US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

**VETERANS HEALTH ADMINISTRATION**

# Healthcare Facility Inspection of the VA Loma Linda Healthcare System in California

| Healthcare Facility Inspection | 25-00208-64 | March 12, 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 Loma Linda Healthcare System (the facility) from April 28 through May 1, 2025.

The facility's services are available to more than 78,000 veterans.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

## What the OIG Examined

- **Culture.** The 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. The OIG team reviewed a 2025 Joint Commission survey that found an eyewash station had mineral deposits.[3] During this inspection, the team observed multiple eyewash stations with deposits around the spouts, which suggested staff had not sustained improvements across the organization. Additionally, there was an open shower room in the locked dementia unit of the community living center that had paper signs taped to the wall, debris on the floor, dirty floor mats, and a dusty blanket warmer plugged into to an electrical socket within the shower room.[4] The team also observed patient information (names and Social Security numbers) at a diagnostic testing station in an open area of the Emergency Department. The OIG made related recommendations.
- **Patient Safety.** The OIG team assessed the facility's processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The team found that leaders did not develop a policy to communicate test results to patients and providers, and only two services had workflows that describe the communication process, as required by VHA Directive 1088(1).[5] The

[1] "About Us," Department of Veterans Affairs, last updated May 13, 2025, https://www.va.gov/lomalindahealthcare.

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

[3] The Joint Commission, *Final Accreditation Report VA Loma Linda Healthcare System*, February 11, 2025. (This report is not publicly accessible.)

[4] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, last updated June 3, 2025, https://www.va.gov/Geriatrics/VA_CLC.asp.

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

team also found the Chief of Staff and Associate Director of Patient Care Services did not review test result communication performance metrics, as required by VHA Directive 1088(1).[6] Although a patient safety manager reported sharing data at the Quality and Patient Safety Council, meeting minutes showed executive leaders did not attend most meetings, as expected per the council's charter. The OIG made recommendations.

- **Primary Care.** The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[7] The OIG made no recommendations.
- **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 efficiency of VA programs and services that improve the health and welfare of veterans and their families.

## What the OIG Recommended

1. Facility leaders ensure the community living center's dementia unit shower room is clean and free from hazards, and that leaders conduct a risk assessment to determine the need for other safety measures.
2. The Medical Center Director ensures facility staff conduct a privacy assessment and take actions to protect patient information in the Emergency Department.
3. Facility leaders ensure all eyewash stations are clean and function properly.
4. The Medical Center Director ensures the facility has a written policy for communication of test results.
5. The Chief of Staff and Associate Director of Patient Care Services ensure leaders in each service develop written service-level workflows that outline the process for staff to communicate test results to providers and patients.
6. The Veterans Integrated Service Network Director ensures executive leaders implement a process to monitor actions related to Veterans Health Administration policy changes.

[6] VHA Directive 1088(1).

[7] 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 Medical Center Director ensures the Chief of Staff and Associate Director of Patient Care Services review performance metrics for test result communications and take action for identified deficiencies.
8. The Medical Center Director ensures executive leaders attend Quality and Patient Safety Council meetings.

## VA Comments and OIG Response

The Interim Veterans Integrated Service Network Director and facility Director concurred with the inspection recommendations and provided acceptable improvement plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments). The OIG continued communication with VHA regarding the findings, which resulted in the closure of recommendations 1, 2, and 3. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

# Abbreviations

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

# Contents

# Introduction

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

In 2018, VHA launched efforts to become a high reliability organization (HRO) and set goals to enhance accountability and reliability and reduce patient harm. The HRO framework provides the blueprint for VHA-wide practices to strengthen the culture of patient safety and high-quality care in medical facilities.[2] VHA has now implemented HRO principles at all VHA facilities.[3]

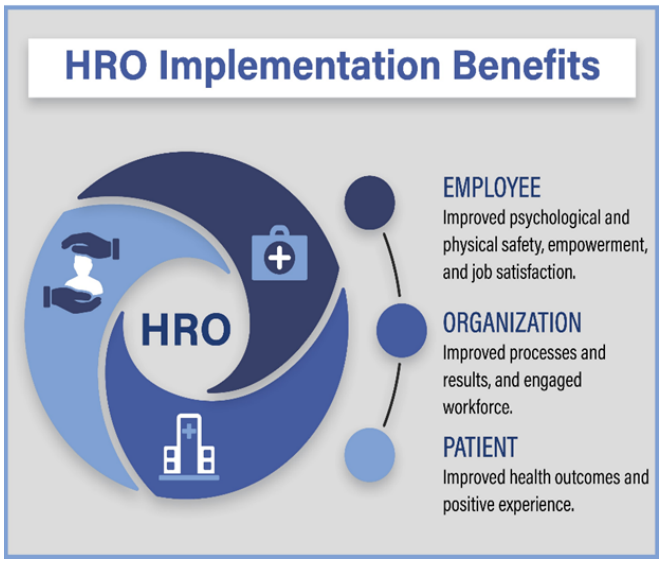


***Figure 1.*** *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Each inspection focuses on five domains: culture, environment of care, patient safety, primary care, and a veteran-centered safety net (comprising programs for veterans experiencing homelessness or recent incarceration).

Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions VHA leaders and staff can take.

[1] "About VHA," Department of Veterans Affairs, last updated January 20, 2025, https://www.va.gov/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.)

## PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[4] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[5] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[6] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[7] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

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

[5] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, last updated April 21, 2025, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

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

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


***Figure 2.*** *Healthcare Facility Inspection's five 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 Jerry L. Pettis Memorial Veterans' Hospital (medical center), now part of the VA Loma Linda Healthcare System (the facility), originally opened in 1977.[8] The facility includes 10 locations in California.[9] According to leaders, the facility's budget obligations were approximately $1.3 billion in fiscal year (FY) 2024, and it had 160 inpatient (129 acute medical surgical and 31 mental health) and 110 community living center beds.[10]

***Figure 3.*** *Jerry L. Pettis Memorial Veterans' Hospital.*
*Source: "VA Loma Linda Health Care," Department of Veterans Affairs, accessed April 1, 2025, https://www.va.gov/loma-linda-health-care/.*

The OIG inspected the facility from April 28 through May 1, 2025. The executive leaders referred to throughout this report include the Medical Center Director (Director), Associate Director for Resources, Associate Director of Operations, Associate Director of Patient Care Services (ADPCS), Chief of Staff, and Assistant Director. The longest tenured leader was the Director (assigned in March 2019), and the newest was the Associate Director of Operations (assigned in July 2024).

## 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.[11] The OIG administered its own facility-wide questionnaire and reviewed VA's All Employee Survey scores for

[8] "About Us," Department of Veterans Affairs, last updated May 13, 2025, https://www.va.gov/lomalindahealthcare.

[9] In addition to the medical center, the facility has an ambulatory care center in Loma Linda and community-based outpatient clinics in Blythe, Corona, Hemet, Murietta, Redlands (North Loma Linda), Rancho Cucamonga, Palm Desert (Sy Kaplan), and Victorville, California. Some of the clinics are VHA-operated and others are non-VHA-operated. See the Primary Care section of this report for a detailed discussion.

[10] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, last updated June 3, 2025, https://www.va.gov/Geriatrics/VA_CLC.asp.

[11] 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.

October 1, 2023, through September 30, 2024. The team also interviewed leaders and employees, and considered data from patient advocates and veterans' feedback.[12]

## System Shocks

Executive leaders reported multiple system shocks, including staffing vacancies during a hiring freeze, the traumatic death of a service leader, and the Palisades fire.[13] The Associate Director of Operations reported being unable to fill non-clinical vacancies due to the hiring freeze. Executive leaders said they reviewed staffing needs weekly to prioritize hiring, and the associate director explained that leaders also evaluated services with vacancies for possible reorganization. For example, leaders said they considered moving the Interior Design Service under the Facilities Management Service, so they would have one chief. Leaders also held additional town halls to address concerns about the hiring changes and potential staffing reductions and allotted time after the meetings for individual questions.

Executive leaders also discussed the November 2024 death of a service leader, explained that a former VA staff member was charged with the murder, and clarified the event did not occur at the facility. The Chief of Staff said the loss deeply affected everyone at the facility and many felt shaken, upset, and emotionally overwhelmed, which negatively affected their daily work. Leaders said chaplains and mental health staff offered support, and leaders made additional visits to work areas to answer questions and listen to concerns. Further, leaders enhanced security in response to staff's concerns, which included adding more lights and a main entrance scanner to detect concealed weapons.

The ADPCS said the West Los Angeles VA Medical Center urgently transferred 25 patients to the facility during the Palisades fire in January 2025. The influx of patients over a short period of time required detailed coordination and support. The ADPCS shared lessons learned from the experience in which staff arranged transportation, ensured timely communication with West Los Angeles VA staff, and accommodated the transferred patients' care and other needs.

## Employee Experiences

During interviews, executive leaders explained that they provided service leaders with leadership development training to strengthen employee engagement and enhance communication

[12] The All Employee Survey is an annual, voluntary survey of VA workforce experiences. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. Patient Advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," Department of Veterans Affairs, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[13] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). The Palisades fire occurred in the Pacific Palisades area of Los Angeles, California. It started on January 7, 2025, and was active for 24 days. "Palisades Fire," California Department of Forestry and Fire Protection, accessed May 6, 2025, https://www.fire.ca.gov/incidents/palisades-fire.

strategies. Additionally, the chief nurse of quality and patient safety highlighted quarterly awards and celebrations that recognize employees who provide exceptional care.

The Director also emphasized breaking down perceived barriers that can make employees feel distanced from executive leaders. Leaders said they periodically attend service-level huddles to improve visibility and provide guidance. The Director answers questions submitted through an "Ask the Director" link on an internal website, shadows employees, and has an employee act as the honorary director for a day.

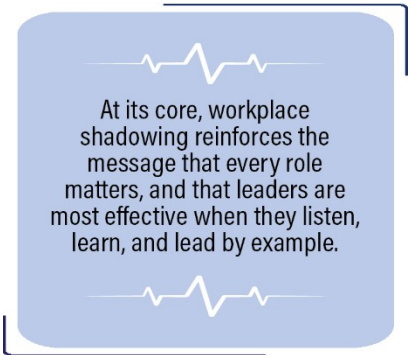


***Figure 4.*** *Improving Employee Experience.*
*Source: Email from the Director.*

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety and found workgroup survey results improved over time.[14] The OIG noted the facility's VA Organizational Health Index score had also improved from FYs 2023 to 2024.[15]

Executive leaders said they empower employees to speak up about issues and encourage rapid improvement events (a quality of care improvement process to address specific problems, identify solutions, and execute change in a short period of time); employees then discuss issues at all-employee meetings.[16] The Director also clarified that it is important for employees to report patient safety events, and leaders to review trends.[17] The Director and service leaders participated in training about barriers to employees reporting patient safety events, including fear of retaliation, and ways to create a culture that encourages employees to report them. Facility leaders said patient safety managers visit work locations to discuss lessons learned from patient safety events and review events during meetings.

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

[15] The Organizational Health Index is a summary of the overall differences in All Employee Survey scores for each facility compared to VHA averages and the facility's prior year. "2024 AES Action Planning Dashboard," Department of Veterans Affairs, accessed June 12, 2025, https://dvagov.sharepoint.com/sites/AESDashboard. (This website is not publicly accessible.)

[16] Susan C. Martin et al., "Rapid Improvement Event: An Alternative Approach to Improving Care Delivery and the Patient Experience," *Journal of Nursing Care Quality* 24, no. 1 (January 2009): 17-24, https://doi:10.1097/NCQ.0b013e31818f52a9.

[17] VHA uses the Joint Patient Safety Reporting system to report patient safety events, such as adverse events and close calls, at VA facilities. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

## Veteran Experiences

Patient advocate respondents to the OIG questionnaire highlighted veterans' common complaints about issues with the phone system and community care.[18] For example, during interviews, a leader reported being aware of issues with the phone tree (which routes callers based on the options they choose during the call), such as callers being looped through automated options without resolution or being incorrectly transferred back to the main menu. In response, executive leaders said they consolidated their call centers (such as those for the pharmacy and primary care scheduling) with the Veterans Integrated Service Network's (VISN's) call center to streamline the system.[19]

To improve veterans' experiences with community care, the Chief of Staff explained that executive leaders expanded VA services to reduce reliance on community care. For example, facility leaders added radiation therapy to the oncology service and offered optometry in some community-based outpatient clinics.[20] In addition, the Director discussed considering ways for rural community-based outpatient clinics to increase access to dental services, physical medicine and rehabilitation, and other services.


Attention to environmental design improves veterans' and staff's safety and experience.[21] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

[18] VA provides care to Veterans through community providers when VA cannot provide the care needed. "Community Care," Department of Veterans Affairs, last updated June 21, 2024, https://www.va.gov/communitycare.

[19] Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, last updated August 11, 2025, https:///www.va.gov/visns.

[20] Radiation therapy uses doses of radiation to treat cancer by reducing tumors and destroying cancer cells. "Radiation Therapy to Treat Cancer," National Cancer Institute, last updated May 15, 2025, https://www.cancer.gov/radiation. Oncology refers to the treatment and study of cancer. *Merriam-Webster*, "Oncology," last updated February 2, 2026, https://www.merriam-webster.com/oncology. Optometry refers to the diagnosis and treatment of eye diseases. *Merriam-Webster*, "Optometry," last updated December 27, 2025, https://www.merriam-webster.com/optometry.

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

The OIG inspectors examined compliance with key VA and VHA guidelines and standards, as well as Architectural Barriers Act and Joint Commission standards. They also considered best practice principles from academic literature.[22]

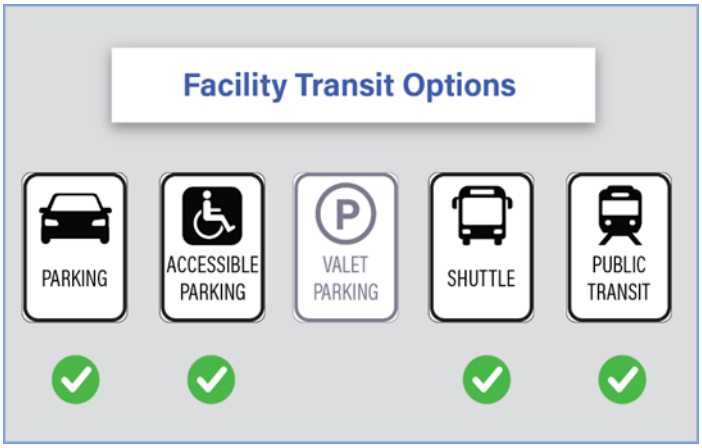


***Figure 5.*** *Transit options for arriving at the facility.*
*Source: OIG analysis of documents, questionnaires, and responses from staff.*

## General Inspection

The OIG easily followed directions to the medical center using a commercial navigation application and found the transit and parking options adequate. The facility offers a shuttle service between its medical center and the Loma Linda VA Clinic. The medical center also has a volunteer-run mobile cart that transports veterans to and from the main entrance and their cars. Parking areas include accessible spots for those with disabilities, and the chief of facility management said a new parking structure is under construction, with completion expected in 2026.


***Figure 6.*** *Accessibility tools available to veterans with sensory impairments.*
*Source: OIG analysis of documents, questionnaire responses, and observations.*

The OIG inspected the main entrances at the medical center, Loma Linda VA Clinic, and Rancho Cucamonga VA Clinic and found each to be spacious and inviting. The medical center entrance features a reception desk with staff available to assist veterans with directions to clinical areas. Additionally, the entrance has a map and directory affixed to the wall, and an electronic kiosk to help veterans navigate the facility.

The facility offered a variety of accessibility tools, including large print signs and tactile cues (braille). Additionally, audio amplifiers were available for hearing-impaired veterans.

The OIG reviewed patient advocate reports and noted a concern about the lack of automated doors with

[22] 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.

push plates that those with disabilities use to open doors. The OIG observed high-traffic medical center locations, such as Emergency Department lobby bathrooms, that did not have automated doors, which may make it difficult for disabled veterans to enter those areas. While there is no VHA requirement for the automated doors, they may improve veterans' experiences.

The OIG noted concerns in the community living center's locked dementia unit. The OIG observed paper signs taped to the wall, dirty mats on the floor, and a dusty blanket warmer covered in old packaging plugged into an electrical socket inside an unlocked and unattended shower room. Although the blanket warmer was not adjacent to a shower, it posed safety risks, such as electrical shock. There was also small debris on the unit's floor, which creates a fall risk for patients. VHA Directive 1608(1) requires facilities to ensure a safe and clean health care environment.[23]

A unit staff member explained they keep the shower room unlocked but remain in the hall to ensure patients do not wander into the room. However, the OIG visited the unit on two separate occasions, determined the room was unlocked, and did not observe staff monitoring the hallway.

## Recommendation 1

Facility leaders ensure the community living center's dementia unit shower room is clean and free from hazards, and that leaders conduct a risk assessment to determine the need for other safety measures.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

### Director Comments

Veterans Affairs Loma Linda Healthcare System (VALLHCS) leaders representing the Community Living Center (CLC), Facility Management Service (FMS), Safety Office, Environmental Management Service (EMS), and Quality and Patient Safety (QPS) met to review the recommendation and formulate a plan of correction to ensure that CLC's dementia unit shower rooms are clean and free from hazards.

On January 13-14, 2026, VALLHCS leaders conducted a comprehensive risk assessment that included several rounds to CLC's 1SW Heritage Inn (Dementia Unit) and follow-up meetings to finalize the implementation plan.

VALLHCS completed the following actions:

[23] VHA Directive 1608(1).

Removal of Hazards: All electrical items, including the blanket warmer, were removed from the shower room.

Access Control: CLC staff were educated by CLC nursing leaders to keep the shower room locked when not in use. The training was reinforced by 1 SW Heritage Inn (Dementia Unit) CLC nurse manager and charge nurse at unit huddles.

Environmental Cleaning: Shower mats were replaced. EMS implemented daily cleaning and sanitization. Deep cleaning is performed by EMS staff as needed when requested by CLC staff.

Floor Safety: Unit floors were cleaned. Ongoing daily inspections were scheduled to prevent debris accumulation.

Signage: All paper signs were removed to maintain a clean environment. Any new paper signs will be placed in sheet protectors or sign holders.

Risk Assessment: Facility leadership conducted a focused risk assessment in the CLC Dementia Unit. It was determined that current measures mitigated identified risks. On January 21, 2026, the completed multidisciplinary risk assessment report was sent by CLC, EMS and FMS leaders to QPS staff for inclusion into the monthly Quality and Patient Safety Council (QPSC) reports through the Continuous Compliance Survey Readiness (CSR) Committee. Additional safety measures will be implemented if future assessments indicate a need.

VALLHCS CLC Nurse Managers and Charge Nurse or designee will conduct regular rounds utilizing a checklist to ensure the dementia unit's shower room is clean and hazard-free.

Compliance will be reported monthly at Quality and Patient Safety Council (QPSC) through the governance structure. Numerator: Number of days/ month where 1SW dementia unit shower is clean and hazard-free. Denominator: Number of days/month 1SW Unit shower is open for use and hazard free. Compliance will be monitored until 90 percent compliance is achieved and sustained for six (6) consecutive months.

### OIG Comments

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

In an Emergency Department diagnostic testing station, which was in an open area near patient rooms, the OIG observed patient identification information (names and Social Security numbers) on a screen and on laboratory collection tubes. The Department of Health and Human Services'

Privacy Rule requires healthcare organizations to protect patient information, including demographic data such as name, birth date, and Social Security number.[24]

## Recommendation 2

The Medical Center Director ensures facility staff conduct a privacy assessment and take actions to protect patient information in the Emergency Department.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

### Director Comments

VALLHCS leaders representing the Emergency Department (ED), Privacy Office, and Quality and Patient Safety (QPS) met to review the recommendation and formulate a plan of correction to ensure patient information is protected in the ED.

On January 14, 2026, QPS and ED leaders conducted rounds in the area and confirmed that the immediate corrective actions implemented by the ED leaders in May 2025 following the OIG HFI survey are sustained, including: 1) the permanent designation of a locked room (1A-236) near the triage area for labeled specimen, 2) the implementation of the Zebra bedside printing and labeling of collected specimen, and 3) the permanent designation of a private room (1A-55) on the isolation side of department where the point of care (POC) testing machines were secured. ED procured Identi-hide labels that staff use to protect patient information prior to disposing of tests in the appropriate waste bin.

On January 15, 2026, VALLHCS's Privacy Officer conducted an unannounced privacy assessment in the ED and convened a debriefing with ED and QPS leaders to share the preliminary assessment findings and recommendations with a plan to do a follow-up privacy assessment in 30 days.

On January 22, 2026, ED and HAS leadership confirmed that the ED staff are current on both VA Privacy and Information Security Awareness and Rules of Behavior (TMS 10176), and the Privacy and HIPAA Focused Training (TMS 10203). Any ED staff member who is not current will be escalated to the manager or supervisor as a TMS notification.

VALLHCS ED Nursing Leadership will continue daily leader rounding utilizing a checklist to ensure patient information is secured and protected in the ED. Compliance will be reported monthly to the Quality and Patient Safety Council (QPSC) through the governance structure.

[24] Department of Health and Human Services, *OCR [Office for Civil Rights] Privacy Brief, Summary of the HIPAA [Health Insurance Portability and Accountability Act] Privacy Rule,* last revised May 2003; 45 C.F.R. § 164 (2000).

Numerator: Number of days/month where privacy compliance is achieved in the ED. Denominator: Number of days/month the ED is open. Compliance will be monitored until 90 percent compliance is achieved and sustained for six (6) consecutive months.

### OIG Comments

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

A prior OIG report noted the facility has a history of their water testing positive for *Legionella* (a bacteria that can cause pneumonia).[25] Staff have had difficulties managing *Legionella* contamination, including notifying staff of positive results after they test water for the bacteria. The VA National Infectious Diseases Service and the Office of Healthcare Engineering visited the facility in July 2024 to review their *Legionella* prevention activities.[26] Additionally, representatives from the VA Central Office and VISN participated in a facility Water Safety Committee meeting in February 2025. The OIG reviewed the facility's *Legionella* risk assessment and mitigation plan and found it addressed their identified deficiencies, such as ensuring staff take ice machines that test positive for *Legionella* out of service and clean them.

However, the OIG noted absent signs on water faucets regarding *Legionella* contamination or risk. The OIG observed multiple water faucets with installed filters, which the chief of facilities management service explained were part of the facility's risk mitigation strategy. Near one filtered faucet, a posted sign stated, "As part of our regular water safety program, this fixture has tested positive for *Legionella*, however it is approved for use due to filtration being installed," but there were no signs for other faucets with similar filters. This may confuse staff and patients on whether the water is safe for use.

The OIG is concerned that staff did not use consistent, standardized signs and verbiage to communicate *Legionella* risk mitigation and management at water faucets. However, because leaders and staff continue to follow their *Legionella* risk management strategy and have engaged

[25] *Legionella* bacteria "are naturally found in water and have been associated with building water distribution systems and cooling towers." *Legionella* disease is "a type of pneumonia caused by pathogenic species of the bacterium." VHA Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, February 16, 2021, amended October 21, 2024. VA OIG, *Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System California*, Report No. 18-02405-146, June 18, 2019.

[26] The Office of Healthcare Engineering is responsible for operating, maintaining, and modernizing VHA infrastructure. VHA Directive 1811, *VHA Healthcare Engineering Program Requirements*, April 10, 2023. The National Infectious Diseases Service provides expert guidance, policy development, data oversight for infectious diseases, antimicrobial stewardship, infection prevention, and bio surveillance across VA and VHA to support high-quality veteran care. "National Infectious Diseases Services Program," Department of Veterans Affairs, last updated April 7, 2025, https://vaww.specialtycare.va.gov/infectious_disease. (This website is not publicly accessible.)

with the VA National Infectious Diseases Service and the Office of Healthcare Engineering, the OIG did not make a recommendation.

The OIG reviewed a February 2025 Joint Commission survey with a finding for an eyewash station with deposits in and around the water openings.[27] Facility records indicated that staff replaced the eyewash spouts for that station on February 5, 2025. However, the OIG observed multiple eyewash stations throughout the facility with mineral deposits around the spouts. The Associate Director of Operations acknowledged they did not develop a plan to monitor and fix other eyewash spouts in the facility, and stated staff needed to address the issue. VHA Directive 1608(1) requires staff to ensure the healthcare environment is safe and clean.[28] Eyewash stations with deposits on the spouts may reduce water flow and contaminate staff's eyes when they use them after being exposed to a hazard.

## Recommendation 3

Facility leaders ensure all eyewash stations are clean and function properly.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

### Director Comments

VALLHCS leaders representing the Facility Management Service (FMS), Safety Office, Environmental Management Service, and Quality and Patient Safety (QPS) met to review the recommendation and formulate a plan of correction to ensure all eyewash stations are clean and function properly.

On January 16, 2026, an electronic system-wide eyewash station assessment was conducted, FMS, EMS and QPS leaders continue to collect and address all eyewash stations across VALLHCS.

VALLHCS will implement the following actions:

1. System-wide Eyewash Station Assessment: Chiefs, managers and supervisors will continue to inspect eyewash stations for calcium deposits and coordinate with the respective EMS supervisor to submit an electronic FMS work order for the replacement of affected eyewash station spray heads.

[27] The Joint Commission, *Final Accreditation Report VA Loma Linda Healthcare System*, February 11, 2025.
[28] VHA Directive 1608(1).

2. Policy Modification: VALLHCS will amend Medical Center Policy (MCP) 00-24 to include cleaning of eyewash stations weekly and delineated responsibilities for cleaning and reporting any buildup of mineral deposits. EMS will clean units every week using soft cloth and warm water, inspect spray heads for calcium deposits; if calcium deposits are identified, this will be reported immediately to the EMS supervisor. EMS supervisor will enter a workorder to FMS to replace the spray heads.

3. Monitoring and Sustainment of all Eyewash Stations: VALLHCS will establish weekly, monthly, and annual maintenance as well as reporting responsibilities through the governance structure with their corresponding process owners and executive oversight. Eyewash stations/emergency showers for mineral deposits are incorporated in the EOC Rounds for all locations with eyewash stations.

4. Compliance will be reported monthly to the Quality and Patient Safety Council (QPSC) through the governance structure. Numerator: number of eyewash stations that are clean and function properly. Denominator: total number of eyewash stations inspected. Compliance will be monitored until 90 percent compliance is achieved and sustained for six (6) consecutive months.

### OIG Comments

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

Additionally, a prior OIG inspection report, published in June 2019, noted staff inconsistently completed a temperature and humidity checklist.[29] The OIG observed a supply room temperature and humidity log that had multiple missing entries, including one six-day period. VHA Directive 1761 requires staff to monitor and record temperature and humidity daily to ensure the integrity of the supplies.[30] However, because there were no missing log entries in any other inspected areas, the OIG did not issue a recommendation.

The prior OIG inspection report also recommended senior (executive) leaders consistently attend comprehensive environment of care inspections.[31] The OIG found the Associate Director had not consistently attended the inspections throughout calendar year 2024, which limits the leader's awareness of environmental needs. The OIG did not make a recommendation after noting the Assistant Director subsequently attended all inspections in March and April 2025.

[29] VA OIG, *Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System California*.

[30] VHA Directive 1761, *Supply Chain Management Operations*, December 20, 2020.

[31] VHA Directive 1608(1); VA OIG, *Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System California*.

## Toxic Exposure Screening Navigators

The VA Toxic Exposure Screening Installation and Identification of Facility Navigators memorandum recommends that each facility identify two toxic exposure screening navigators.[32] The chief of administrative medicine reported the facility has one full-time navigator and two who perform the work as an additional duty.

The OIG examined toxic exposure screening data and found staff had screened over 60,000 veterans with only about 13 incomplete screenings (screenings staff initiated but did not complete). The chief explained that navigators review the number of incomplete screenings daily and contact veterans by phone to finish them. The OIG determined the facility had a well-managed screening process.


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

## Communication of Urgent, Noncritical Test Results

The facility did not have a policy to communicate test results, including urgent, noncritical results as required by VHA Directive 1088(1), and staff did not provide the OIG with any drafts or demonstrate progress toward creating one.[33] VHA Directive 1088(1) requires staff to develop a policy and service-level workflows that outline the communication process.[34] The OIG is concerned that executive leaders took no action, despite multiple opportunities for them to be aware of and comply with VHA requirements. Missed opportunities include the following:

- On July 11, 2023, VHA published VHA Directive 1088, with a 6- to 12-month requirement to develop a local policy and service-level workflows.[35]

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

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

[34] VHA Directive 1088(1).

[35] VHA Directive 1088(1).

- On September 20, 2024, VHA amended the directive to 1088(1), which further clarified expectations for service-level workflows.[36]
- In December 2024, a patient safety manager told the Chief of Staff about test result data trends and providers' lack of awareness of VHA requirements and expressed concerns that providers who order tests did not communicate or document the results as required.
- In February 2025, VISN staff asked the facility to conduct a self-assessment on their compliance with VHA requirements to communicate test results.[37]
- In March 2025, the OIG requested facility policies and service-level workflows related to test result communications.
- Prior to the site visit, the OIG published several reports with findings and recommendations related to facilities' lack of policies and procedures that are compliant with VHA requirements for communication of test results.[38]

Facility leaders gave several reasons they did not comply with the VHA directive. The ADPCS cited competing priorities and the absence of a permanent chief for the Quality and Patient Safety service in the prior two years as contributing factors. The chief nurse of quality and patient safety said staff lacked a standard process to evaluate VHA policies, update requirements, and communicate them to facility leaders.[39]

The VISN quality management officer reported expecting each VISN program leader, such as the primary care program leader, to work with their respective facility leaders to ensure they comply with changes to VHA requirements. The OIG asked executive leaders about the VISN review, and the Chief of Staff and ADPCS both denied they were aware of it. However, quality and patient safety staff provided the OIG with an email about the review that they sent to the Quality and Patient Safety Council email distribution list, and it showed both leaders were email recipients.

[36] VHA Directive 1088(1).

[37] According to correspondence examined by the OIG, the facility's response to the VISN's request for a self-assessment included a test result communication process presentation, an overview of data, and a plan to educate staff on VHA requirements to communicate test results.

[38] Two examples of OIG reports with findings and recommendations for communication of test results are: VA OIG, *Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia*, Report No. 24-00592-60, March 6, 2025; VA OIG, *Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia*, Report No. 24-00603-86, March 26, 2025.

[39] In interviews, the OIG learned the chief nurse of quality and patient safety was hired in February 2025. The deputy chief of quality and patient safety served as acting chief of this service for the two years the position was vacant.

## Recommendation 4

The Medical Center Director ensures the facility has a written policy for communication of test results.

__X__ Concur

____ Nonconcur

Target date for completion: May 31, 2026

### Director Comments

VALLHCS leaders representing various clinical service and section chiefs, Chief of Staff (COS), and Associate Director of Patient Care Services (ADPCS), Quality and Patient Safety (QPS) leadership have been collaborating to draft the Medical Center Policy (MCP) 11-78, Communication of Test Results (CTR).

On January 23, 2026, VALLHCS MCP 11-78 draft was sent to stakeholders for review by the Policy Manager. VALLHCS will send the draft MCP 11-78 to key stakeholders including service/section chiefs, QPS leaders and Medical Executive Council for a thorough review and concurrence that MCP 11-78 meets requirements of VHA Directive 1088 and local needs. The finalized MCP 11-78 will be sent to the Executive Leadership Team (ELT) and the Medical Center Director (MCD) for review, approval and signature. VALLHCS will ensure the signed MCP 11-78 is published and disseminated to all VALLHCS staff through the employee's email distribution list and the VALLHCS intranet Policy page. Continuous monitoring will be reported to the Patient Safety Council (QPSC) until the MCP 11-78 is approved through governance.

## Recommendation 5

The Chief of Staff and Associate Director of Patient Care Services ensure leaders in each service develop written service-level workflows that outline the process for staff to communicate test results to providers and patients.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2026

### Director Comments

VALLHCS leaders representing various clinical service and section chiefs, Chief of Staff (COS), and Associate Director of Patient Care Services (ADPCS), Quality and Patient Safety

(QPS) leadership have been collaborating to develop written service-level workflows that outline the process for staff to communicate test results to providers and patients.

On January 22, 2026, the draft MCP 11-78, Communication of Test Results, was sent to VALLHCS stakeholders for review of the service level workflows to ensure it meets the team-based approach and chain of responsibility requirements of VHA Directive 1088. VALLHCS will also establish a centralized Intranet repository within VALLHCS's Policies Page SharePoint in collaboration with the COS Office. Continuous monitoring will be reported to the Patient Safety Council (QPSC) until the MCP 11-78 incorporates the service-level workflows that outlines the process for staff to communicate test results to providers and patients is approved through governance.

## Recommendation 6

The Veterans Integrated Service Network Director ensures executive leaders implement a process to monitor actions related to Veterans Health Administration policy changes.

__X__ Concur

____ Nonconcur

Target date for completion: July 31, 2026

### Director Comments

Veterans Integrated Service Network (VISN) 22 will collaborate with VA Loma Linda VA Healthcare System (VALLHCS) executive leaders to ensure a formal process is implemented to monitor actions related to VHA policy changes. VISN 22 will ensure VHA policy changes are communicated and integrated through the facility governance structure with monthly reporting to the VALLHCS Quality and Patient Safety Council with the VALLHCS Policy Tracking Tool. The VALLHCS Quality and Patient Safety Council will track any corrective action plans from VHA policy changes monthly for identified gaps until mitigation strategies are implemented, if applicable. Compliance of the VALLHCS process for communicating VHA policy changes and subsequent action to the Quality and Patient Safety Council will be monitored for six (6) consecutive months of 90% or greater.

The OIG reviewed documents from the facility's external peer review process coordinator that indicated the coordinator reported test result communication data to facility leaders quarterly.[40] The coordinator described emailing the provider who ordered the test, service chief, chief of primary care, Chief of Staff, Director, and ADPCS when providers did not communicate results

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

as required. VHA Directive 1088(1) requires the director to ensure staff monitor performance metrics for communication of test results and address identified deficiencies, and for the Chief of Staff and ADPCS to ensure "corrective action is taken when non-compliance is identified."[41] However, the Chief of Staff said leaders did not formally audit or monitor providers' test result communications, but believed staff would inform leaders of any issues.

## Recommendation 7

The Medical Center Director ensures the Chief of Staff and Associate Director of Patient Care Services review performance metrics for test result communications and take action for identified deficiencies.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2026

### Director Comments

The Medical Center Director (MCD), Chief of Staff (COS), the Associate Director of Patient Care Services (ADPCS), and Quality and Patient Safety (QPS) leadership reviewed the recommendations, follow-up actions taken, and additional measures to ensure the COS and ADPCS review performance metrics for test result communications and take action for identified deficiencies.

Performance metrics for communication of test results (CTR) have been consistently reviewed through the Data Accountability Checklist (DAC) Review of the External Peer Review Program (EPRP) and reported to QPS Council, as well as to the MCD, COS and ADPCS in the last 12 months.

VALLHCS will continue to monitor compliance with communication of test results to the patients utilizing the VISN 22 Outpatient Labs and Radiology Power BI Report. The Chief of Staff will be responsible for auditing compliance to the MCP, 11-78, Communication of Test Results. Thirty (30) charts per month will be randomly selected from outpatient patient care areas by the Chief of Staff or delegate for review by the respective Service/Section Chiefs.

Compliance will be reported monthly to the Quality and Patient Safety Council (QPSC) through the governance structure. Numerator: number of charts with communication of test results in adherence to MCP 11-78. Denominator: number of charts audited. Compliance will be monitored until 90 percent compliance is achieved and sustained for six (6) consecutive months.

[41] VHA Directive 1088(1).

## Action Plans and Process Improvements

The chief of pathology and laboratory services stated there were no recommendations from oversight inspections from the past three years related to test result communication. Further, the chief nurse of quality and patient safety reported the facility had no action plans or formal quality improvement projects in the last 12 months related to test result communication. The OIG noted the prior comprehensive healthcare inspection report's five recommendations were all closed, and as of June 2025, recommendations from a hotline report were also closed (discussed in the Primary Care section below).[42]

The OIG reviewed a prior VHA Office of the Medical Inspector report and noted staff planned or implemented actions and sustained improvements for the findings and recommendations.[43] For example, the medical inspector found the facility did not comply with VHA cardiopulmonary resuscitation training requirements and medical emergency response simulation procedures, such as mock codes.[44] The OIG reviewed Quality and Patient Safety Council meeting minutes and noted staff provided hands-on cardiopulmonary resuscitation training at least twice per year and conducted unannounced mock code simulations.

A patient safety manager said quality and patient safety staff report patient safety data and trends to executive leaders at Quality and Patient Safety Council meetings. However, the OIG reviewed council members' attendance on meeting minutes and noted the absence of executive leaders at most council meetings over a 10-month period during FYs 2024 and 2025. VHA Directive 1050.01(1) requires that quality and patient safety oversight include the Chief of Staff and ADPCS, which is reflected in the council's charter.[45] The OIG also reviewed the facility's committee governance structure policy, which states members, including executive leaders, are expected to attend meetings regularly (at least 80 percent of the time).[46] In addition, Joint Commission standard LD 01.03.01 expects a hospital's governing body to be responsible for safety and quality.[47]

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[42] VA OIG, *Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California*, Report No. 22-00048-120, May 24, 2023. VA OIG, *Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California*, Report No. 23-01602-147, April 23, 2024.

[43] Department of Veterans Affairs, *Report to the Under Secretary for Health, VA Loma Linda Healthcare System, Loma Linda, California*, Content Manager 2023-C-32, March 5, 2023. (This report is not publicly accessible.)

[44] A mock code "is defined as a simulation exercise with a mannequin/human patient simulator." Tarek R. Hazwani et al., "The Impact of Mock Code Simulation on the Resuscitation Practice and Patient Outcome for Children With Cardiopulmonary Arrest," *Cureus Journal of Medical Science* 12, No. 7 (July 15, 2020): e9197, https://doi:919710.7759/cureus.9197.

[45] VHA Directive 1050.01(1).

[46] VA Loma Linda Healthcare System, *VA Loma Linda Healthcare System Governance Management Policy*, Memorandum 00-04, February 15, 2022.

[47] The Joint Commission, *Standards Manual*, E-dition, LD 01.03.01, March 30, 2025.

The Chief of Staff and Assistant Director acknowledged opportunities to improve meeting attendance and said they plan to consolidate the committee governance structure to reduce scheduling conflicts, so members can regularly attend meetings. The Director explained the governance structure is the primary item on the agenda at the next Executive Leadership Board meeting. The Director also described staying informed about patient safety concerns through daily huddles and at monthly meetings with quality and patient safety staff. Despite these efforts, the OIG is concerned about the Chief of Staff's and the ADPCS's inconsistent attendance at Quality and Patient Safety Council meetings.

## Recommendation 8

The Medical Center Director ensures executive leaders attend Quality and Patient Safety Council meetings.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2026

### Director Comments

The Medical Center Director, Chief of Staff (COS), the Associate Director of Patient Care Services (ADPCS), and Quality and Patient Safety (QPS) leadership reviewed the recommendation, follow-up actions taken, and additional measures to ensure executive leaders attend Quality and Patient Safety Council meetings as required by VHA Directive 1050.01, VHA Quality and Patient Safety Programs.

On July 11, 2025, VALLHCS implemented a reporting cadence of committees and programs that reflect adherence to VHA Directive 1050.01.

On January 6, 2026, VALLHCS updated the QPSC Charter membership to ensure executive leaders attend Quality and Patient Safety Council, in alignment with VHA Directive 1050.01.

VALLHCS will monitor the executive leaders' attendance at the Quality and Patient Safety Council. Compliance will be reported monthly to the Quality and Patient Safety Council (QPSC) through the governance structure. Numerator: number of monthly meetings executive leaders (COS and ADPCS) attended. Denominator: total number of monthly QPSC meetings held. Compliance will be monitored until 90 percent compliance is achieved and sustained for six (6) consecutive months.


The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[48] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

## Primary Care Teams

During an interview, the primary care manager program analyst confirmed the facility had seven VHA-operated clinics and three non-VHA-operated clinics. The non-VHA-operated clinics were staffed and managed by a contracted company. During a prior OIG hotline inspection in May 2023, the facility had five non-VHA-operated community-based outpatient clinics.[49] The Associate Director of Operations explained the company managing those clinics was unable to provide adequate staffing. In FY 2024, facility leaders began to manage staffing for two of the five non-VHA-operated clinics and opened another community-based outpatient clinic, with plans to assume responsibility for staffing at the remaining non-VHA-operated clinics within the next two years.[50]

The program analyst stated there are 53 primary care teams at the VHA-operated clinics (which includes the medical center clinic) and 15 teams at the three non-VHA-operated clinics, for a total of 68 primary care teams. The program analyst said vacant positions included two providers and two licensed vocational nurses at the non-VHA-operated clinics, and four registered nurses and five medical support assistants at the VHA-operated clinics. The program analyst reported that recruitment efforts were underway to fully staff a new primary care team at one of the facility's non-VHA-operated clinics.

The OIG found panel size (number of patients assigned to a care team) for primary care teams at VHA-operated clinics averaged 96 percent, while non-VHA-operated clinics averaged

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

[49] "In February 2023, the OIG's data analytics team identified that the system had the highest utilization of community care for new primary care services among all VHA facilities from February 1, 2022, through February 3, 2023. As a result, the OIG initiated a healthcare inspection." VA OIG, *Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California*.

[50] The facility opened the Hemet VA Clinic in May 2024. The Sy Kaplan (in Palm Desert) and Murrieta VA Clinics remain leased space, but they became VHA-operated in April 2024 when their staff became part of VHA.

109 percent of the size recommended in VHA Directive 1406(2).[51] The program analyst explained that over-sized panels were due to the two provider vacancies at the non-VHA-operated clinics. For VHA-operated clinics, the analyst described reviewing weekly reports to track how many patients were assigned to each primary care team. The analyst reported that when a team's panel reached 100 percent of its established capacity, they met with the chief of primary care and stopped adding patients to that team.

For non-VHA-operated clinics, the program analyst said clinic managers update staffing information in an internal VHA website application, and the application sends the program analyst a real-time automated email whenever the managers enter updates or comments. The program analyst reported monitoring the site daily.

Primary care staff and a leader explained that they implemented rapid improvement events to increase primary care team efficiency. For example, a staff member said that over the past three years, primary care physicians developed a quick start guide that simplified workflows in patients' electronic health records by adding keyboard shortcuts. Additionally, the primary care manager provided a standard work communication plan to staff, which helped primary care teams clarify who was responsible for key steps in patient care and standardized processes to support more organized workflows.

## The PACT Act and Primary Care

The OIG noted the number of enrolled veterans increased 2.4 percent from FYs 2022 through 2024. A primary care staff member said they did not believe the PACT Act and associated toxic exposure screenings caused a significant increase in their workload.

Additionally, the OIG compared data from the first quarters of FYs 2023, 2024, and 2025, and noted wait times decreased from 8 to 5 days for established patients and from 37 to 36 days for new patients. The chief of primary care explained that many patients chose to wait for a VA appointment instead of scheduling care in the community. The OIG did not make a recommendation because data shows wait times had decreased.

[51] "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).VHA policy states the baseline capacity for a full-time primary care team with a physician provider is 1,200 patients, depending on patient characteristics and level of clinic staff and administrative support. VHA Directive 1406(2).

# VETERAN-CENTERED SAFETY NET

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

## Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[52]

HCHV staff engaged with an elderly veteran and their spouse, who were living behind a restaurant. The veteran said they believed they were ineligible for VA services. Staff determined the veteran was eligible and worked with community partners to shelter the couple in a motel and secured them permanent housing by the end of the week.

***Figure 7.*** *Success story. Source: OIG analysis of questionnaire responses.*

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.[53] However, this fiscal year (FY 2026), VHA no longer uses this intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted residential emergency services and low-demand safe haven.[54] Finally, HCHV2 (negative exits) measured 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."[55]

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

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

[54] VHA sets the target for HCHV1 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*. Contracted residential emergency services provide stable living arrangements for veterans while they seek permanent housing. Low-demand safe haven programs are transitional residences for homeless veterans with mental illness or substance use issues. Department of Veterans Affairs, "Health Care for Homeless Veterans" (fact sheet), December 2024.

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

## Program Highlights

- The program did not meet the HCHV5 target in FYs 2023 or 2024. The assistant chief for homeless services explained that staffing vacancies hampered outreach efforts in the program's service area, which included two large counties, and the program had one vacant social service assistant and two open social worker positions. The associate chief of staff of the mental health service explained that recent obstacles in hiring staff were due to budget constraints.

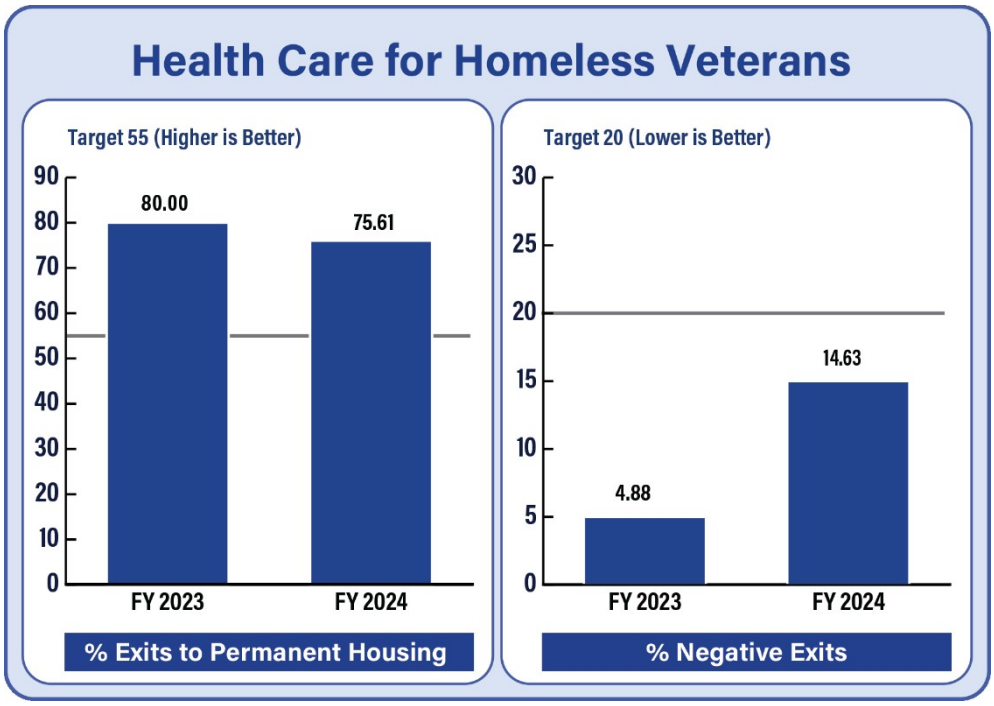


***Figure 8.*** *HCHV program performance measures.*
*Source: VHA Homeless Performance Measures data.*

- The program met both HCHV1 and HCHV2 targets from FYs 2023 through 2024. The associate chief of staff of the mental health service said program staff rely on community partners and other VA facilities for shelter beds and gave an example where staff identified a veteran living in a car and expecting a child. Staff worked with community partners to shelter the veteran in a motel and helped them obtain a voucher for permanent housing.

## 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."[56] The program uses the housing first approach to prioritize rapid placement into housing followed by individualized services.[57]

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).[58]

## Program Highlights

- The program did not meet the HMLS3 target from FYs 2023 through 2024. The assistant chief for homeless services explained that a major barrier was the San Bernardino County Public Housing Authority's updated housing model, implemented in FY 2021, which prevented the program from using all their assigned housing vouchers. The leader said the San Bernardino County Public Housing Authority had not issued any new vouchers for about the past 18 months because they could not afford to pay for those already designated for the facility. In response, the assistant chief explained the program offered veterans the option to transfer their vouchers to the Riverside County Public Housing Authority. The assistant chief also said program leaders notified the VISN and the VHA Homeless Programs Office in FY 2021 about restricted voucher funding associated with San Bernardino's updated housing model.
- The program did not meet the VASH3 target from FYs 2023 through 2024. The associate chief of staff of the mental health service said staff documented employment information incorrectly in the VA's national system. The associate chief told the OIG that in January 2025, the assistant chief for homeless services began mentoring the program supervisor to ensure program staff understood their roles in helping veterans gain employment, and leaders also trained staff how to properly document employment information, which resulted in improved system entries.

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

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

[58] 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*.

## 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.[59] 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).[60]

Veterans Justice Program staff enrolled a homeless veteran with criminal charges and a history of drug use in the program. The veteran agreed to treatment, and staff facilitated their admission into a drug treatment program. After successfully completing the program, the veteran began intensive outpatient substance use disorder treatment while residing in a sober living facility. Program staff helped the veteran apply for permanent housing and enroll in a local community college. The veteran now has over two years of sobriety and has accomplished many of their veterans treatment court goals.

***Figure 9.*** *Success story. Source: OIG analysis of questionnaire responses.*

### Program Highlights

- The program had mixed success with the target, meeting it in FY 2023 but not in FY 2024. The veterans justice program coordinator said the program had a vacant position in fall 2023 and gained a new position in February 2024. Although program leaders filled the new position, the staff member was unable to perform outreach in jails and prisons until receiving clearance from the California Department of Corrections. The coordinator reported that because it took about five months to get the clearance, productivity lagged and negatively affected meeting the target in FY 2024.
- The coordinator stated that program staff complete assessments and refer the veterans to needed services.[61] A staff member reported their primary goal is to prevent veterans' homelessness, facilitate mental health care and substance use recovery, and support reintegration into the community after incarceration. Further, the staff member explained they coordinate with Veterans Benefits Administration staff to jointly meet with veterans and help them assess benefits information and file compensation claims.

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

[60] 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*.

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

# Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted an inspection across five domains. The OIG provided recommendations on issues related to eyewash station cleanliness and functionality, shower room safety, patient privacy, Quality and Patient Safety Council meeting attendance, and test result communication. Facility leaders have started to implement corrective actions, which resulted in the OIG closing three recommendations. 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.

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

# Appendix A: Methodology

## Inspection Processes

The OIG inspection team reviewed 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 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 inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[2] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[3]

Potential limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the interviews; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2023, through September 30, 2024.

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

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

[4] 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from April 28 through May 1, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

# Appendix B: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: January 28, 2026

From: Interim Network Director, Department of Veterans Affairs (VA) Desert Pacific Healthcare Network (10N22)

Subj: VA Office of Inspector General (OIG) Report, Healthcare Facility Inspection of the VA Loma Linda Healthcare System in California

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the OIG Draft Report-Healthcare Facility Inspection of the VA Loma Linda Healthcare System in California. I have completed a full review of the draft report and concur with the findings.
2. I concur with the recommendations and action plan submitted by VA Loma Linda Healthcare System and VISN 22.
3. Should you need further information, please contact the VISN 22 Quality Management.

*(Original signed by:)*

Bryan E. Arnette, FACHE
Interim Network Director
VA Desert Pacific Healthcare Network (VISN 22)

# Appendix C: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: January 23, 2026

From: Interim Director, Department of Veterans Affairs (VA) Loma Linda Healthcare System (605)

Subj: VA OIG Draft Report—Healthcare Facility Inspection of the VA Loma Linda Healthcare System in California

To: Interim Director, VA Desert Pacific Healthcare Network (10N22)

1. We appreciate the opportunity to review and comment on the OIG draft report—Healthcare Facility Inspection of the VA Loma Linda Healthcare System. VA Loma Linda Healthcare System concurs with the recommendations and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Interim Chief of Quality Management & Patient Safety.

*(Original signed by:)*

Scott D. Kelter
Interim Medical Center Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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