US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA San Diego Healthcare System in California

Healthcare Facility Inspection	25-00253-156	July 16, 2026

OUR MISSION

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

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA San Diego Healthcare System (the facility) from September 9 through 11, 2025. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to over 97,000 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team identified improperly stored equipment and oxygen tanks, as well as dirty ice machines.[3] The OIG made three recommendations to correct issues that staff did not address during the September 2025 inspection.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility's test result communication policy did not include clear delegate responsibilities, patient notification methods, electronic health record documentation responsibilities, or compliance monitoring procedures, as required in VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[4] The OIG made one recommendation.

[1] VHA classifies facilities based on their complexity level. Highest-complexity facilities have "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through September," VHA Support Service Center, last updated April 1, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

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

[3] VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023; VHA Directive 1850.01(1), *Health Care Environmental Sanitation Program*, March 29, 2023; VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023; "Standards FAQs," The Joint Commission, last updated May 5, 2023, https://www.jointcommission.org/standardsfaqs.

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

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

What the OIG Recommended

Facility leaders ensure completion of the following actions:

1. Staff follow procedures to properly separate and store soiled and clean equipment.
2. Environmental management services staff clean ice machines daily to help prevent infection risk.
3. Staff properly label and store oxygen tanks.
4. Staff update the facility policy to include all elements to communicate test results to patients, as required in Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

VA Comments and OIG Response

The Interim Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C). 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 recommendation until they are completed.

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

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

Abbreviations

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

Contents

Introduction

The Office of Inspector General'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.[6] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[7]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[8]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[9]

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

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[10]

---

[6] "About VHA," VA, last updated January 20, 2025, https://www.va.gov/aboutvha.

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

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

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

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

The VA San Diego Healthcare System (the facility) began serving patients in February 1972. In fiscal year (FY) 2025, the medical care budget was approximately $1.9 billion. The facility had 160 hospital, 30 community living center, and 59 domiciliary beds.[11]

Figure 1. *Facility photo.*
Source: "VA San Diego Health Care," VA, accessed September 23, 2025, https://www.va.gov/san-diego-health-care.

The OIG team inspected the facility from September 9 through 11, 2025. The executive leaders referred to throughout this report include the Director, Chief of Staff, Associate Director, acting Associate Director for Patient Care Services/Nurse Executive, and Assistant Director. The newest member of the team, the acting Associate Director for Patient Care Services/Nurse Executive, was assigned to the position in April 2024.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[12] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[13] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[14]

[11] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated June 3, 2025, https://www.va.gov/VA_CLC. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. "Trip Pack - Operational Statistics Table FY2026 Through September," VHA Support Service Center, last updated April 1, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

[12] 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.

[13] "Veteran Trust in VA," VA, last updated January 20, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

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

System Shocks

Executive leaders identified presidential executive orders and memorandums, such as the deferred resignation program, hiring freeze, and anticipated reductions in force (layoffs) as system shocks.[15] The Assistant Director shared that executive leaders conducted two training sessions to guide facility leaders on how to communicate with employees and prepare for potential staffing losses.

Specifically, executive leaders stated that 61 employees accepted deferred resignations, and some of these departures changed facility operations.[16] For example, the supply chain management department, which was already experiencing vacancies, lost additional supply technicians and inventory managers. As a result, department leaders reassigned employees from evening and weekend shifts to the day shift, when workload demands were greater. To compensate for limited staffing during evening and weekends, department employees overstocked supply areas to ensure adequate supplies were available. Executive leaders also said the hiring freeze did not allow them to create new primary care positions, which made it difficult for current employees to keep up with the growing number of patients seeking care at the facility.[17]

The Associate Director also explained that potential layoffs discouraged applicants from accepting job offers, particularly those relocating from out of state. In one instance, leaders extended two offers for the Safe Patient Handling and Mobility Program's manager position (responsible for helping staff safely move patients), but both applicants declined due to concerns with job security.[18]

[15] VHA placed full-time employees who accepted the deferred resignation program on paid administrative leave until September 30, 2025, unless they were eligible to retire earlier. Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025. Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025.

[16] Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum.

[17] Hiring Freeze, 90 Fed. Reg. 8247.

[18] VHA Directive 1611, *Safe Patient Handling and Mobility Program*, July 11, 2023.

Employee Experiences

Facility leaders interviewed said they demonstrated a commitment to open communication, encouraged respectful dialogue, and facilitated psychologically safe conversations around workplace behavior and expectations.[19] Executive leaders reported that methods used to share information with staff included

- weekly emails from the Director with facility updates,
- leaders' visits to the departments,
- tiered huddles (short meetings between leaders and employees to share problems and identify solutions), and
- monthly town halls.

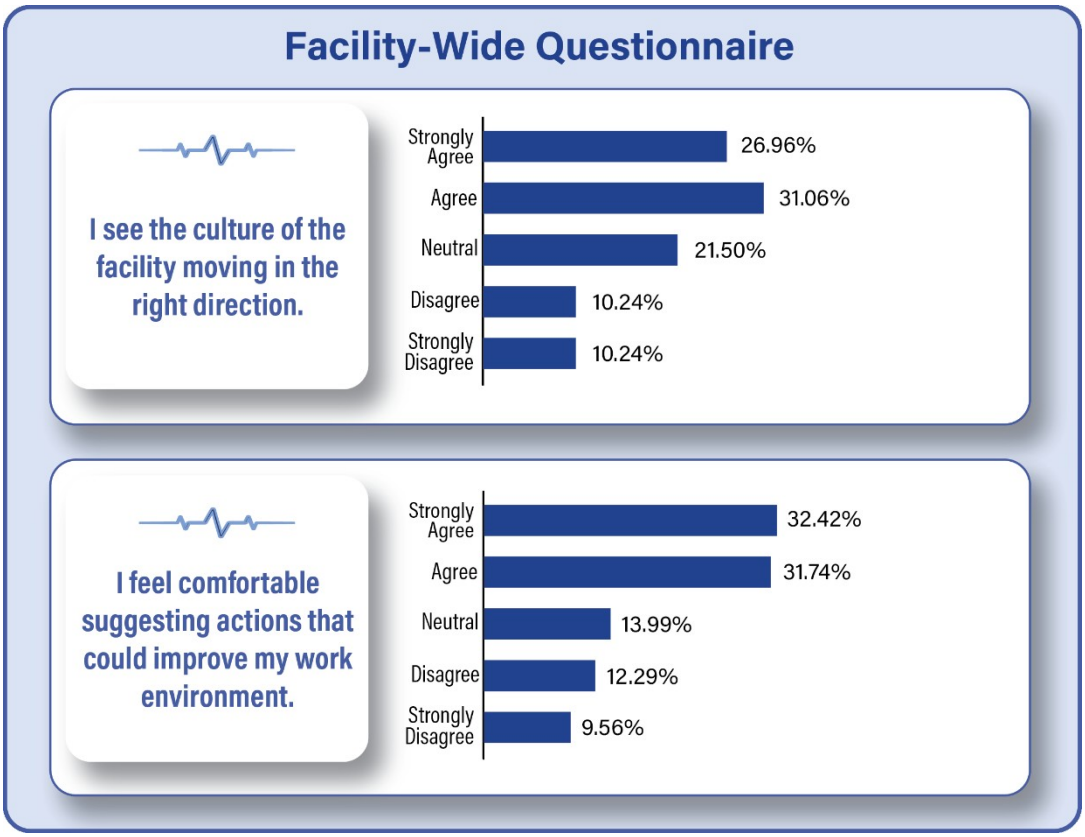

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

[19] "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.

Executive leaders reported encouraging everyone to be involved in establishing the facility's culture. In one such initiative, staff created poster boards with cartoon characters or movie themes to showcase their department's performance improvement activities to others.

Veteran Experiences

The OIG team determined that one of the top concerns patient advocates received from veterans during the first six months of FY 2025 were delays in staff scheduling or rescheduling appointments canceled by VA. According to the Chief of Staff, the Director and group practice manager (who oversees access to care in outpatient clinics) initiated a process improvement project to reduce disruptions to patient care by decreasing VA-canceled appointments and quickly rescheduling them. Staff have reduced the number of appointments they cancel with short notice but still face challenges with rescheduling appointments quickly. The Chief of Staff reported the project was ongoing, and staff will adjust processes based on outcomes.

However, according to the veteran experience officer (who leads, facilitates, and collaborates on veteran experience practices and improvement efforts), veterans shared far more compliments than complaints with patient advocates when evaluated by individual issue category.[20] The OIG team confirmed that for the first six months of FY 2025, patient advocates received over 1,700 compliments for staff and services provided, which far exceeded any individual issue category.

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.

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

[20] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

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

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

General Inspection

The facility had sufficient transit options, including a trolley, bus, and shuttle. Parking attendants directed veterans to available spaces in three parking garages, and staff escorted them to their destinations, if needed.

The facility was easy to navigate. It had colorful wall maps, paper maps located near the elevators on every floor, and an online interactive map, as well as assistive listening systems and other accessibility tools. Front desk staff also used written instructions or arranged for escorts to help veterans get to their destinations.

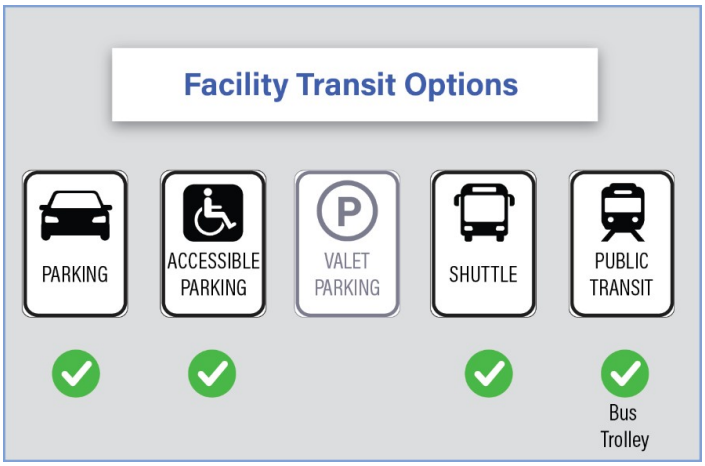

Figure 3. *Transit options for arriving at the facility.*
Source: OIG analysis of a shuttle location document, observations, and Environment of Care Council interview.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: OIG analysis of questionnaire responses, observations, and Environment of Care Council interview.

The OIG team inspected the community living center, primary care clinic, intensive care unit, emergency department, and medicine inpatient unit. Of note, in the intensive care unit, community living center, and medicine inpatient unit, staff labeled separate rooms for clean and soiled equipment storage. However, the equipment itself was not clearly marked as either clean or soiled, and staff had stored clean equipment in a soiled equipment storage room.

In an interview following the inspection in September 2025, members of the Environment of Care Council were unable to state the facility policy for cleaning and storing equipment. VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs* requires that executive leaders ensure staff store clean and soiled items in separate areas

to prevent infections.[23] If staff do not understand the policy, they might use contaminated equipment, which increases the risk of infection.

Recommendation 1

Facility leaders ensure staff follow procedures to properly separate and store soiled and clean equipment.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

VA San Diego Healthcare System is committed to ensure staff follow procedures to properly separate and store soiled from clean equipment. The Infection Prevention and Control (IPC) Nurse Manager reviewed the procedures in place for staff to maintain physical separation of clean and dirty work and storage areas. The IPC Nurses provided just in time training to areas identified as having deficiencies related to separation of clean and dirty and ensured the current process was being followed. Additionally, as part of the annual VASDHS [VA San Diego Healthcare System] Environment of Care Training, all staff complete training demonstrating knowledge on procedures to properly separate and store soiled from clean equipment. To ensure compliance with properly separating and storing soiled from clean equipment, audits will occur during Environment of Care rounds with a goal of 90% compliance.

Audit results from October 2025 through April 2026 showed 100% compliance for seven (7) consecutive months with properly separating and storing soiled from clean equipment. Compliance was reported to the VASDHS Quality and Patient Safety Council (QPSC) through the governance structure.

VA San Diego Healthcare System recommends closure of this recommendation prior to publication.

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.

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

Additionally, there was trash on the floor in the emergency department and the medicine inpatient and intensive care units. The emergency department also had trash on top of an infusion pump (which delivers fluids, medications, or nutrients directly into a patient's bloodstream).[24] VHA Directive 1850.01(1), *Health Care Environmental Sanitation Program* requires environmental management services staff to ensure facilities are clean and safe to reduce the risk of infection and patient harm.[25] Staff removed all the trash immediately, so the OIG did not make a recommendation for further action.

There was also visible dirt inside ice machine dispensers in the community living center and intensive care unit. When the OIG team asked the Environment of Care Committee members about the issue, they were unable to explain which department cleaned the ice machine dispensers. Engineering staff reported cleaning the inside of the ice machines quarterly during preventive maintenance, and environmental management services staff said they cleaned the outside of the machines daily. Although neither service initially claimed responsibility for cleaning inside the dispenser daily, the chief of environmental management services reviewed the policy and acknowledged environmental management services staff were responsible for cleaning the ice dispenser daily.

Recommendation 2

Facility leaders ensure environmental management services staff clean ice machines daily to help prevent infection risk.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Acting Assistant Director and the Chief of Environmental Management Services (EMS) reviewed the procedures put in place for daily cleaning of ice dispensers. The Chief of EMS ensured all staff were educated to cleaning procedures for ice dispensers to include interior chutes, absence of water residue buildup, and completion of the cleaning log. To address this, EMS conducted weekly random audits of ice dispensers to verify cleanliness.

[24] "What is an Infusion Pump?," Food & Drug Administration, accessed June 10, 2025, https://www.fda.gov/what-infusion-pump.

[25] VHA Directive 1850.01(1), *Health Care Environmental Sanitation Program,* March 29, 2023.

Audit results from October 2025 through April 2026 showed 100% compliance for seven (7) consecutive months with cleaning of ice machines. Compliance was reported to the VASDHS Quality and Patient Safety Council (QPSC) through the governance structure.

VA San Diego Healthcare System recommends closure of this recommendation prior to publication.

OIG Comments

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

The OIG team also found unsecured personally identifiable patient information in a primary care unit and in the intensive care unit. VHA Directive 1605.01, *Privacy and Release of Information* requires staff to properly safeguard personally identifiable and protected health information in all clinical areas.[26] Staff in both areas removed the information immediately, so the OIG did not make a recommendation.

Further, the team reviewed the facility's most recent Joint Commission report, which identified the need for staff to clearly label and improve oxygen cylinder storage.[27] During the OIG's September 2025 inspection, three intensive care unit storage rooms still contained oxygen tanks that staff did not label as full, partially full, or empty, and staff did not store empty tanks separately, as required by Joint Commission standards.[28] If staff improperly label and store oxygen tanks, they might attempt to use an empty tank during a medical emergency, which could delay care. Nurse managers interviewed stated they were unaware of oxygen tank storage requirements.

Recommendation 3

Facility leaders ensure staff properly label and store oxygen tanks.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

[26] VHA Directive 1605.01, *Privacy and Release of Information*, July 24, 2023.

[27] The Joint Commission, *Final Accreditation Report: VA San Diego Healthcare System*, December 10, 2022.

[28] "Standards FAQs," The Joint Commission, last updated May 5, 2023, https://www.jointcommission.org/standards-faqs.

Director Comments

The Chief of Supply Chain Management, Chief of Environmental Health and Safety, and Chief Nurse of Inpatient Care reviewed the procedures in place for staff to store oxygen tanks. To address this, nursing staff were educated on proper labeling and storage of oxygen tanks during daily safety huddles in September 2025. The standard operating procedure (SOP) for Oxygen E-Cylinder Storage and Oxygen Availability was updated on February 9, 2026, clearly delineating oxygen storage, training, and signage. The SOP was published and readily accessible to all staff for reference in the VA San Diego Policy Center. To ensure compliance with labeling and storing of oxygen tanks, audits will occur during Environment of Care rounds with a goal of 90% compliance.

Audit results from October 2025 through April 2026 showed 100% compliance for seven (7) consecutive months with proper labeling and storage of oxygen tanks. Compliance was reported to the VASDHS Quality and Patient Safety Council (QPSC) through the governance structure.

VA San Diego Healthcare System recommends closure of this recommendation prior to publication.

OIG Comments

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

The OIG team also reviewed documents from the facility liaison about the most common deficiencies staff identified during environment of care rounds (facility inspections to identify unsafe conditions) and determined there were stained, missing, or broken ceiling tiles and damaged walls. During the September 2025 inspection, the OIG found damaged walls in the community living center and emergency department. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires leaders to ensure staff maintain a safe and clean environment.[29] Damaged walls may prevent staff from properly cleaning walls, which could in turn increase the risk of infection.

The community living center and primary care clinics had stained ceiling tiles, which did not comply with VHA Directive 1608(1). The chief of engineering said the facility's plumbing system was more than 50 years old and often had leaks, which stained the ceiling tiles. The Environment of Care Committee further explained that the facility would replace the plumbing in phases through a maintenance project funded by the Veterans Integrated Service Network

[29] VHA Directive 1608(1).

(VISN), and staff had placed work orders to replace stained tiles and fix damaged walls.[30] The OIG recognizes the facility's ongoing efforts to address the issues, and therefore, did not make any further recommendations.

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

Communication of Urgent but Noncritical Test Results

The facility had established processes to notify providers and patients of urgent, noncritical test results. However, leaders had not developed written service-level workflows that outline team members' roles in the communication process. In addition, the facility's policy did not align with standards set forth in VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[31] Specifically, the policy lacked several required elements, which included a description of how staff clearly delegate responsibility to communicate test results to patients; methods used (phone, letter, secure messaging); practices to document notifications in the electronic health record; and procedures to monitor compliance with the directive.

The chief of health informatics and the chief of primary care both stated that providers receive alerts through the electronic health record system when test results are available and must then notify patients within seven days to ensure timely care. The chief of primary care confirmed the seven-day time frame applied to all abnormal, noncritical test results, regardless of whether they required follow-up. However, the facility's written policy did not align with the reported practice.

Recommendation 4

Facility leaders ensure staff update the facility policy to include all elements to communicate test results to patients, as required in Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

_X_ Concur

[30] Veterans Integrated Service Networks are "regional systems of care working together to better meet local healthcare needs and provides greater access to care." "Veterans Integrated Service Networks," VA, last updated July 28, 2025, https://www.va.gov/visns.

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

____Nonconcur

Target date for completion: September 30, 2026

Director Comments

The VASDHS Chief of Staff, Chief of Pathology and Laboratory Management Service, and Chief of Primary Care reviewed VHA Directive 1088(1) *Communicating Test Results to Providers and Patients*, dated July 11, 2023 (amended September 20, 2024) and the Medical Center Policy (MCP) for Communicating Test Results. The corresponding MCP (11-99) was updated to reflect a description of how staff clearly delegate responsibility to communicate test results to patients, methods used to communicate test results, practices to document notifications in the electronic health record, procedures to monitor compliance with the directive, and written service-level workflows.

The applicable MCP 11-99 was approved by the VASDHS Medical Executive Committee, signed, and published for staff on February 10, 2026. The updated MCP was disseminated to all clinicians and members of the medical staff. The revised MCP 11-99 is also a published reference in the VA San Diego Healthcare System Policy Center.

VA San Diego Healthcare System recommends closure of this recommendation prior to publication.

OIG Comments

The OIG team reviewed the documents provided by facility leaders for closure of this recommendation. The team determined that additional items were needed and considers this recommendation open to allow time for leaders to submit documents to support closure.

Action Plan and Process Improvements

The patient safety manager and performance improvement coordinator explained that simulated reviews of patient care experiences can help identify opportunities for staff to improve care. Nurses conducted two reviews each month in areas outside their usual assignments, then shared findings in town halls and nursing leadership forums. Facility leaders stated the program enhances patient safety and fosters a culture of continuous learning and accountability.

The chief health informatics officer said the provider orientation and efficiency team implemented an automated letter system that generated test result letters for providers to review and sign before they send them to patients. The chief said the system improved providers' efficiency and timeliness of test result communications.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[32] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

At the time of the inspection in September 2025, the facility provided documents showing 25 vacant primary care positions: 1 provider, 11 registered nurses, and 13 licensed vocational nurses. Of the vacancies, leaders could not recruit for 9 licensed vocational nurse and 5 registered nurse positions because of the hiring freeze.[33] Facility leaders and staff said the vacancies and inability to hire negatively affected communications within teams and work efficiency. For example, a primary care provider explained that licensed vocational nurses rotate among primary care teams numerous times each day, leaving providers unclear as to which nurse was checking in their next patient and made it hard to keep up with the appointments. Facility leaders reported plans to improve the workload by prioritizing hiring, supporting recruitment through higher pay approvals, and expanding recruitment outreach.

The Director said the number of patients seeking primary care at the facility increased significantly over the past four years, which pushed panels over capacity. The OIG team found that from FYs 2021 to 2025, the number of patients treated by primary care providers increased by 19 percent, and some teams elected to remain over capacity to maintain continuity of care, rather than having patients redistributed to other teams.

The OIG team also found that new patient appointment wait times decreased from approximately 25 to 21 days from FY 2024 to FY 2025. The Code of Federal Regulations (C.F.R.) title 38, section 17.4040 states that patients may be referred to community providers if the wait time is greater than 20 days.[34] Facility leaders explained they added primary care staff in the past year but needed more to meet the growing number of patients and anticipated future demand.

[32] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care. VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

[33] Hiring Freeze, 90 Fed. Reg. 8247.

[34] 38 C.F.R. § 17.4040 (2025).

Community Care Staffing and Access to Care

The acting associate chief of staff for community care said the facility had low community care staffing levels, particularly among advanced medical support assistants. Additionally, the facility's contract with a third-party administrator (a company that VA contracts with to create a regional network of providers to care for veterans in the community), who assisted with scheduling appointments, ended in October 2024, which shifted 42 percent of scheduling responsibilities back to facility staff and further increased workloads.[35] Leaders approved hiring for additional advanced medical support assistants to address the heightened work demands.

Further, the OIG team determined that for FY 2025, community care staff took an average of 29 days to schedule appointments with community providers. This significantly exceeded the 7-day requirement found in VHA's *Consult Timeliness Standard Operating Procedure,* which may delay care.[36] Most OIG community care staff questionnaire respondents attributed the delays to heavy workloads.

The OIG team also found that as of August 28, 2025, the facility had over 17,700 incomplete community care consults (care had not been provided or staff had not received medical documents from the appointment) that were older than 90 days, which may delay care and negatively affect patient outcomes. VHA's *Consult Timeliness Standard Operating Procedure* requires staff to complete community care consults within 90 calendar days from the date the patient and provider agree community care is clinically indicated. Staff explained that low staffing levels forced them to prioritize scheduling appointments over completing consults, which contributed to the backlog. Facility leaders described a plan to use contract staff, temporarily assign staff from other departments, or hire staff to fill vacant positions to address the backlog. The OIG did not make a recommendation because as of February 19, 2026, the backlog of incomplete community care consults older than 90 days had decreased to approximately 10,000.

[35] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

[36] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," last updated June 12, 2025.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[37]

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 veterans who received an HCHV program intake assessment.[38] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[39] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[40]

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

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

[39] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[40] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

Performance and Improvement Highlights

- The facility's program fell below the intake percentage (HCHV5) target in the first two quarters of FY 2025. The chief of social work and the program supervisor expressed concern that the targets reflected a higher number of veterans experiencing homelessness than the community data, which indicated a 25 percent decrease in the 2025 local point-in-time count (an annual estimate of the number of homeless Americans).[41]
- The VA Homeless Program Office exempted the facility from the percentage of veterans placed into permanent housing (HCHV1) measure in FY 2024 because it operates a medical respite program that provides short-term residential care and medical and supportive services for homeless veterans.[42] The HCHV coordinator said veterans in the program need extensive medical and mental health treatment, so staff often discharge them to other types of transitional housing rather than permanent housing.
- The facility's program did not keep negative exits (HCHV2) below the target for the first two quarters of FY 2025 but exceeded its FY 2024 performance. The coordinator attributed the improved performance to strong communication and coordination with medical respite program staff to reduce veterans' disruptive behaviors.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[43] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[44]

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

[41] "Point-In-Time (PIT) Count," VA Homeless Programs, last updated March 12, 2026, https://department.va.gov/point-in-time-count.

[42] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Health Care for Homeless Veterans (HCHV) Contracted Residential Services (CRS) Medical Respite Pilot (VIEWS 8548768)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), VISN Network Homeless Coordinators (10N1-23), Medical Center Directors (00), October 5, 2022.

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

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

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[45]

Performance and Improvement Highlights

- The facility program surpassed the voucher use (HMLS3) target for the first two quarters of FY 2025, improving on previous fiscal years. Facility program supervisors said staff helped veterans obtain documents, streamlined housing applications, and added project-based housing units, which decreased delays to permanent housing.[46] To keep veterans permanently housed, staff formed an after-care team that periodically contacted graduates of case management and offered support when needed.
- A supervisor said about half the program's veterans had complex medical needs requiring extra support. To meet those needs, the facility became the first in the state to use vouchers for assisted living.[47]
- Facility program staff exceeded the employment (VASH3) target for enrolled veterans for the first two quarters of FY 2025. A supervisor said they improved after hiring an additional staff member.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[48] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[49]

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

[46] Project-based housing assistance is tied to the unit and stays with the unit after the family moves out. VHA Directive 1162.05(2), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program*, June 29, 2017, amended June 24, 2024.

[47] "Long-Term Care Facilities: Assisted Living, Nursing Homes, and Other Residential Care," National Institute on Aging, accessed September 30, 2025, https://www.nia.nih.gov/health//long-term-care-facilities.

[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 enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

Performance and Improvement Highlights

- The facility's program met the enrollment (VJP1) target for the first two quarters of FY 2025. Facility program staff credited that performance to leaders hiring an additional staff member to conduct outreach, which freed others to focus on an initiative to train VA police officers to recognize mental health symptoms during crises.[50] Staff said this effort strengthened collaboration with VA police to assess treatment options as alternatives to arrest.
- The outreach specialist said that staff participated in nine treatment courts. They assessed veterans for mental health and substance use needs and referred them to housing and food resources.

Conclusion

To assist leaders in evaluating the quality of care at the San Diego facility, the OIG conducted an inspection across five domains. The OIG made four recommendations on issues related to equipment and oxygen storage, ice machines, and the facility's medical test results communication policy. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendations 1, 2, and 3. 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, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

[50] Legislative Analysis and Public Policy Association, *Model Law Enforcement and Other First Responder Deflection Act*, September 2021, https://legislativeanalysis.org/Model-Law-Enforcement-and-Other-First-Responder-Deflection-Act.pdf.

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[51] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

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.[52] 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.*[53]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[54] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The team inspected the facility from September 9 through 11, 2025. During site visits, the team

[51] Accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

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

[53] 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.

[54] 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.

refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[55] 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.

[55] 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: May 28, 2026

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

Subj: VA Office of Inspector General (OIG) Draft Report, Healthcare Facility Inspection of the VA San Diego Health Care System in California

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the OIG Draft Report-Healthcare Facility Inspection of the VA San Diego 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 San Diego Healthcare System.
3. Should you need further information, please contact the VISN 22 Quality Management Officer.

(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: May 14, 2026

From: Director, Department of Veterans Affairs (VA) San Diego Healthcare System (664)

Subj: VA OIG Draft Report—Healthcare Facility Inspection of the VA San Diego Health Care 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 San Diego Healthcare System. VA San Diego Healthcare System concurs with the recommendations and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality Management Service.

(Original signed by:)

Frank P. Pearson, DPT, PA-C
Director, VA San Diego Healthcare System

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Joseph Giries, MHA, Director Robert Ordonez, MPA, Project Leader Stephanie Stall, MSN, RN, Team Leader Shelia Farrington-Sherrod, MSN, RN Laura Harrington, DBA, MSN Laura Pond, MSW, LCSW
Other Contributors	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dan Zhang, MSC

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Office of Accountability and Whistleblower Protection
Office of Public and Intergovernmental Affairs
Office of General Counsel
Office of Congressional and Legislative Affairs
Director, VISN 22: VA Desert Pacific Healthcare Network
Director, VA San Diego Healthcare System (664)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Alex Padilla, Adam Schiff
US House of Representatives: Darrell Issa, Sara Jacobs, Mike Levin, Scott Peters, Raul Ruiz, Juan Vargas

OIG reports are available at www.vaoig.gov.

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