Department of Veterans Affairs, accessed May 20, 2025, https://www.va.gov/care.

[23] Third-party administrators are companies contracted by VA to "create a regional network of providers that provide care to Veterans" in the community. VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

[24] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed September 23, 2025, https://department.va.gov/integrated-service-networks/. Telehealth is "health care provided remotely to a patient in a separate location using two-way voice and visual communication (as by computer or cell phone)." *Merriam-Webster*, "Telehealth," accessed July 24, 2025, https://www.merriam-webster.com/telehealth.

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

[26] Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum.

[27] Return to In-Person Work, 90 Fed. Reg. 8251; 5 C.F.R. § 351 and 430.

[28] The Voluntary Early Retirement Authority allows employees at federal "agencies that are undergoing substantial restructuring" and who meet lower age and service requirements to retire. "Voluntary Early Retirement Authority," Office of Personnel Management, accessed July 24, 2025, https://www.opm.gov/voluntary-early-retirement.

information to answer their questions. Executive leaders said they understood staff's worries and described VA's Employee Whole Health program as a resource to support their well-being.[29]

The Acting Executive Director shared that aging infrastructure and medical equipment were further challenges to veterans' care, although the facility was only 12 to 14 years old. For example, executive leaders described issues with heating, ventilation, air-conditioning systems; water leaks; and operating room equipment; as well as with flooring and fire doors. The Deputy Chief of Staff shared that when construction temporarily closed the operating room for about six weeks at the end of 2024, staff communicated with veterans beforehand to reschedule procedures, and informed veterans service organizations and elected officials.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[30] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[31] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[32]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[33] Scores for executive leaders' communication, transparency, and information sharing were consistent with VHA averages from FYs 2022 through 2023, but slightly decreased in FY 2024. To improve, the executive leaders said they increased the number of town halls, met with leaders in different services to discuss their hiring needs, and kept staff informed of changes.

Leaders also described various other methods they use to communicate, such as daily emails, monthly video updates, and visits to employees at their work locations. The Acting Executive Director addresses rumors and asks leaders to share the information with their employees to

[29] VA's Whole Health program includes education, resources, tools, and services to promote VA employee well-being. "Employee Whole Health," Department of Veterans Affairs, accessed June 9, 2025, https://www.va.gov/WholeHealth.

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

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

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

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

increase transparency. OIG questionnaire respondents indicated employees found executive leader communications to be clear.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[34] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[35] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

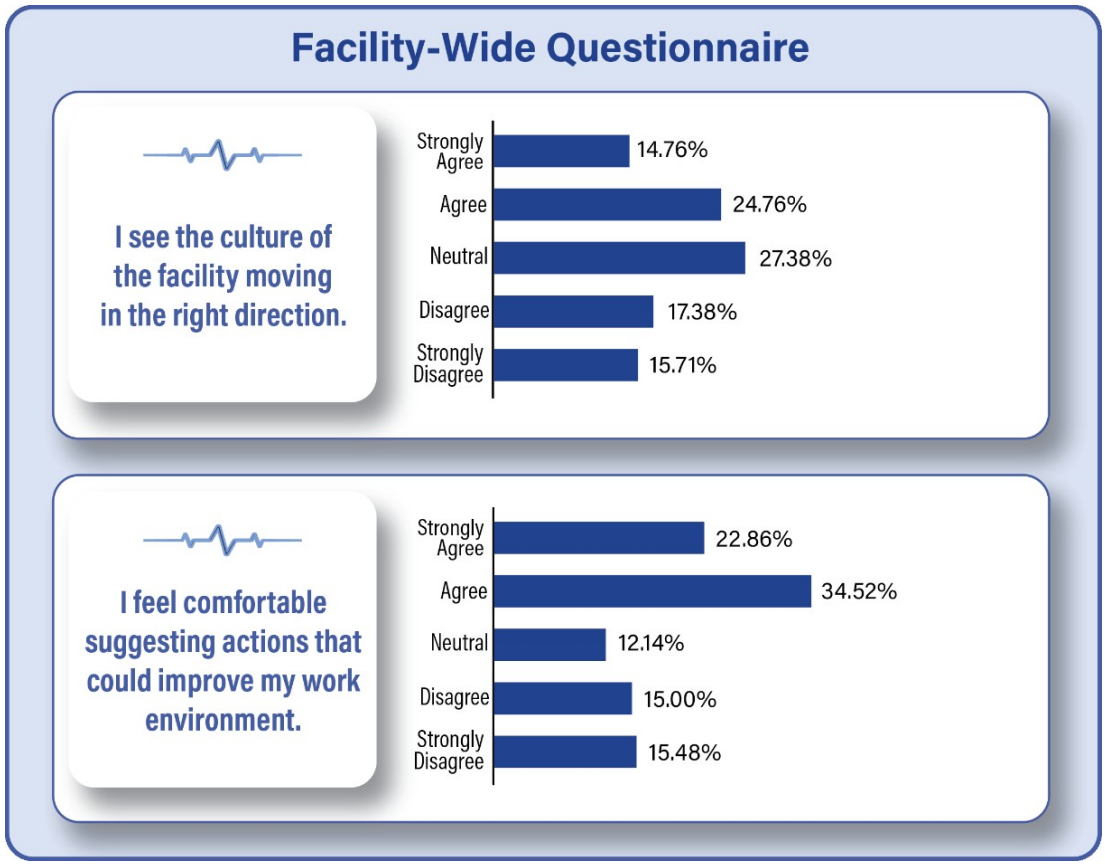

Figure 5. *Employees' perceptions of facility culture.*
Source: OIG questionnaire responses.

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

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

The OIG found VA All Employee survey scores for best places to work, psychological safety, and no fear of reprisal were at or above VHA averages in FYs 2022 and 2023 but declined in FY 2024. Leaders said scores for best places to work declined because staff were dissatisfied with changes that slowed hiring, despite growth in veteran enrollment.

The Acting Executive Director stressed the importance of transparency and communication with employees in building a psychologically safe culture. Executive leaders said they believe employees feel psychologically safe, pointing to examples of employees contacting them directly with questions and concerns; OIG questionnaire responses supported that belief.

Additionally, leaders described efforts to build and improve psychological safety through HRO principles and employee training focused on improving communication, accountability, and integrity. The Communications and Customer Experience Executive said employees prefer to receive most information from service leaders, who create action plans to address issues employees identify in the VA survey and follow up on plans to improve communications.

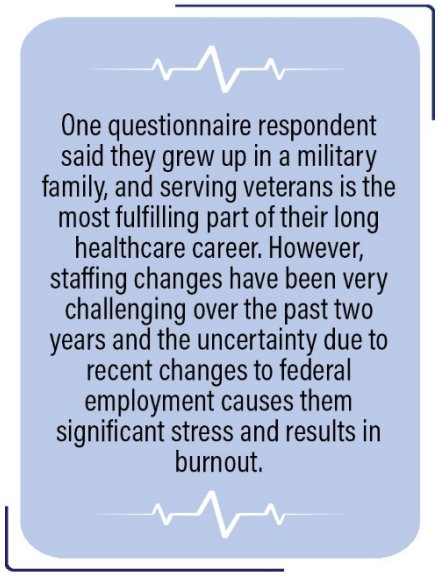

Figure 6. *Highlighted information from the staff questionnaire.*
Source: OIG questionnaire.

Veteran Experience

VHA evaluates veterans' experiences indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[36] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

The Patient Advocates indicated facility staff are responsive to veterans' concerns, including common issues like long appointment wait times. Executive leaders said they track appointment concerns for performance improvement, while patient advocates follow up with veterans and the individual clinics to address and resolve the concerns.

The Communications and Customer Experience Executive explained that executive leaders meet monthly with veterans service organization staff, who contact executive leaders when issues arise. Leaders also hold town halls in partnership with the Veterans Benefits Administration and state partners to hear from veterans directly. Additionally, Veterans Experience staff meet monthly with the Veterans and Families Advisory Committee to learn about veterans' experiences and use the feedback to improve care and services.

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[37] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 7. *Facility photo.*
Source: "North Las Vegas VA Medical Center," Department of Veterans Affairs, accessed June 5, 2025, https://www.va.gov/southern-nevada-health-care/locations.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[38] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[39]

[37] VHA Directive 1608(1).

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

[39] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 2023; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

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

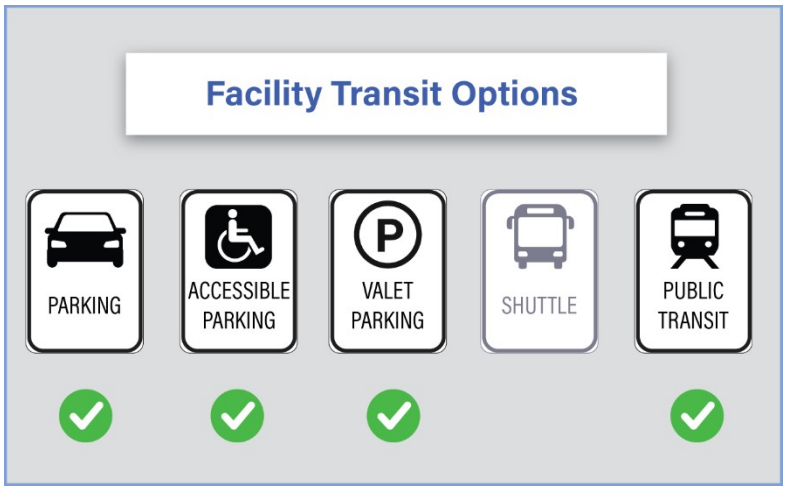

Figure 8. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG used the facility's public website to obtain directions and found the information clear and easy to follow.[40] On arrival, the OIG observed signs that directed vehicles to parking areas and guided traffic entering and exiting the facility. The parking zones were clearly marked, which made it easy for drivers to locate available spaces. The parking lots were well-lit and had sufficient capacity, including accessible spaces for individuals with mobility limitations. The OIG also noted emergency call buttons and security cameras, which appeared well positioned throughout the parking areas. There was also valet parking and a public bus stop located just outside the main entrance.

Main Entrance

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

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[41]

The main entrance had signs, passenger loading zones, power-assisted doors, and wheelchairs readily available for veterans to use, if needed. Inside, the entrance area was spacious and well-lit by natural light and appeared to be well-maintained. The OIG observed a nearby seating area and a canteen that offered drinks and snacks.

[40] "North Las Vegas VA Medical Center," Department of Veterans Affairs, accessed June 5, 2025, https://www.va.gov/southern-nevada-health-care/locations/north-las-vegas-va-medical-center/.

[41] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[42]

The OIG found information desks at the main and another entrance and noted they were both staffed by employees and volunteers. Wall signs, large video monitors, interactive maps, and kiosks with a mobile application further assisted veterans with finding their way around.

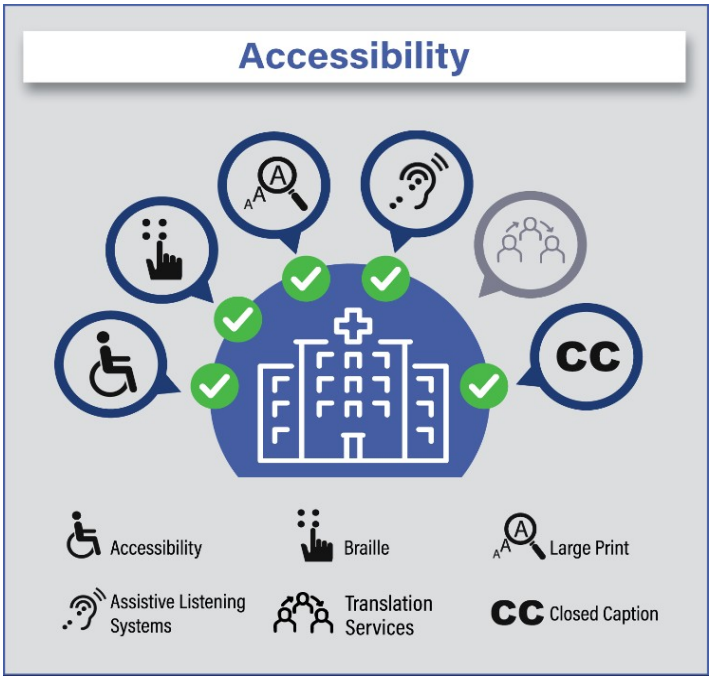

Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of document.

The OIG also observed kiosks located throughout the facility that allow veterans to check in for appointments. The kiosks also provided wayfinding, and the mobile application displayed real-time directions to clinic locations, with clinic names on each floor map. It also allowed veterans to mark their parking location. The OIG tested the application and confirmed it worked on both smartphones and tablets, giving veterans multiple ways to access the tool.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[43] The OIG did not identify any complaints to the Patient Advocate's office from veterans regarding accessibility. Staff and volunteers confirmed they are available to assist those with sensory impairments, which is consistent with responses to an OIG questionnaire. The OIG also observed braille signs installed at elevators.

[42] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

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

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[44]

One of the toxic exposure screening navigators indicated on an OIG questionnaire that three staff members screen veterans. The OIG reviewed data that showed navigators completed follow-up screenings within 30 days for veterans who reported exposure to a toxic substance or were uncertain about their exposure, and one screening exceeded the time frame.[45]

The OIG observed informational handouts about screenings in the Primary Care Clinic and at information desks. Information desk volunteers explained they were familiar with the screening initiative and referred veterans with questions to the welcome center, the Primary Care Clinic, or the Compensation and Pension Service.

During interviews, the Chief of Primary Care voiced concerns with the initial toxic exposure screening process. The chief explained that primary care providers screened veterans during clinic appointments, leaving less time to address their other health issues. To address the chief's concerns, primary care leaders had specialty care providers, nurses, and social workers assist with the screenings, which alleviated some of the workload. Primary care staff clarified that primary care providers could still screen and educate veterans, but they minimized the amount of time they spent on the screenings during regularly scheduled appointments. Additionally, the navigator said staff now have a well-defined process to manage and schedule screenings efficiently.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[46]

The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

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

[45] VHA expects staff to complete toxic exposure screenings within 30 days. Department of Veterans Affairs, "Toxic Exposure Screening Process," updated January 2025.

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

The OIG reviewed the most recent Joint Commission survey report and did not identify any repeat environment of care findings.[47] The OIG also reviewed the facility's environment of care summary report and found the Comprehensive Environment of Care committee identified deficiencies, developed performance improvement plans with outcome measures, and presented trends to facility leaders. Additionally, the OIG examined the most recent Annual Facility Evaluation report from the VISN and determined staff corrected the deficiencies or planned corrective actions. The OIG did not identify any repeat environment of care findings during the inspection.

General Inspection

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

The OIG observed unobstructed exit routes, secured supply rooms, clean refrigerators and ice machines, and biohazard signs on soiled utility rooms in all inspected clinical areas.[48] However, the OIG found a significant amount of dust on medical equipment in both the Emergency Department and the Primary Care Clinic. The OIG also observed dirty microwaves used to warm patient food in both the Emergency Department and Intensive Care Unit. VHA requires the director to ensure a clean and safe environment.[49] The Chief of Environmental Management Services said housekeeping staff immediately cleaned all identified equipment, and Environmental Management Services supervisors would reeducate them on appropriate protocols. The OIG recognizes the facility's efforts to address the issue and therefore did not make a recommendation.

In the Emergency Department, the OIG also found staff did not consistently label reusable medical equipment so they could differentiate dirty items from those that were clean and ready for use. While some items had proper bags and labels, other equipment, such as vital sign monitors and infusion pumps, lacked any visible signs or tags that identified them as clean.[50] VHA requires the Director to ensure staff separate soiled or contaminated items from clean or

[47] The Joint Commission, *Final Accreditation Report: VA Southern Nevada Healthcare System*, April 5, 2023.

[48] The OIG inspected the Intensive Care Unit, Emergency Department, Medical/Surgical Unit, and Primary Care Clinic.

[49] VHA Directive 1850, *Environmental Programs Service*, January 30, 2023.

[50] A vital sign monitor measures various vital signs such as heart rate, blood pressure, and oxygen levels. Raghbir Singh Khandpur, "Vital Signs Monitor," in chap. 396 of *Compendium of Biomedical Instrumentation, Volume 2*, (John Wiley & Sons, 2019), https://onlinelibrary.wiley.com/doi/10.1002/9781119288190.ch396. An infusion pump delivers fluids, medications, or nutrients directly into a patient's body. "What is an Infusion Pump?," Food and Drug Administration, accessed June 10, 2025, https://www.fda.gov/medical-devices/infusion-pumps/what-infusion-pump.

sterile equipment to prevent the spread of infection.[51] The OIG recommended the Executive Director ensures staff consistently label reusable medical equipment to show it is clean and ready for use. In response, the Executive Director stated leaders established labeling procedures, educated staff, and initiated compliance audits to ensure staff clean, label, and properly store reusable medical equipment (see OIG Recommendations and VA Responses).

The OIG observed a temporary plastic enclosure between the Pharmacy and the Emergency Department. The Chief of Engineering explained that staff installed the structure to prevent visitors from crossing an area affected by a water leak from a detached drain line located directly above. The OIG noted an additional ceiling leak in the Primary Care Clinic, which the Chief of Engineering said was from an iron pipe located above the area. Ceiling leaks can compromise staff's ability to maintain a safe, functional environment.[52]

The Chief of Engineering reported that engineering staff temporarily repaired the pipe above the Primary Care Clinic during the inspection in April 2025. However, facility leaders explained they would not temporarily repair the leak above the Pharmacy and Emergency Department because they would have to close the Sterile Processing Service unit, which would limit sterile equipment and delay procedures. Instead, leaders planned a long-term solution through a maintenance project that had already received funding. The project includes drainage repairs, equipment replacement, and new flooring installation.[53] Because leaders secured funding and initiated plans to address the issue, the OIG did not issue a recommendation.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt

[51] VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

[52] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

[53] Sterile Processing Service staff are responsible for cleaning, disinfecting, and preparing reusable medical equipment to ensure they are safe and sterile before being used in patient care. Department of Veterans Affairs, *Design Guide: Sterile Processing Service (SPS) and Logistics Service*, October 1, 2015, revised September 1, 2022, https://www.cfm.va.gov/til/dGuide/dgSPS-Log.pdf.

action when needed.[54] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[55]

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. The OIG determined through interviews and document reviews that leaders had processes for staff to communicate test results to providers and patients; assign a backup provider when needed; and communicate test results outside regular clinic hours. They also had service-level workflows that described staff members' roles in the communication process, which aligned with VHA requirements.[56] Leaders said they implemented an automated system to notify patients of test results and decrease providers' workload.

However, the Chief of Staff identified residents' (physicians in training) involvement in communicating test results as a challenge because they had rotating schedules and sometimes moved to a different service or were no longer on-site when test results were available, making it difficult for laboratory staff to reach them. To address this, the Chief of Pathology and Laboratory Medicine said residents now add the supervising provider in the electronic health record as another provider who can receive test results, which has helped.

The Performance Improvement Coordinator described auditing test result communication through the External Peer Review Program.[57] The coordinator said that when the audits reveal deficiencies in providers communicating results to patients timely, quality management send providers feedback forms to determine the cause. Then, they share the feedback with Patient Safety and Systems Redesign staff to address the problems.

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

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

[56] VHA Directive 1088(1).

[57] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and take corrective action when needed. VHA Directive 1088(1).

Action Plan Implementation and Sustainability

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

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[58] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG reviewed its previously published report and found no open recommendations.[59] Six months prior to the OIG's April 2025 inspection, staff conducted a root cause analysis related to test result communications and have since implemented improvement actions.

The Patient Safety Manager, Risk Manager, and Quality, Safety and Value Executive all said executive leaders support the patient safety program. The OIG did not identify any deficiencies related to facility leaders and staff implementing improvement actions or sustaining improvements.

Continuous Learning Through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[60] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[61] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The Quality, Safety and Value Executive described reviewing the patient safety events staff enter in the Joint Patient Safety Reporting system to identify issues and trends.[62] Facility leaders use this information to monitor trends, share findings, and route safety issues to various groups and

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

[59] VA OIG, *Comprehensive Healthcare Inspection of the VA Southern Nevada Healthcare System in North Las Vegas*, Report No. 22-00062-139, June 28, 2023.

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

[61] VHA Directive 1050.01(1).

[62] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events, such as adverse events and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, October 2023.

committees. For example, they report surgery concerns to the Invasive Procedure Committee and medication issues to the Pharmacy and Therapeutics Committee.

The Systems Redesign Coordinator said staff from systems redesign and quality management collaborate to address patient safety issues. Both the coordinator and Quality, Safety and Value Executive stated the facility is a top performer in the VISN, with the most ongoing and completed process improvement projects. One example of an improvement project shared by the Systems Redesign Coordinator is the Primary Care Provider Alert Burden Project, which aimed to reduce clinical alerts for providers.

Despite the facility's robust patient safety processes, the OIG learned the Mental Health Residential Rehabilitation Treatment Program was not accredited. According to the Quality, Safety and Value Executive, the program opened in October 2019 with 20 beds and expanded to 40 in May 2022 due to increased demand. VHA required the program to be accredited through the Commission on Accreditation of Rehabilitation Facilities within 18 months of opening.[63]

According to a facility leader, they tried to get the program accredited after opening in 2019, but the COVID-19 pandemic, leadership changes, and reassignment of some individuals from the Behavioral Health Unit to the nursing service delayed progress. Following the site visit in April 2025, the facility obtained a waiver for the accreditation requirement from the VA Office of Mental Health. However, through a VA Healthcare Accreditation and Readiness Program update in June 2025, the facility learned that accreditation was no longer a VA requirement.

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[64] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

[63] The directive defines the Mental Health Residential Rehabilitation Treatment Program as a residential program that supports veterans recovering from mental health or substance use issues. VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019. The directive describes the Commission on Accreditation of Rehabilitation Facilities (CARF) as "an independent, peer review system of accreditation" that uses "consumer-focused, field-driven standards" to maintain compliance with the standards and demonstrate the "delivery of safe, high quality rehabilitative care." VHA Directive 1170.01, *Accreditation of VHA Rehabilitation Programs*, September 23, 2022.

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

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[65] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[66] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The primary care administrative officer reported vacancies for seven providers, four registered nurses, five licensed practical nurses, and one medical support assistant. Executive leaders said healthcare provider shortages throughout the community made it difficult to recruit and hire qualified providers, or for veterans to receive care from community providers. The Acting Executive Director explained that Nevada had one of the lowest numbers of healthcare providers per resident in the nation and the facility competed for health care providers with the private sector. Additionally, the Chief of Staff said some applicants declined job offers due to concerns about the stability of government employment. For example, five physicians who had accepted job offers ultimately decided not to take the positions because of these concerns.

To address vacant provider positions, the Chief of Staff highlighted the facility's expanded training programs that educated a large number of physicians, nurses, and specialty healthcare providers annually. The Chief of Staff noted the community opened a medical school six years earlier, and the Quality, Safety, and Value Executive explained that healthcare providers often remain in the same area where they complete their education.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[67] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[68] Facility staff reported to the OIG that 27 primary care teams with panel sizes larger than suggested guidelines, and 11 teams with smaller panel sizes.[69]

The Chief of Primary Care attributed smaller panel sizes to new providers, who start with fewer patients then increase throughout their first year. Primary Care staff and leaders reported that large panel sizes, space constraints, position vacancies, and increased veteran enrollment caused

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

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

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

[68] VHA Directive 1406(2).

[69] The panel capacity for a full-time primary care physician is 1,200 patients, while a non-physician provider panel capacity is 900 patients, VHA Directive 1406(2).

facility leaders to pause new patient appointments at the Northwest Las Vegas VA Clinic. Primary Care leaders explained that patients received care at alternate clinics until leaders created new primary care teams.

Primary Care staff and the administrative officer said staff work on multiple teams to balance the workload. The Chief of Staff also said providers who are not assigned to a specific team cover some open positions, and they refer patients to the VISN's Clinical Resource Hub for primary care.[70] As of August 2025, the facility had referred over 2,100 patients in FY 2025 to the Clinical Resource Hub. However, due to increased patient enrollment, new patient wait times increased from 38.5 days in FY 2024 to 42.7 days for the first three quarters of FY 2025.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[71] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

A primary care provider stated that a main concern affecting workload was the volume of clinical alerts providers received every day.[72] The Chief of Primary Care implemented a standard operating procedure and established agreements that limited staff from sending non-clinical alerts to primary care providers to reduce the overall volume of alerts. The chief also streamlined a new laboratory reporting system that decreased the number of alerts.

One primary care staff member said VISN call center staff lacked familiarity with scheduling requirements, which required primary care staff to correct scheduling errors, such as overbooking. As another example, call center staff did not recognize differences in schedules between physicians in training and providers. To address these and other scheduling issues, Primary Care leaders said staff implemented a virtual chat room and email group to report the issues when they occurred, and for call center staff to report back the actions they took to resolve the issues.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG reviewed data from the

[70] Clinical resource hubs are VISN programs assist local VA facilities to provide clinical services to veterans through telehealth or in-person visits. "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed February 10, 2025, https://www.patientcare.va.gov/primarycare/CRH.asp.

[71] VHA Handbook 1101.10(2).

[72] Alerts provide interactive electronic notifications of pending activities, such as the need to review patients' test results. Department of Veterans Affairs, *VistA Computerized Patient Record System (CPRS) Setup Guide*, revised June 2021.

prior three years and found an increase in veteran enrollment. The Chief of Staff said enrollments in FY 2025 increased because of a favorable financial climate in the area and not due to the PACT Act.

VETERAN-CENTERED SAFETY NET

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[73]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[74] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[75] The facility did not meet the target in FY 2022.

The Social Work Supervisor for the Community Resource and Referral Center explained the underperformance occurred after staff left during the pandemic, which limited outreach to

> The Coordinated Entry Specialist said staff encountered a veteran sleeping behind a grocery store. Staff enrolled the veteran into a transitional housing program that day. The veteran eventually moved to permanent housing.

Figure 12. *HCHV success story. Source: OIG interview.*

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

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

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

community partners and homeless veterans.[76] To address staffing needs, the Social Work Supervisor secured funding from the VA Homeless Programs Office to hire a coordinated entry specialist, an outreach social worker, and a chaplain for the program, as well as a peer support specialist for the Community Resource and Referral Center. The supervisor said having additional staff enabled the program to rebuild its outreach efforts and collaborate more effectively with community partners.

Although the facility did not meet HCHV5 targets in FYs 2023 and 2024, it showed significant improvement. The supervisor shared that the program was one of six nationwide selected by the VA Homeless Programs Office to participate in a "One Team" pilot initiative. The initiative helped staff work with community partners to identify homeless veterans. They also have a street outreach response team that engaged with veterans within 48 hours of referral to the program.

HCHV staff also said they conduct community and street outreach and participate in the point-in-time count to identify homeless veterans, enroll them in the program, and sometimes place them in same-day housing.[77]

[76] Community Resource and Referral Centers "provide Veterans who are homeless and at risk of homelessness with one-stop access to community-based, multi-agency services to promote permanent housing, health and mental health care, career development and access to VA and non-VA benefits." "VA Homeless Programs, Community Resource and Referral Centers (CRRCs)," Department of Veterans Affairs, accessed September 29, 2025, https://www.va.gov/HOMELESS/Crrc.asp.

[77] For community outreach, program staff connect with homeless veterans in community-based settings like shelters, meal sites, job fairs, and community resource centers and outreach events. For street outreach, program staff interact with veterans experiencing "homelessness taking place in non-traditional settings such as on the street, under bridges, in homeless encampments and in parks or other places not meant for human habitation." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services,* February 18, 2022.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[78]

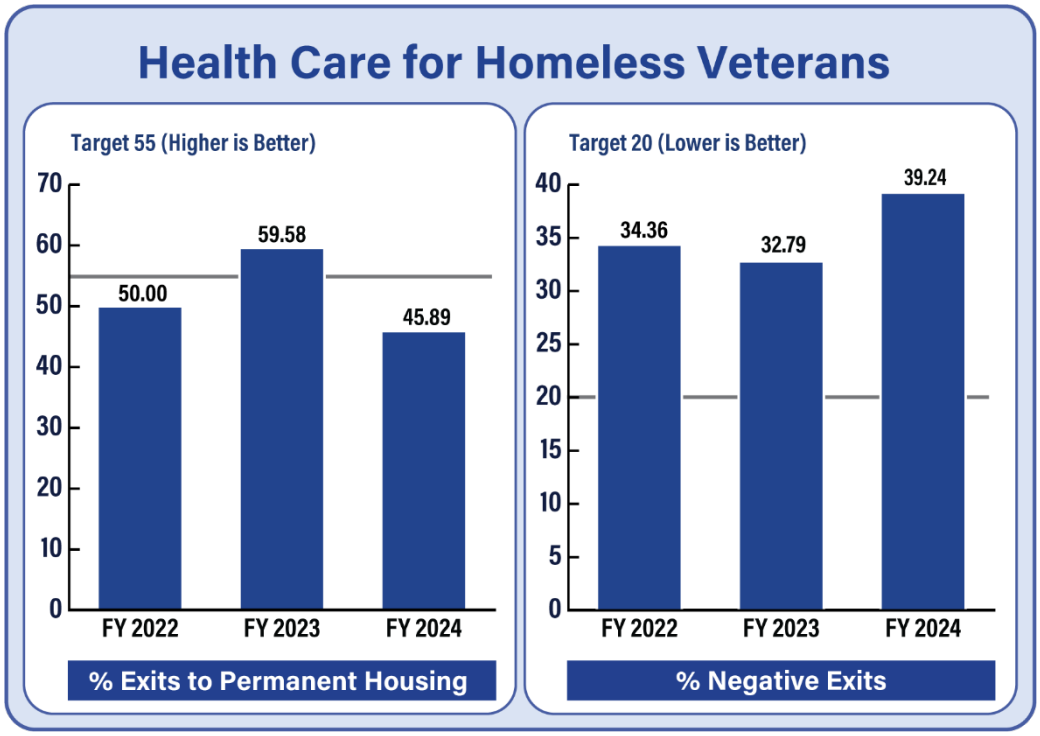

Figure 13. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The facility did not meet the HCHV1 target in FYs 2022 and 2024 but exceeded it in FY 2023. To top it in FY 2023, HCHV staff said they collaborated with community partners to identify landlords willing to accept veterans with legal issues, and program employment coordinators helped veterans find jobs to earn the income needed to pay for housing.

The HCHV Program Supervisor explained they missed the FY 2022 target in part because some veterans in the Contract Emergency Residential Services program required a higher level of care,

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

so they were discharged to a hospital or a similar setting instead of permanent housing.[79] To improve performance, the program supervisor said staff identified housing resources, such as group homes where veterans can receive a higher level of care.

The facility did not meet the HCHV2 target in FYs 2022 through 2024. Program staff said some veterans left the program over the last two to three years because they felt unsafe after violent incidents occurred. Staff met with their transitional housing partners to discuss ways to increase safety for the veterans enrolled in the programs.

The Coordinated Entry Specialist identified several needs among program participants, including medical and mental health care; housing; substance use treatment; transportation; and assistance obtaining photo identification cards, birth certificates, and Social Security cards. The specialist said staff work with facility and community providers to assist veterans in obtaining documents they need to apply for permanent housing.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[80] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[81]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[82] The facility did not meet the target in FYs 2022 through 2024 but improved the percentage of veterans housed during this time.

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[79] In addition to outreach services, HCHV programs include transitional housing and case management services through contracts with community providers. "Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program,* February 22, 2022, amended March 7, 2025.

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

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

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

The program coordinator stated vacant positions were barriers to meeting the target. The coordinator and the Chief of Social Work said leaders offered incentives such as education debt reduction and special salary ratings to applicants and existing staff, which improved hiring and retention. Program leaders also said lack of affordable housing was a barrier to meeting the target, especially when investors purchase and renovate properties then charge higher rental costs. To address this, the coordinator described collaborating with a community partner who offered financial incentives to landlords willing to rent to veterans enrolled in the program. While housing availability remains a challenge, staff said they receive referrals from both facility and community providers and are able to enroll eligible veterans.

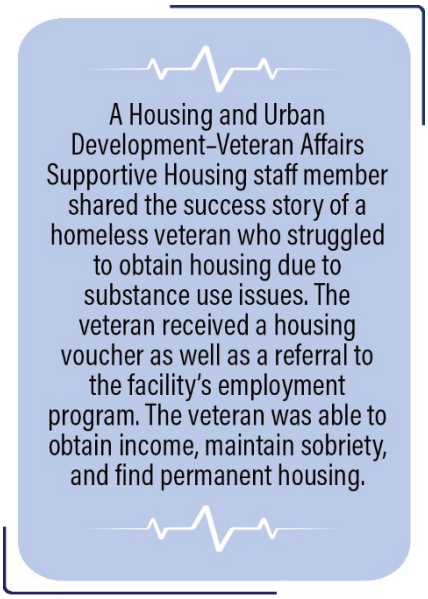

Figure 14. *Success story.*
Source: OIG questionnaire response.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[83] The facility did not meet the target in FYs 2022 through 2024.

The program coordinator identified several challenges to meeting the target, such as limited in-person interactions with veterans during the pandemic and data discrepancies when staff did not update veterans' employment status in the program database. To improve performance, the coordinator said program staff refer veterans to the employment specialists, who help them write resumes, practice interview skills, and access computers for employment searches. In addition, the Chief of Social Work discussed reminding staff to update veterans' employment status in the homeless database to address any data discrepancies.

Program staff explained they assist enrolled veterans with medical and mental health care, substance abuse treatment, income, transportation, and food assistance by directing them to the appropriate programs. They also refer veterans to the compensated work therapy program and to

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

veterans service organizations, who help them apply for VA benefits. In addition, program staff also assisted veterans in applying for Social Security benefits.[84]

When veterans require transportation, staff said they direct them to local transit services and VA's beneficiary travel program, which includes VHA-Uber Health Connect, and offer bus passes, or provide rides.[85] To assist veterans with obtaining food, staff stock emergency food kits and send them to local food pantries and community partners who deliver meals, offer benefits to low-income families, and provide monthly transportation to grocery stores.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[86] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[87]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[88] The facility did not meet the target in FY 2023 but did reach it in FY 2024. The Veterans Justice Program Supervisor said the program improved its performance in FY 2024 due to leaders hiring two additional staff members and staff correctly entering veterans' information into the national homeless program's database.

Program staff explained they receive referrals from court coordinators, probation and parole officers, attorneys, and jail and prison staff. In addition, they attend a monthly resource fair held at local jails to teach veterans about the program and enroll them in VA services. Staff said these

[84] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry and government agencies to provide Veteran candidates for employment and Veteran labor, and employment supports to Veterans and employers." "Compensated Work Therapy," Department of Veterans Affairs, accessed July 11, 2024, https://www.va.gov/health/cwt/.

[85] Beneficiary travel is a program offered by VA that provides eligible veterans with transportation assistance to appointments. VHA Directive 1601B.05, *Beneficiary Travel*, January 20, 2022. VHA-Uber Health Connect "provides veterans with a supplemental transportation option to get to and from approved medical appointments via Uber Health." "What is the VHA-Uber Health Connect (VUHC) Initiative?," Department of Veterans Affairs, accessed May 9, 2024, https://www.innovation.va.gov/VHA-Uber-Health-Connect-Initiative-FAQ.pdf.

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

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

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

efforts are effective, as shown by increased referrals and success stories when veterans are released from incarceration and obtain housing.

Meeting Veteran Needs

Staff said they help veterans obtain appointments for VA services, including mental health and benefits, and refer veterans to VA and community programs to address other needs. The program supervisor stated staff work with six veterans treatment courts.[89] Staff explained the courts are effective (one has a low re-offense rate of less than 10 percent) and may reduce charges for veterans who graduate. In addition, staff said graduates often reunite with family, return to school, and find employment.

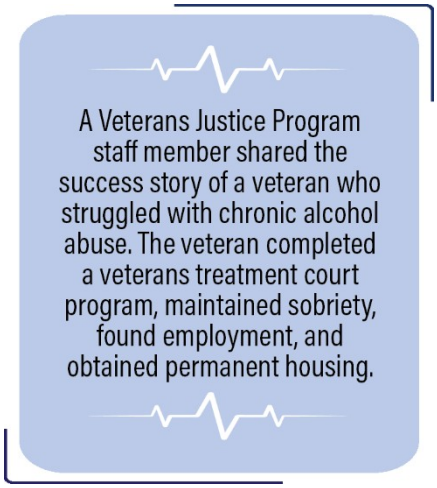

Figure 15. *Program success story. Source: OIG questionnaire response.*

However, staff also said some veterans enrolled in the program experience employment challenges because they have a felony record. For example, a veteran with a criminal record had trouble finding employment for several months, but after staff assisted with a resume, the veteran participated in a community event and was hired the same day.

Program staff also said some veterans treatment court participants received referrals to the facility's inpatient substance abuse program as part of their treatment, but staff denied admission and did not provide an explanation.[90] The Veterans Justice Program Supervisor reported meeting regularly with the inpatient substance abuse program's nurse manager to improve the admission process. Leaders also defined new admission criteria in a policy.

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

[90] The Las Vegas VA Residential Recovery and Renewal Center (LVR3) is a "30–45 day, 40-bed substance use and gambling residential treatment program that provide research-based, high-quality interventions to assist residents through individualized and person-centered recovery plans." Department of Veterans Affairs, "LVR3 Recognized for 'State-of-the-Art' Gambling Treatment Facility," news release, May 26, 2023, https://www.va.gov/southern-nevada-health-care/news-releases/lvr3-recognized-for-state-of-the-art-gambling-treatment-facility/.

Conclusion

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

OIG Recommendations and VA Responses

Recommendation 1

The Executive Director ensures staff consistently label reusable medical equipment to show it is clean and ready for use.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

The Executive Director ensured that staff consistently label reusable medical equipment to show it is clean and ready for use. The Emergency Department leaders have established procedures to ensure that reusable medical equipment is labeled to indicate it has been cleaned, disinfected, and is ready for patient use, in compliance with facility policy MCP 118-06 Cleaning and Disinfection of Non-Critical Reusable Medical Devices.

Corrective actions began on July 1, 2025, which included reorganizing the clean storage area (clean utility room), relocating a large rack to improve workflow, and ensuring all reusable equipment was cleaned and labeled. Equipment unsuitable for the designated clean storage area was removed. The Assistant Nurse Manager then began conducting compliance checks in the clean storage area.

On August 27, 2025, at the ED staff meeting, staff were re-educated on the requirements that all reusable medical equipment stored in the clean storage area needs to be properly labeled to indicate it has been cleaned, disinfected, and is ready for patient use, in compliance with MCP 118-06 Cleaning and Disinfection of Non-Critical Reusable Medical Devices. Additionally, after use, items will be placed in the soiled utility room and will remain there until properly cleaned, disinfected and labeled. This topic was also discussed at the ED staff meeting on September 26, 2025.

On September 25, 2025, re-education of staff was sent via email to ED staff which included instructions to ensure that any reusable medical equipment that is placed in the clean utility room has been cleaned and is labeled appropriately.

To reinforce expectations, a follow-up email was sent to ED staff on December 3, 2025, including MCP 118-06 Cleaning and Disinfection of Non-Critical Reusable Medical Devices and key reminders on cleaning responsibilities, designated cleaning areas, storage guidelines, labeling, documentation and staff accountability.

Compliance audits were initiated in July 2025 and will be conducted until three (3) consecutive months of 90% or higher is met. Audit results will be reported at the Survey Readiness Committee, until sustained compliance is met. ED leaders will continue daily rounding with real-time feedback and reinforcement of expectations.

Appendix A: Methodology

Inspection Processes

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

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from April 29 through May 1, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024.

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

[3] 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.

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

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.

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 9, 2025

From: Director, VA Sierra Pacific Network (10N21)

Subj: Healthcare Facility Inspection of the VA Southern Nevada Healthcare System in North Las Vegas

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the VA Southern Nevada Healthcare System in North Las Vegas.
2. I concur with the findings, recommendations, and submitted action plans of VA Southern Nevada Healthcare System in North Las Vegas.
3. If you have any questions, please contact the VISN 21 Quality Management Officer.

(Original signed by:)

Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network (VISN 21)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 1, 2025

From: Director, VA Southern Nevada Healthcare System (593)

Subj: Healthcare Facility Inspection of the VA Southern Nevada Healthcare System in North Las Vegas

To: Director, VA Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report and the recommendation from the OIG Healthcare Facility Inspection of the VA Southern Nevada Healthcare System in North Las Vegas conducted at the VA Southern Nevada Healthcare System from April 29 through May 1, 2025.
2. Please find the attached response to the recommendation outlined in the report. We have either completed or are actively implementing the necessary actions to address and resolve the identified issue.

(Original signed by:)

Michael L. Kiefer, MHA, FACHE
Executive Director
VA Southern Neveda 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.