US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Eastern Colorado Health Care System in Aurora

Healthcare Facility Inspection	25-00200-48	February 24, 2026

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

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Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Eastern Colorado Health Care System (facility) from March 10 through 13, 2025, and examined the quality of care provided using five content domains.[1]

What the OIG Found

- **Culture.** The OIG examined system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** The OIG inspected the main entrance and patient care areas and compared findings from prior inspections to determine if there were recurring issues. The OIG reviewed a previous accreditation survey report, which included findings involving expired supplies, multidose medication labels that lacked expiration dates, and clean and soiled items stored together.[2] The OIG observed similar findings and made recommendations. In response, the Director stated staff audit supplies weekly, verify labels on multidose medications, and leaders trained staff to store clean and dirty items separately. The OIG also found small devices containing liquid nitrogen that staff use for patient care left unmonitored in examination rooms and made a related recommendation.[3] The Director explained staff started a risk assessment on liquid nitrogen storage and will take appropriate actions based on the results.
- **Patient Safety.** The OIG assessed the facility's processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not have an approved test result communication policy, and staff did not develop service-level workflows that describe team members' roles in the communication process, as required by VHA

[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.

[2] The Joint Commission performed hospital, behavioral health and human services, and home accreditation inspection in August 2024. The Joint Commission, *Final Accreditation Report VA Eastern Colorado Health Care System*, November 18, 2024.

[3] Liquid nitrogen is a hazard because it is a simple asphyxiant ("a substance or mixture that displaces oxygen in the ambient atmosphere, and can thus cause oxygen deprivation in those who are exposed") and if not used properly, can cause injury or death. 29 C.F.R. § 1910.1200 (2024).

Directive 1088(1).[4] The OIG made a related recommendation. In response, the Director stated staff drafted a revised policy and created service-level workflows. Leaders also had limited some diagnostic radiology services due to staffing vacancies, and there were delays in staff receiving imaging results from community providers and uploading them into the electronic health record. The OIG made recommendations. In response, the Director explained that Veterans Integrated Service Network (VISN) leaders initiated an assessment of the facility's radiology service in December 2025. VISN staff also assisted with the work, contracted staff helped review records, and leaders streamlined the scanning process. The OIG was also concerned about staff sustaining improvements in completing root cause analysis actions and made a recommendation.[5] The Director explained that facility staff developed a consultative process that monitors root cause analysis improvement actions past implementation to ensure those improvements are sustained.

- **Primary Care.** The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[6] The facility had 63 panels (the number of patients assigned to a care team) that were larger than VHA's expected size, per VHA Directive 1406(2).[7] Of the 95 primary care teams, 59 were not fully staffed. The OIG made a recommendation. In response, the Director stated leaders continue recruitment efforts for providers.
- **Veteran-Centered Safety Net.** The OIG assessed programs that offer medical care and social support services to vulnerable veterans who are homeless and recently incarcerated. The OIG made no recommendations.

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

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

[5] A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[6] VHA Directive 1406(2) *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[7] "The baseline capacity for a full-time Patient Aligned Care Team (PACT) is 1,200 patients." VHA Directive 1406(2).

What the OIG Recommended

1. Facility leaders direct staff to conduct a risk assessment on liquid nitrogen storage, to include the small devices stored in examination rooms, and implement changes if needed.
2. Facility leaders determine appropriate supply storage locations and, for any supplies stored outside of the defined locations, implement a process to ensure staff identify and remove expired supplies.
3. Facility leaders ensure staff label opened multidose medications with expiration dates.
4. Facility leaders ensure staff store clean and dirty items separately.
5. The Director ensures staff implement processes to prevent repeat environment of care findings.
6. Facility leaders ensure the facility has a policy for the communication of test results and staff develop service-level workflows that align with VHA requirements.
7. Veterans Integrated Service Network 19 leaders assess the staffing needs for the facility's radiology service and provide additional resources to ensure services are readily available to patients.
8. Veterans Integrated Service Network 19 leaders evaluate the reasons for delays in uploading images and reporting test results and assist the facility's community care leaders to mitigate future delays.
9. Executive leaders monitor root cause analysis improvement actions through completion, monitor outcome measures, and ensure staff implement processes to sustain the improvements.
10. Facility leaders attain appropriate primary care staffing and manageable panel sizes to ensure patients have timely access to high-quality care.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Interim Director concurred with the inspection recommendations and provided acceptable action plans, and leaders are implementing corrective actions (see the responses in the body of the report and appendixes C and D for the full text of the directors' comments). The OIG considers recommendation 10 closed and will follow up on the planned actions for the open recommendation until they are completed.

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

Abbreviations

ADPCS	Associate Director, Patient Care Services
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

FACILITY IN CONTEXT

VA Eastern Colorado Health Care System
Aurora, Colorado
Level 1a-High Complexity
Adams County
Hospital Referral Region: Denver

Description of Community

POPULATION

Female **2,227,839**	Male **2,252,049**
Veteran Female **27,542**	Veteran Male **220,664**

Homeless - State **10,397**
Homeless Veteran - State **738**

MEDIAN INCOME

$59,174

EDUCATION

93% Completed High School
72% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **159**

SUBSTANCE USE

31.4% Driving Deaths Involving Alcohol
20.2% Excessive Drinking
1,086 Drug Overdose Deaths

UNEMPLOYMENT RATE

3% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	1,681,434
Work at Home	263,488
Carpool	186,818
Public Transportation	76,299
Walk to Work	61,407
Other Means	52,365

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**68 Minutes, 72 Miles**
Specialty Care	**119 Minutes, 121 Miles**
Tertiary Care	**184 Minutes, 199 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **38,190**

Veterans Receiving Telehealth (Facility)	43%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	15%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

26,477

296 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.62 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
29	56

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	104K
Unique Patients VA Care	97K
Unique Patients Non-VA Care	51K

COMMUNITY CARE COSTS

Unique Patient $31,787	Outpatient Visit $309
Line Item $1,984	Bed Day of Care $312

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.99%
Facility Total Loss Rate	15.04%
Facility Retire Rate	1.95%
Facility Quit Rate	12.13%
Facility Termination Rate	0.99%

★ VA MEDICAL CENTER

VETERAN POPULATION

0.02% 5.15% 10.25% 15.35% 20.45% 25.54%

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 1,380 healthcare facilities.[1] VHA's vast care delivery structure requires sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Each review includes a set of content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net.

Healthcare Facility Inspection reports provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care delivered; and highlight specific actions leaders and staff can take to improve patient safety and care.

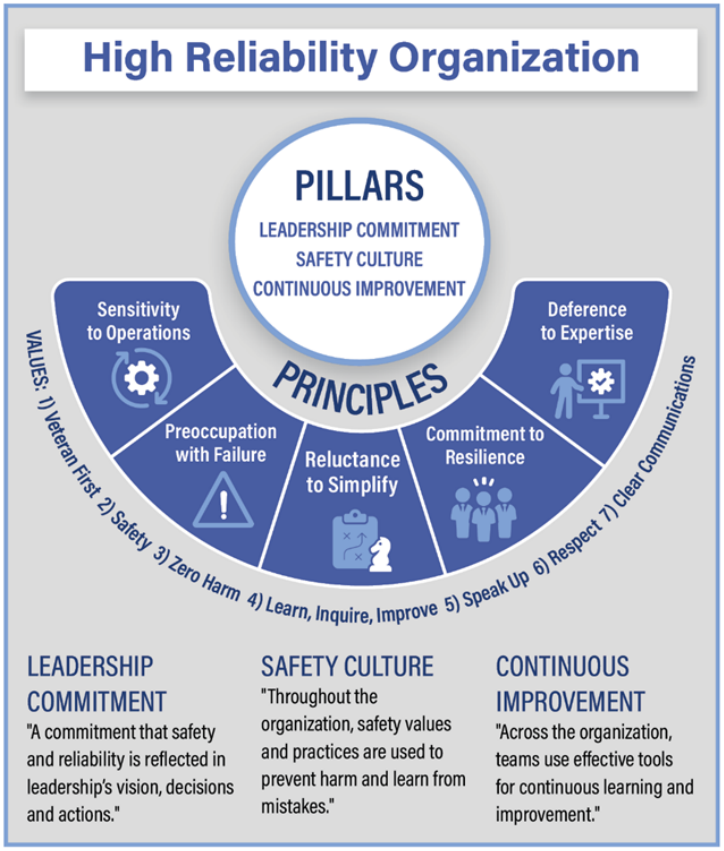

Figure 1. *VHA's high reliability organization framework. Source: Department of Veterans Affairs (VA), "VHA's Journey to High Reliability."*

In 2018, VHA officially began the journey to become a high reliability organization (HRO) and set goals to improve accountability and reliability and reduce patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[2] VHA has now implemented HRO principles at all VHA facilities.[3]

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[1] "About VHA," Department of Veterans Affairs, accessed August 8, 2025, https://www.va.gov/health/aboutvha.

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

[3] "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.)

Content Domains

Figure 2. *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 VA Eastern Colorado Health Care System (facility), which includes the Rocky Mountain Regional VA Medical Center, originally opened in 1951. The Quality and Patient Safety Chief reported several recent facility additions, including a new 20-bed residential treatment center, which opened in January 2025, and the Lieutenant Colonel John W. Mosley VA Clinic, which opened in February 2025. The chief also said the facility planned to open three additional clinics.

Figure 3. *Rocky Mountain Regional VA Medical Center. Source: "VA Eastern Colorado Health Care," Department of Veterans Affairs, accessed January 2, 2025, https://www.va.gov/easterncolorado.*

The facility's fiscal year (FY) 2024 budget was approximately $1.16 billion. The Nursing Operations Manager stated the facility had 227 operating beds (133 hospital, 40 community living center, and 54 domiciliary beds).[4]

The OIG inspected the facility from March 10 through 13, 2025. The executive leaders consisted of the Interim Medical Center Director (Director); Acting Chief of Staff; Associate Director, Patient Care Services (ADPCS); Associate Director; Assistant Director of Northern Colorado; and Assistant Director of Southern Colorado, who was assigned the additional duty of Interim Deputy Director. A staff member said the ADPCS and both assistant directors were the most tenured in their roles, all having served at least two years.[5]

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's usual daily operations), and both employees' and veterans' experiences.[6] The OIG administered

[4] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/Geriatrics/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/homeless/dchv.asp.

[5] The ADPCS was temporarily reassigned to Veterans Integrated Service Network (VISN) 19 during the week of the OIG's on-site inspection. 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 October 8, 2025, https://department.va.gov/integrated-service-networks/.

[6] 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.

a facility-wide questionnaire, interviewed leaders and employees, and reviewed data from patient advocates and veterans' feedback.[7]

System Shocks

Executive leaders described debris in sterilized instrument trays, executive leadership turnover, and reduced staffing as system shocks.[8] After an operating room technician discovered black debris in a sterile instrument tray, the leaders said they immediately took action.[9] Leaders had staff inspect other sterile instrument trays and, after finding more debris, they stopped surgical procedures for approximately two months. The leaders acknowledged this affected patient care delivery, but made efforts to ensure patients received necessary care as soon as possible. They also worked with experts from VHA program offices to help determine and address the cause of the debris.[10]

Leaders shared mitigation efforts, which included using disposable sterile instruments and protective wraps to cover surgical trays. Staff also replaced containers they used to clean and store sterile instruments, rebuilt instrument washers, and changed filters more frequently. Executive leaders plan to purchase new instrument washers while they continue to monitor and maintain ongoing mitigation efforts. Because executive leaders have actively investigated the cause of this issue and taken actions to reduce risks, the OIG did not make a recommendation.

The second system shock, according to the Acting Chief of Staff, was leadership turnover, including the removal of the previous Director and Chief of Staff from their leadership positions. A staff member stated that since then, three different interim leaders have covered the director position. During the week of March 10, 2025, the latest Interim Director had been in place for nine weeks, the Acting Chief of Staff had been at the facility for one week, and the Assistant Director of Southern Colorado had been temporarily assigned the additional responsibilities of

[7] Patient Advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed August 4, 2025, https://www.va.gov/HEALTH/patientadvocate/. 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.

[8] Sterile processing staff clean, disinfect, sterilize, and prepare reusable medical instruments for patient procedures and surgeries. "Sterile Processing Week," Department of Veterans Affairs, accessed October 8, 2025, https://www.patientcare.va.gov/Office_Sterile_Processing.

[9] Staff must decontaminate and clean sterile instruments of biological debris and contaminants prior to being used. VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023, amended September 9, 2024.

[10] Experts included staff from the VA Central Office, Healthcare Engineers and Facilities Programs, and the Office of Sterile Processing.

the deputy director role. The OIG also found acting staff filled key leadership positions in multiple departments.[11]

Furthermore, the OIG reviewed a previously published OIG report that highlighted poor leadership and culture of safety concerns at the facility.[12] The Interim Director shared that current executive leaders engaged with staff, community, and congressional leaders to prioritize concerns and rebuild trust.

Third, executive leaders described reduced staffing as a system shock. The leaders explained that in response to VHA's FY 2024 memorandum to reduce overall staffing, and the Veterans Integrated Service Network (VISN) Director's related request, they eliminated hundreds of vacant positions and paused hiring.[13] The leaders also said staff resignations had negatively affected patients' access to care (see the Patient Safety section for further discussion).

In addition, when the facility's sole mammographer left in March 2024, the facility was unable to maintain its mammography accreditation, and staff referred all mammography imaging to community providers. The OIG requested documents to determine how facility staff track completed exams and monitor those exams that require further action. The OIG reviewed the facility's tracking spreadsheets and found they were incomplete and inaccurate. The OIG referred these concerns to the OIG hotline management team for further review.

To address staffing issues, leaders reported a process change in which a facility committee reviews position vacancies monthly and if the committee members deem appropriate, they approve positions to hire. For instance, the ADPCS shared the committee had recently approved multiple primary care nursing positions.

Employee Experiences

Executive leaders said they implemented recognition awards to highlight employees' achievements and shared governance processes across services to promote their involvement and ownership for improvements.[14] Leaders added since they implemented these changes, employees

[11] Some of the key leaders in acting roles included the Chief of Radiology, Chief Health Informatics Officer, Chief of Facilities Management Service, Chief and Deputy Chief of Nursing Outpatient Services, Chief of Nutrition and Food Service, Chief of Pharmacy, Chief of Police, Chief of Public Affairs, and Chief of Sterile Processing Service.

[12] VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, Report No. 23-02179-188, June 24, 2024.

[13] 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 [VHA Central Office] Program Office Leadership, May 31, 2024.

[14] Shared governance enables employees to influence practice through participation in policy-making, quality improvement, and professional development processes. Department of Veterans Affairs, Office of Nursing Services, *2024 Annual Report, The Nursing Workforce*, accessed November 17, 2025, https://www.va.gov/Nursing.pdf.

have provided ideas that resulted in policy and procedure changes, enhanced skills, and new equipment at the facility.

The leaders also explained they communicated with employees through town halls, tiered huddles (focused daily conversations between employees and leaders), and visits to various locations throughout the healthcare system.[15] Additionally, leaders developed a question-and-answer platform called Ask the ELT [executive leadership team], which routes employees' questions to the appropriate leader, and displays the responses for everyone to view.

Veteran Experiences

The patient advocates reported that veterans' common complaints involved unanswered phone calls and scheduling delays. Questionnaire responses from patient advocates identified staffing within services as one barrier to addressing veterans' concerns, but they noted accountability and responsiveness to veterans' complaints had improved. Additionally, executive leaders stated they are working with frontline staff to develop patient advocate champions to assist with responses to veterans' concerns. Executive leaders said patient advocate staff are very engaged and proactively address concerns.

Leaders reported holding monthly virtual town halls for veterans to ask questions directly to facility staff on topics such as community care and care coordination. These events attracted thousands of participants.[16] Leaders also planned to reinstate a customer service veteran experience committee comprised of various stakeholders, including veterans. Leaders had recently approved the committee's charter and said they hoped it could start operations within two months.

[15] "Tiered Safety Huddles, What are Tiered Safety Huddles?," Department of Veterans Affairs, accessed April 10, 2025, https://dvagov.sharepoint.com/sites/vhahrojourney/huddles. (This website is not publicly accessible.)

[16] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed November 1, 2024, https://www.va.gov/communitycare.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[17] The OIG assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The OIG also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

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.[18]

General Inspection

Upon arrival, the OIG observed signs directing veterans to parking and building locations.[19] The OIG also noted the two parking garages included spaces accessible for those with disabilities.

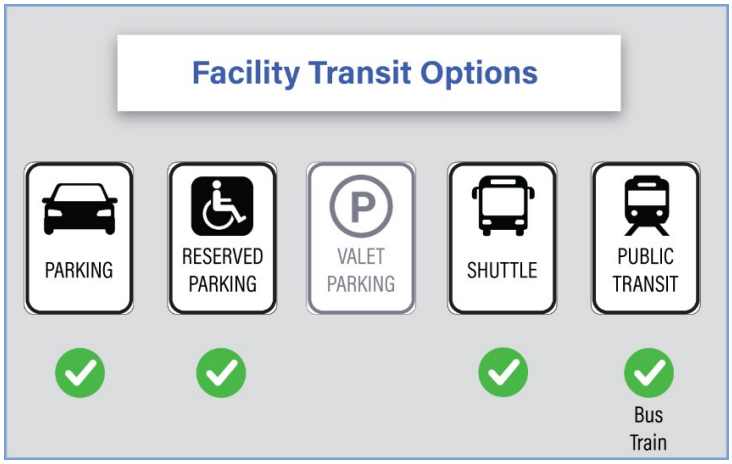

Figure 4. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

The medical center had multiple connected buildings, and the OIG evaluated two commonly used entrances, referred to as the north and south entrances. Each entrance had a passenger loading zone, power-assisted doors, and available wheelchairs. Additionally, the OIG found the entrances generally clean and well-lit, with seating areas and an information desk staffed with volunteers from 6 a.m. to 8 p.m. The main entrances at the Pueblo VA Community Living Center, PFC [Private First Class] Floyd K. Lindstrom VA Clinic, and PFC James Dunn VA Clinic were also clean, well-lit, and had seating areas, and the two clinics had information desks staffed with volunteers during clinic operating hours.

[17] "Informing Healing Spaces through Environmental Design: Thirteen Tips," Department of Veterans Affairs, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

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

[19] The facility has several locations, and the OIG visited four of them: the Rocky Mountain VA Medical Center, PFC [Private First Class] Floyd K. Lindstrom Department of VA Clinic, PFC James Dunn VA Clinic, and Pueblo VA Community Living Center.

Figure 5. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

In addition to the information desk volunteers who assist with navigation, the OIG found the medical center had electronic maps on kiosks near the north and south entrances. These kiosks were generally up to date and provided turn-by-turn directions. The OIG was able to use the maps and wall directories to navigate around the medical center, clinics, and community living center.

In addition to those features identified in figure 5, information desk volunteers stated they help veterans with visual impairments get to their locations. Although the volunteers could not use sign language, they communicated in writing and requested translation services when needed. Further, televisions had closed captioning capability, but the OIG did not see it in use on any televisions in common areas.

The OIG inspected several clinical areas and noted clear exit paths, generally clean floors, and medical equipment with evidence of current preventative maintenance.[20] However, the OIG found small devices containing liquid nitrogen used for patient care left unmonitored in examination rooms, which could pose a hazard if patients used the devices.[21]

Recommendation 1

Facility leaders direct staff to conduct a risk assessment on liquid nitrogen storage, to include the small devices stored in examination rooms, and implement changes if needed.

_X_ Concur

____ Nonconcur

Target date for completion: October 31, 2026

[20] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, January 1, 2025.

[21] Liquid nitrogen is a hazard because it is a simple asphyxiant ("a substance or mixture that displaces oxygen in the ambient atmosphere, and can thus cause oxygen deprivation in those who are exposed") and if not used properly, can cause injury or death. 29 C.F.R. § 1910.1200 (2024). The OIG found these devices at the PFC James Dunn and PFC Floyd K. Lindstrom VA Clinics.

Director Comments

Actions taken thus far: The Quality and Patient Safety Service's Regulatory Compliance Section Chief/Accreditations initiated a risk assessment of liquid nitrogen storage with deadline target for completion January 31, 2026.

Action plan: The risk assessment team, led by the Regulatory Compliance Section Chief/Accreditations, will determine if changes to storage processes of liquid nitrogen for safety are warranted. Deadline for determination February 28, 2026, after review and consultation with all areas storing and utilizing liquid nitrogen by the risk assessment team. Liquid nitrogen storage procedures will be outlined and laminated for posting in liquid nitrogen storage rooms as a quick reference guide for staff refresher and safety. Deadline for posting reference guides to all locations where liquid nitrogen is stored April 30, 2026. Ongoing monitoring and sustainment will utilize tracer audits with data reported out to Quality and Patient Safety Council (QPSC) until two (2) consecutive quarters (or six [6] consecutive months) of data is >/= 90% compliance.

Measured by: Tracer audit data of compliance of safe liquid nitrogen storage per safety requirements

Numerator: Number of compliant tracer audit observations

Denominator: Number of total tracer audit observations

During the community living center inspection, the OIG also observed that staff stored hazardous materials, such as bleach and aerosol paints, in an unlocked cabinet with craft supplies for veterans to use in a common area. Staff were unable to locate the keys to lock the cabinet. The OIG did not make a recommendation because staff removed the items from the common area but encourages them to safely store hazardous materials.

VHA Directive 1608(1) requires facilities to adhere to regulatory and accrediting bodies' requirements and ensure the healthcare environment is safe and clean.[22] The OIG reviewed The Joint Commission's 2024 inspection report, which included findings of expired supplies, opened multidose medication labels that lacked expiration dates, and clean and soiled items stored together.[23] During the inspection, the OIG also observed similar findings.

The OIG noted expired supplies in equipment carts and other locations outside standard supply rooms. VHA Directive 1761 requires staff to monitor supply rooms "routinely for proper storage conditions as well as accuracy of inventory balances, expired/outdated items, damaged, or

[22] VHA Directive 1608(1).

[23] The Joint Commission performed hospital, behavioral health and human services, and home accreditation inspection in August 2024. The Joint Commission, *Final Accreditation Report VA Eastern Colorado Health Care System,* November 18, 2024.

obsolete items."[24] Staff in these areas were not able to provide a reason for the expired supplies or explain the facility's process for monitoring the supplies. The OIG would expect facility staff to maintain and inventory all supplies in the same manner as those kept in standard supply rooms.

Recommendation 2

Facility leaders determine appropriate supply storage locations and, for any supplies stored outside of the defined locations, implement a process to ensure staff identify and remove expired supplies.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2026

Director Comments

Actions taken thus far: Quality and Patient Safety (QPS) Service's Regulatory Compliance Section engage in weekly (at minimum) tracer audits of compliance with regulatory requirements which includes environment of care (EOC) assessments of strong practices and identified vulnerabilities. Currently, tracer audits completed at various site locations show 100% compliance (26/26 tracer audit observations) with supplies within expiration dates.

Action plan: Leadership will review current storage locations for their area(s) of oversight and determine if supplies are stored outside of their assigned/defined location(s). Deadline target for completion of leadership review and assessment January 31, 2026. Outcomes/data will be reported out to Quality and Patient Safety Council (QPSC) by leadership. The governance group will determine, based on outcomes/data reported, if written procedures need to be clarified and implemented. If so, QPS Service will facilitate the processing of the written publication for all-staff dissemination/awareness. Ongoing monitoring and sustainment will utilize tracer audits with data reported out to Quality and Patient Safety Council (QPSC) until two (2) consecutive quarters (or six [6] consecutive months) of data is >/= 90% compliance.

Measured by: Tracer audit data of presence of expired supplies

Numerator: Number of compliant tracer audit observations

Denominator: Number of total tracer audit observations

The OIG observed open multidose medication vials without expiration dates. VHA Directive 1108.07(2) requires staff to label multidose medications with expiration dates once

[24] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

first used, which supports medication safety.[25] The nurse manager immediately disposed of the medications but did not explain why they were undated.

Recommendation 3

Facility leaders ensure staff label opened multidose medications with expiration dates.

_X_ Concur

____ Nonconcur

Target date for completion: June 20, 2026

Director Comments

Actions taken thus far: Quality and Patient Safety (QPS) Service's Regulatory Compliance Section engage in weekly (at minimum) tracer audits of compliance with regulatory requirements which includes environment of care (EOC) assessments of strong practices and identified vulnerabilities. Currently, tracer audits completed at various site locations show 50% compliance (7/14 tracer audit observations) with multi-dose medications being labeled with expiration dates.

Action plan: The responsible owners of VA Eastern Colorado Health Care System policies 119-36 Medication Administration, 118-23 Bar Code Medication Administration, and 119-42 Medication Room Storage will consult with the QPS Service's Regulatory Compliance Section to ensure local written procedures are clarified on the requirement for labeling of expiration date on multi-dose medications. The deadline target for the consultation and draft verbiage (as applicable) is December 31, 2025. Ongoing monitoring and sustainment will utilize tracer audits with data reported out to Quality and Patient Safety Council (QPSC) until two (2) consecutive quarters (or six [6] consecutive months) of data is >/= 90% compliance.

Measured by: Tracer audit data of presence of correct expiration date labels on multi-dose medications

Numerator: Number of compliant tracer audit observations

Denominator: Number of total tracer audit observations

The OIG also found clean items in the same room where dirty and biohazardous (contaminated) materials were stored. Storing clean and contaminated supplies together can increase the risk of

[25] VHA Directive 1108.07(2), *General Pharmacy Service Requirements,* November 28, 2022, amended December 6, 2024. "All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings." The Joint Commission, *Standards Manual*, E-dition, EC.03.01.01, January 1, 2025.

infection.[26] The Chief of Environmental Management Service identified the clean items as housekeeping supplies and reported staff would be retrained on their proper storage.

Recommendation 4

Facility leaders ensure staff store clean and dirty items separately.

_X_ Concur

____ Nonconcur

Target date for completion: August 31, 2026

Director Comments

Actions taken thus far: Environmental Management Service (EMS) leadership provided just-in-time training to staff during the Healthcare Facility Inspection (HFI) to ensure immediate correction.

Action plan: EMS leadership will develop refresher training on storage separation of clean and dirty items with deadline for refresher training development January 31, 2026. EMS leadership will provide refresher training to >/= 90% of EMS staff with attendance captured via sign-in attendance list. The deadline target for provision of refresher training is February 28, 2026, with status of completion and attendance percentage (numerator: number of EMS staff in attendance / denominator: number of total EMS staff). Ongoing monitoring and sustainment will utilize tracer audits with data reported out to Quality and Patient Safety Council (QPSC) until two (2) consecutive quarters (or six [6] consecutive months) of data is >/= 90% compliance.

Measured by: Tracer audit data of clean and dirty items correctly stored separately

Numerator: Number of compliant tracer audit observations

Denominator: Number of total tracer audit observations

Although facility staff submitted action plans and documented corrections for the specific locations where The Joint Commission had findings, the OIG determined that leaders did not ensure staff assessed whether similar vulnerabilities existed in other areas of the facility, did not implement corrective actions beyond the identified issues, nor sustain improvements. The Associate Director explained that after The Joint Commission inspection, there was inconsistent leadership, specifically, multiple acting associate directors for about three months, and some service chiefs were new to their roles, which hindered their ability to make and sustain the improvements throughout the facility.

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

Recommendation 5

The Director ensures staff implement processes to prevent repeat environment of care findings.

_X_ Concur

____ Nonconcur

Target date for completion: August 31, 2026

Director Comments

Actions taken thus far: Quality and Patient Safety (QPS) Service's Regulatory Compliance Section engage in weekly (at minimum) tracer audits of compliance with regulatory requirements with top identified vulnerabilities of noncompliant standards/requirements reported out to stakeholders (executive leaders, service chiefs, and administrative officers) on a recurring monthly basis at the Continuous Mission Readiness (CMR) themed Daily Management System (DMS) huddle. In addition to this current process, QPS Service's Regulatory Compliance Section has revamped VA Eastern Colorado Health Care System tracer audits in preparation for re-inclusion of frontline staff in completing tracer audit observations which include environment of care (EOC) regulatory requirements. Lastly, the Regulatory Compliance Section has scheduled open office hours to provide education on regulatory requirements (accreditation standards, VA/VHA national policy/directive, and local policy) with how-to instruction on completing tracer audit observations.

Action plan: Executive Leadership Team (ELT) will communicate the expectation of frontline staff/all areas returning to tracer audit participation monthly (at minimum) to monitor, assess, and ensure compliance with Environment of Care requirements. Deadline target for Executive Leadership Team communication to all staff December 31, 2025. Target for tracer audit observations completed by frontline staff/all areas to be implemented no later than February 28, 2026. Ongoing monitoring and sustainment will utilize tracer audits with data reported out to Quality and Patient Safety Council (QPSC) until two (2) consecutive quarters (or six [6] consecutive months) of data is >/= 90% compliance.

Measured by: Tracer audit data of compliance of repeat EOC findings

Numerator: Number of compliant tracer audit observations

Denominator: Number of total tracer audit observations

Toxic Exposure Screening Navigators

VA's "Toxic Exposure Screening Installation and Identification of Facility Navigators" memorandum recommends that each facility identify two toxic exposure screening navigators.[27] The OIG determined the facility had nine toxic exposure screening navigators, although each had other primary job duties. VHA's Toxic Exposure Screening Process expects designated staff to complete toxic exposure screenings within 30 days.[28] However, in March 2025, the OIG found staff had more than 2,000 screenings over 30 days old.

During an interview, the Chief of Vaccine and Environmental Employee Occupational Health stated that staff in their service conduct the screenings. The chief explained that, initially, the registered nurses were assigned to complete all parts of the screenings. However, after the ADPCS informed staff that registered nurses were not authorized to close out the screening, the number of staff allowed to complete this task decreased, which resulted in a backlog.[29] The chief explained the priority was for staff to complete the oldest screenings first, which delayed newer screenings. The chief also described reporting the number of past-due screenings to executive leaders weekly, and added the facility has an agreement with the VA VET-HOME program to help them complete the delinquent screenings.[30] The OIG recognizes leaders' efforts to address the incomplete screenings and did not make a recommendation.[31]

[27] 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; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

[28] Department of Veterans Affairs, *Toxic Exposure Screening Process*, updated January 2025.

[29] "An Authorized Closer is a physician (MD), osteopathic doctor (DO), advanced practice registered nurse (APRN), and/or physician assistant (PA) with clinical privileges. Registered Nurses (RN)s may also be Authorized Closers if they are permitted, by scope, policy, or SOP, to complete Stage 2 required actions." Department of Veterans Affairs, *Toxic Exposure Screening Process*.

[30] The VET-HOME program provides environmental health registry evaluations to veterans. "Welcome to VET-HOME (Veterans Exposure Team-Health Outcomes Military Exposures)," Department of Veterans Affairs, accessed March 19, 2025, https://vethome.va.gov/.

[31] VHA recently issued a memorandum that authorizes registered nurses to complete the toxic exposure screening as an authorized closer. Acting Chief Nursing Officer (12), "For Action Memorandum: Standard Operating Procedures for Toxic Exposure Screening (TES) Navigator Registered Nurses Completing Toxic Exposure Screening as an Authorized Closer in the Electronic Health Record," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23) VISN Chief Nursing Officers (10N1-23), and VISN Chief Medical Officers (10N1-23), November 20, 2025. The OIG conducted this inspection in March 2025, before VHA issued the memorandum.

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

Communication of Urgent, Noncritical Test Results

The OIG found that staff had not developed a facility policy and service-level workflows that outline the process for communicating test results, as required by VHA Directive 1088(1).[32] A leader explained that staffing turnover and competing priorities delayed staff in drafting the policy, but they completed the draft on March 10, 2025, the first day of OIG's inspection. Further, one service chief described the test result communication process for their service but did not have it in writing.

Recommendation 6

The OIG recommends facility leaders ensure the facility has a policy for the communication of test results and staff develop service-level workflows that align with VHA requirements.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2026

Director Comments

Actions taken thus far: System-wide stakeholder and collaboration for development of Communication of Test Result (CTR) policy with service-level workflows was facilitated by the Quality and Patient Safety (QPS) Service's Regulatory Compliance Section. Timeline includes:

1. March 17, 2025: Multidisciplinary stakeholder update to draft medical center policy (MCP) for communication of test results implemented with explanation of the "why" behind the "what" provided by Quality and Patient Safety Service's Regulatory Compliance Section to foster buy-in and reluctance to simplify with stakeholders.

[32] A service-level workflow is "a written document that describes the processes for communicating test results for each clinic, service, department, unit or other point of service where tests are ordered." VHA Directive 1088(1).

2. April 17-18, 2025: Refined edits and collation by QPS Service's Regulatory Compliance Section, including service-level workflows to be included as appendices to the MCP. Creation of policy identified need for 25 Service Level Workflows.
3. July 18, 2025: Routed to Review of Clinical Publications Committee for first stages of governance approval after stakeholder concurrence completed
4. December 8, 2025: Currently pending final stages of governance approval; must be vetted and approved through Nurse Executive Council (NEC) and then Healthcare Delivery Council (HDC) prior to Director approval/signature and publication to policy repository/disseminated to staff. The final MCP appendices includes 100% required 25 workflows.

Action plan: Finalize completion and publication of CTR policy with all service-level workflow appendices, publish to policy repository for all-staff access/dissemination. Target deadline for governance completion and approval January 31, 2026. Education regarding workflows will be provided by Regulatory Compliance Coordinators of QPS service to 100% of service chiefs with a specified workflow(s), with the expectation that education will be rolled down to front line staff by service leaders. Compliance will be demonstrated by obtaining attestations from service chiefs affirming education has been provided to at least 90% of the staff impacted by the workflow. Ongoing monitoring will be reported out to Quality and Patient Safety Council (QPSC) until 100% of attestations have been received.

Measured by: Attestations completed by Service Chiefs with a specified workflow(s).

Numerator: Number of completed attestations provided to QPS

Denominator: Number of total attestations tasked to service chiefs.

A patient safety manager reported staff enter patient safety concerns, including test result delays, into the Joint Patient Safety Reporting system.[33] Service chiefs confirmed they use the system to monitor test result communication, in addition to other mechanisms, such as reviewing patient complaints and conducting internal quality reviews for laboratory and radiology results.

The OIG identified delays in staff communicating radiology test results to patients and discussed them with facility leaders. The Acting Chief of Radiology, who had served in the role for approximately one year, stated that vacancies in radiologist positions required the facility to rely on staff from VHA's National Teleradiology Program and a contract service to review imaging studies during and after normal business hours. The Acting Chief of Staff added that the facility

[33] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

began using an additional contracted teleradiology service the previous year to further manage the radiology workload.

The Acting Chief of Radiology also stated that in December 2024, facility leaders limited the diagnostic imaging services they offered due to vacant technologist positions.[34] As a result, the Acting Chief of Staff said staff transferred some patients requiring these services after hours to community hospitals. Although executive leaders stated they continue to recruit radiologists and technologists, the OIG remains concerned that lack of staff makes care coordination challenging and delays staff in communicating test results to providers and patients.

Recommendation 7

Veterans Integrated Service Network 19 leaders assess the staffing needs for the facility's radiology service and provide additional resources to ensure services are readily available to patients.

_X_ Concur

____ Nonconcur

Target date for completion: September 30, 2026

Director Comments

Actions taken thus far: Veterans Integrated Service Network (VISN) 19 has been aware of ongoing Radiology staffing challenges and concerns with National Tele-Radiology coverage, having received several Issue Briefs from Eastern Colorado Health Care System (ECHCS). This issue is being monitored through the Chief Medical Officer and Oversight office at VISN 19. Discussions pertaining to gaps in reading radiology studies are discussed ad hoc at VISN 19 Tier 4 Huddle. VISN 19 elevated concerns related to salary gaps between the VA physician salary cap and community positions as well as coverage in the National Teleradiology Program to the national level and VA central office. VISN 19 requested copies of ECHCS Memorandums of Understanding (MOU) and contingency plans for addressing gaps in radiology coverage.

Action plan: VISN 19 initiated a comprehensive assessment of ECHCS Radiology Service on December 5, 2025. This assessment included the number of on-site/local Radiologist positions (vacant and filled), coverage for Weekend/Holiday/Evening (WHEN) hours, support from other sites, copies of agreements, MOUs and contingency plans, positions currently in recruitment/position numbers/status, and any further efforts explored. VISN 19 is receiving updates in real time as recruiting progress is made and focusing on establishing vendor

[34] The OIG received documentation from staff identifying the limited availability of ultrasound and magnetic resonance imaging due to limited staffing.

specific contracts for more needed coverage. Ongoing progress will be reported monthly at the VISN 19 Healthcare Delivery Council until 90% of ECHCS Radiologist positions are submitted to Human Resources for recruitment within 30 business days of being vacated, for 6 consecutive months. This data will be cumulative starting October 1, 2025.

Measured by: cumulative percentage of ECHCS Radiologist positions being submitted to Human Resources for recruitment within 30 days of being vacated

Numerator: cumulative number of ECHCS Radiologist positions submitted to Human Resources within 30 days of vacancy.

Denominator: cumulative number of ECHCS Radiologist positions vacated since October 1, 2025

Additionally, the OIG found delays with facility providers' receipt of imaging results from community providers. Leaders attributed the challenges to facility community care staff vacancies, which delayed both obtaining the results and uploading them into the electronic health record. The Acting Chief of Staff explained that staff could not enter specialty care consults until test results were available in the electronic health record.

The OIG interviewed leaders and staff from the VISN and the facility's community care and women's health programs to determine how VISN leaders supported the facility's community care program, and to identify any barriers to staff receiving mammography and other imaging results from community providers. Facility community care leaders stated VISN and facility leaders provided additional staff to support their service and recently approved them to hire 10 registered nurses and 17 medical support assistants.

Although facility leaders said they received staff from the VISN and other facility departments to assist with the workload, the OIG remains concerned that if staff do not receive and upload images and test results from community providers in a timely manner, patients may experience delays in receiving needed treatment and follow-up care.

Recommendation 8

Veterans Integrated Service Network 19 leaders evaluate the reasons for delays in uploading images and reporting test results and assist the facility's community care leaders to mitigate future delays.

_X_ Concur

____ Nonconcur

Target date for completion: September 30, 2026

Director Comments

Actions taken thus far: Veterans Integrated Service Network (VISN) 19 became aware of ongoing Community Care Scanning backlogs in early Fiscal Year 2025 having received several Issue Briefs from Eastern Colorado Health Care System (ECHCS). This issue is currently being monitored through the VISN 19 Community Care Manager. Comprehensive assessment of staffing and process gaps at ECHCS resulted in development of a multipronged approach to implementing software and improving processes. In January 2025, VISN 19 consolidated unit dedicated 34 employees to assist with daily work. Comprehensive training was given to current staff to ensure consistency in process. Staffing methodologies were implemented to meet established guidelines. Additional contracted staff have been dedicated to records review resulting in a 34% reduction in backlog since the start of the calendar year. Training was conducted and overtime approved for staff outside of the department, both local and VISN 19, to assist with processing records. Software solutions included eFax and Health Share Referral Manager (HSRM). Further, Enterprise Precision Scanning and Indexing (EPSI) was fully implemented in June 2025 ensuring streamlined processes for indexing and clinical review. Automatic naming capabilities in EPSI allow VA staff to locate medical records by patient name immediately upon loading into the system.

Action plan: Local leadership will continue to monitor community care scanning backlog volume daily. Staff will continue to be dedicated to resolving records backlog. Total records inventory is reported weekly to VISN 19 Health Informatics Management and Community Care. Target will be a monthly incremental decrease in Community Care scanning backlog for 6 consecutive months. Data will be monitored by reporting to VISN Community Care Oversight Committee and ultimately reported to VISN 19 Health Care Operations Council.

Measured by: percentage of months that demonstrate decreasing numbers of Community Care records backlog

Numerator: number of months that demonstrate decreased numbers of Community Care records pending indexing greater than 5 days

Denominator: all medical records requiring indexing in Community Care

Action Plan and Process Improvements

The OIG reviewed a report from VHA's Office of the Medical Inspector that found a provider had placed an expired implant into a patient.[35] The OIG also reviewed documents showing a

[35] The Office of Medical Inspector's site visit occurred in December 2023. Department of Veterans Affairs, *Report to the Under Secretary for Health, VA Eastern Colorado Health Care System, Aurora, Colorado*, Content Manager 2023-C-47, May 7, 2024. An implant is defined as a device made from biological materials, such as tissue, bone, skin, or non-biological, such as metal, plastic, or ceramic that can be placed into or on the body's surface. "Implants and Prosthetics," Food & Drug Administration, accessed March 24, 2025, https://www.fda.gov/implants.

similar issue occurred in FY 2024 and determined facility leaders took appropriate actions to prevent future occurrences. Therefore, the OIG did not make a recommendation.

The OIG also reviewed action plans for two root cause analyses related to test result communications.[36] The OIG found staff were implementing action plans and measuring the outcomes for one root cause analysis, but had not completed the other within the facility's established time frame. A patient safety manager stated quality and patient safety staff assigned action plans to primary care staff to complete, but due to turnover in the primary care service, they had not implemented the actions. When asked how patient safety staff track and monitor root cause analysis action plans, the manager explained they use a project tracker that allows them to assign action plans to specific staff and alerts them when the assigned staff update it. The manager also said staff developed a patient safety dashboard to track actions and improvements over time.

The manager stated that facility staff are still working on improvement actions and measuring associated outcomes from 26 root cause analyses from previous years. The manager attributed the backlog to the lack of patient safety staff to monitor and follow up with facility staff, explaining that until 2024 there was only one patient safety manager to support the program, but leaders hired three more last year. The manager added that with additional staff to oversee the process, overdue actions decreased from 67 percent to 37 percent over the last 10 months. Although patient safety staff have made progress in closing out past-due actions, the OIG is concerned about sustainment during this time of leadership transition.

Recommendation 9

Executive leaders monitor root cause analysis improvement actions through completion, monitor outcome measures, and ensure staff implement processes to sustain the improvements.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

Actions taken thus far: Patient Safety Committee (PSC) utilizes the governance structure to refer Root Cause Analysis (RCA) action items to the appropriate governance group to address resolution/closure, as applicable. ***NOTE:*** *Not all RCA action items require governance referral (e.g., just-do-it items).*

[36] A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

Action plan: In addition to current action of PSC referring applicable RCA action items to the appropriate governance group for resolution/closure, PSC will update their referral template no later than December 31, 2025, to include consultative recommendation(s) for sustainment monitoring of referred RCA action items. This consultative practice fosters preoccupation with failure by assisting governance groups with choices to consider, to accept or refine, for sustainment to mitigate potential reoccurrence. Ongoing monitoring and sustainment will utilize tracer audits with data reported out to Quality and Patient Safety Council (QPSC) until two (2) consecutive quarters (or six [6] consecutive months) of data is >/= 90% compliance.

Measured by: Percentage of action items closed per the RCA action item completion tracker

Numerator: Number of RCA action items completed

Denominator: Number of total action items

The OIG asked quality and patient safety staff to identify barriers that limit long-term improvements in the patient safety program. The Chief of Quality and Patient Safety stated facility-wide staffing issues are the largest barrier, but current executive leaders have been supportive and actively engaged with patient safety concerns. The patient safety manager explained that frequent turnover among service leaders created challenges in completing assigned actions on time. Leaders originally responsible for the actions had left their roles, and new or interim leaders often lacked awareness of the outstanding requirements. The manager acknowledged that the current executive leadership team has improved accountability and helped address these issues.

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[37] The OIG interviewed staff and analyzed primary care team staffing data and new patient appointment wait times.

Primary Care Teams

In March 2025, the facility had 95 primary care teams; 59 were not fully staffed, but leaders had approved hiring 52 nurses, 21 medical support assistants, and 16 providers. Primary care staff stated staffing, turnover, and an insufficient number of teams to provide patient care were challenges, and a registered nurse said many staff cover more than one team.

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

The Chief Nurse for Outpatient Services said many of the vacancies were due to the executive leaders' actions to reduce staffing to meet VHA's FY 2024 guidance.[38] The ADPCS described a plan to obtain a nursing staff contract in the interim until they fill the vacancies and staff could begin work. The Chief of Health Administrative Services also stated they will use contracted staff to cover medical support assistant positions until they fill the current vacancies.

The Deputy Associate Chief of Staff noted challenges with hiring providers. For example, the Acting Chief of Staff explained that rural sites are the most difficult to staff because of their remote locations. To attract more providers to the remote locations, the acting chief described collaborating with a local university that has a rural health training program. The acting chief added that before leaders hired the current Associate Chief of Staff for Primary Care, the position had been vacant for almost two years and attributed this, in part, to the need for this leader to cover a large geographic region covered by the healthcare system, which includes both urban and rural locations.

Primary care staff said existing staff provide leave coverage because the facility has no float team (staff who are not assigned to a specific team) for nurses or providers. A primary care provider clarified that providers hired for float coverage are currently assigned to teams on a long-term basis. The Chief Nurse for Outpatient Services said despite the lack of a float team, they have three part-time staff who cover positions similar to float nurses.

Primary care team members stated that with current staffing, panel sizes are not manageable. As of February 2025, the OIG determined that 63 of the 95 team panels were over capacity, with the panel size averaging 105 percent of VHA Directive 1406(2)'s expected size.[39] The Group Practice Manager stated the larger panel sizes began in FY 2023 when some providers resigned, and the prior Chief of Staff assigned more patients to providers to accommodate new patients. According to the practice manager, in the second quarter of FY 2024, the new Chief of Staff authorized a decrease in providers' panel sizes and explained that new patients are only assigned to providers with panel sizes under 120 percent expected size.

The OIG reviewed data for new patient appointments and determined wait times had increased from 44 days in the first quarter, to just over 62 days in the third quarter of FY 2023. Primary care nursing staff attributed those long wait times to the large panel sizes and lack of providers to create new teams. The Deputy Associate Chief of Staff stated they added clinic hours on Saturdays, when staff can work overtime, to help decrease new patient wait times. The deputy

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

[39] Panel size is the number of patients assigned to a care team "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). "The baseline capacity for a full-time Patient Aligned Care Team (PACT) is 1,200 patients." VHA Directive 1406(2).

also said wait times for new patient appointments in February 2025 had improved to approximately 48 days.

The practice manager and the Program Analyst for the Patient Centered Management Module stated they meet every two weeks with nursing leaders to discuss staffing and patient schedules and monthly with primary care leaders to discuss panel sizes, wait times, and staffing concerns.[40] The Deputy Associate Chief of Staff reported monitoring panel sizes closely and adjusting them as needed, with a goal of reaching 95 percent of VHA's expected capacity.

For the new outpatient clinic in Castle Rock, leaders planned to add two or three teams in May 2025, and up to eight teams there over the next year. The ADPCS stated they may also add a clinic in the Denver area due to the growing veteran population, but no timeline has been set. Leaders said they are hopeful these changes will help decrease overall panel sizes and wait times. Larger panel sizes and staffing shortages increase staff workload and patient wait times.

Recommendation 10

Facility leaders attain appropriate primary care staffing and manageable panel sizes to ensure patients have timely access to high-quality care.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

Actions taken thus far: Recruitment efforts for primary care providers (PCPs) are ongoing, with 30 openings identified and 19 selections made. There are two (2) of the three (3) section chief positions with selected candidates. For the rural clinics, there are two (2) incoming PCPs for the three (3) openings. The Pueblo site has three (3) open PCP positions and is seeking contracted providers.

Union clinic (located in Colorado Springs) has three (3) open PCP positions and anticipated transfers in March 2026. Space Center Clinic (located in Colorado Springs) will see the retirement of two (2) PCPs soon. Staffing efforts aim to strengthen Teamlet ratios, with 40.57% of teams meeting the target ratio. Current nursing staff vacancies are 32. The healthcare system's current Primary Care panel size is 81,110 patients, with an overall panel fullness of 98.45%. For November 2025, primary care (PC) wait times decreased 3.04 days from October 2025 and still trends above the expected wait time metric performance.

[40] "PCMM [Patient Centered Management Module] is a VHA Web-based application that allows input of facility specific and PC [primary care] panel specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes." VHA Directive 1406(2).

New patient wait time initiatives include Open Slot Management (OSM) across 279 clinics, appointment scrubbing, and expanded scheduling grids for new providers completing onboarding.

Action plan: Full time equivalent employee (FTEE) ceilings will directly impact results. Executive Leadership Team (ELT) will prioritize hiring PC team members through local Position Management Committee (PMC) and Veterans Integrated Service Network (VISN) 19 processes, as applicable, to ensure efforts towards right-sizing panel sizes is achieved. The facility will maintain awareness of primary care wait times and appropriately refer Veterans to the Community for primary care when needed. Ongoing monitoring and sustainment will utilize Primary Care panel status that is reported at Patient Aligned Care Team (PACT) Steering Committee until two (2) consecutive quarters (or six (6) consecutive months) of data is >/= 90% compliance.

Measured by: Percentage of PACT Panels that are operating consistently less than 105% of calculated capacity

Numerator: Number of PACT panels at less than 105% of calculated capacity

Denominator: Number of total of PACT panels

OIG Comments

The OIG closed the recommendation as leaders developed improvement plans and completed actions before publication of the report.

At the Rocky Mountain Regional VA Medical Center primary care location, the OIG observed licensed practical nurses did not have a private location to obtain vital signs, complete clinical reminders (electronic health record prompts to remind healthcare providers to follow up on specific actions or tests related to a patient's care), or perform any physical exam prior to the provider seeing the patient. The Chief Nurse for Outpatient Services explained there are not enough rooms at this location for the number of teams and patients. The OIG toured the clinic and spoke with the nurse manager, who clarified the clinic contains 29 exam rooms for 25 primary care teams, the Rapid Access Clinic, and 2 nursing procedure rooms.

The chief nurse stated that space constraints limit privacy for nursing staff when discussing health information with patients. For example, licensed practical nurses lacked private areas to meet with patients, so staff created a handout for patients to complete. The handout helps staff collect necessary information and complete clinical reminders. However, the document does not include suicide screening questions, which staff must ask during a private discussion; as a result, providers ask during their appointment, which can be additional workload.

The chief nurse further stated leaders monitor staff's compliance with quality metrics and share the data with staff during meetings. The chief nurse explained that staff had improved quality

metrics, including those related to breast and colorectal cancer screenings, despite workload challenges.

The OIG reviewed 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 aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[41]

During this inspection, VHA used three performance measures to determine the success of each facility's program. The first, HCHV5, measures the percentage of unsheltered veterans who receive a program intake assessment.[42] However, beginning in FY 2026, VHA no longer uses this as a performance measure. Next, HCHV1 measures the percentage of veterans who are discharged from contracted residential services and low-demand safe haven programs into permanent housing.[43] Finally, HCHV2 (negative exits) measures 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).[44]

Program Highlights

- The program met the HCHV5 target in FY 2024. The Section Chief of Homeless Programs explained an outreach coordinator visited homeless encampments and

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

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

[43] Low-demand safe havens are transitional residences with minimal restrictions for veterans with mental health or substance use issues. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[44] 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*.

other HCHV staff traveled to local shelters to engage veterans. Staff also met with community partners weekly to coordinate outreach efforts.

- The section chief reported the HCHV1 and HCHV2 metrics were not applicable to their program because it has not had contracted residential services since 2022. Instead, staff referred homeless veterans to community shelters. A staff member explained that community partners provide temporary shelter for those veterans awaiting transition to permanent housing.

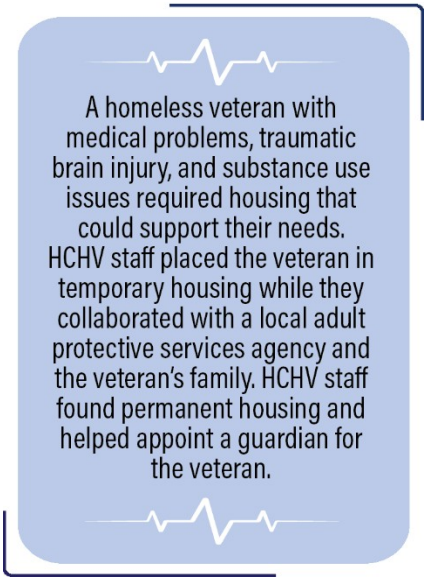

Figure 6. *Example of veteran engagement.*
Source: OIG analysis of questionnaire.

Housing and Urban Development–Veterans Affairs Supportive Housing

The Housing and Urban Development–Veterans Affairs Supportive Housing program combines Department of Housing and Urban Development rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[45] The program uses the housing first approach to prioritize rapid placement into housing followed by individualized services.[46]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[47]

Program Highlights

- The program fell short of meeting the HMLS3 target in FYs 2022 through 2024. The Section Chief of Homeless Programs shared that working with eight different local public housing authorities was a barrier to using housing vouchers. Each housing authority has a distinct voucher application process, and staff may encounter difficulty navigating the differences when helping veterans apply for rental assistance, which results in housing delays.

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

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

[47] VHA sets the HMLS3 target at 90 percent or above and the VASH3 target at 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

- The program met the VASH3 target in FYs 2022 and 2023 but missed it in FY 2024. The section chief explained that staff had not updated veterans' employment status in the electronic database, so the data to support the measure was not accurate. To improve data entry, the section chief planned to train program staff on the employment metric in March 2025.

Veterans Justice Program

VHA's Veterans Justice Program serves veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration.[48] Recognizing incarceration as a strong predictor of homelessness, the program focuses on connecting veterans to VA health care, services, and benefits. VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[49]

Program Highlights

- The facility's program met the target in FYs 2023 and 2024. The Veterans Justice Outreach Program Coordinator discussed conducting regular outreach at jails and meeting with incarcerated veterans to complete intake assessments and enroll them in the program.
- The coordinator reported staff provide outreach at veteran pods (areas in jails and prisons where incarcerated veterans are co-located) and coordinate with community agencies that provide educational classes to promote a more therapeutic environment. In addition to creating a supportive environment, veteran pods can make outreach and coordinating services more efficient.[50]

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

[49] 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*.

[50] "Post-Traumatic Stress Disorder And Criminal Legal System-Involved Veterans Information Brief," Department of Veterans Affairs, accessed March 19, 2025, https://www.va.gov/Involved_Veterans_Information_Brief.pdf.

Conclusion

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

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG issued recommendations on issues related to supplies, liquid nitrogen storage, medication labels, repeat environment of care findings, test result communication, staffing, process improvements, and primary care panel sizes. Facility leaders have started to implement corrective actions, which resulted in the OIG closing one recommendation. 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.

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 March 10 through 13, 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, 2022, 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.*

‡*A September 5, 2025, executive order designated the Department of War as a secondary title for the Department of Defense. Restoring the United States Department of War, 90 Fed. Reg. 43893 (Sep. 10, 2025).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 13, 2026

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Facility Inspection of the VA Eastern Colorado Health Care System in Aurora

To: Director, Office of Healthcare Inspections (54HF03)

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 Eastern Colorado Health Care System in Aurora.
2. Based upon a thorough review of the report by VISN 19 leadership, I concur with the findings, recommendations and submitted action plans of VA Eastern Colorado Health Care System and VISN 19 subject matter experts. As we remain committed to ensuring our Veterans receive exceptional care, VISN 19 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.
3. If you have any questions or require further information, please contact the VISN 19 Quality Management Officer.

(Original signed by:)

Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 15, 2025

From: Director, VA Eastern Colorado Health Care System (554)

Subj: Healthcare Facility Inspection of the VA Eastern Colorado Heath Care System in Aurora

To: Director, Rocky Mountain Network (10N19)

Enclosed are the required items listed in the email received on December 8, 2025, in reference to our March OIG Healthcare Facility Inspection.

(Original signed by:)

Amanda Martinez, MBA, MHM
Acting Director, VA ECHCS
Acting Associate Director
for
Paul Roberts, MHA, FACHE
Interim Director, VA ECHCS

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